

THE INFLUENCE OF PEER EDUCATION ON THE LEVEL OF KNOWLEDGE
OF HIV/AIDS AMONGST GRADE TEN LEARNERS IN AN EASTERN CAPE
HIGH SCHOOL

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Assignment presented in partial fulfillment of the requirements for the degree of Master of
Philosophy (HIV/AIDS Management) at Stellenbosch University

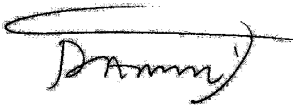


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December 2006

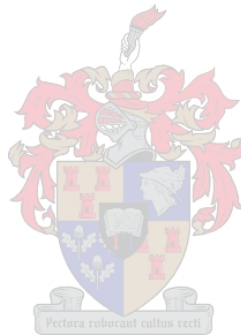
DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.



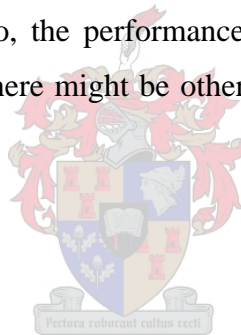
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ABSTRACT

A peer education programme was implemented during 2005 in high schools in the Mdantsane area in the Eastern Cape as a strategy to combat the spread of HIV/AIDS among school going learners. This research paper looks at whether the use of peer education as opposed to the traditional teacher method is effective in giving correct facts and whether or not it increases the level of knowledge of HIV/AIDS and related health issues. Data about the effectiveness of the programme was collected through questionnaires, using a two group between participant research design and a sample of 100 learners (i.e. 50 learners from each group). Two groups of participants, those taught by peer educators and those taught by teachers at Masixole High School were given questionnaires to answer and the responses were analysed using the SPSS (version 13) package. Results showed that the group that received peer education performed better than the one that did not receive peer education. A limitation of the study is the small sample size, which creates a problem when the results are generalized to a wider population. Also, the performance of the peer education group cannot be solely attributed to peer education, as there might be other extraneous variables, which might have contributed to the group's performance.



OPSOMMING

'n Portuurgroep-opleidingsprogram is in 2005 in hoërskole in die Mdantsane distrik van die Oos-Kaap ontwikkel om die verspreiding van MIV/VIGS onder leerders te bekamp. Die doel van hierdie navorsing is om vas te stel of portuurgroep-opleiding meer effektief is as die tradisionele onderwysmetode en of dit kennis rakende MIV/VIGS en ander gesondheidskwessies verbeter. Data is deur middel van vraelyste ingesamel. Daar was 100 leerders van Masixole Hoërskool wat aan die studie deelgeneem het. Die leerders is in 2 groepe verdeel, waar een groep portuurgroep-opleiding ontvang het en die ander inligting van onderwysers verkry het. Data is deur middel van SPSS (weergawe 13) verwerk en die resultate toon dat die groep wat die portuurgroep-opleiding ontvang het beter as die ander groep gevaar het. 'n Beperking van die studie is die klein populasie wat gebruik is, wat 'n probleem veroorsaak wanneer die resultate na 'n weier populasie veralgemeen word. 'n Ander punt is dat die sukses van die portuurgroep se opleiding nie noodwendig aan portuurgroep-opleiding toegeskryf kan word nie, eksterne veranderlikes kon ook 'n rol gespeel het.



ACKNOWLEDGEMENTS

I would like to thank Mthobeli Gaca, my husband for letting me use his computer and for his support, Stephen Kigundu for his IT skills and statistical analysis, Anda Kema for her technical support and Dr Anton Schlechter, my supervisor for his support and guidance towards the completion of this work.



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CHAPTER 1

Introduction

South Africa has a serious Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS) epidemic, with millions of its people living with the disease. At the current rate of infection, it is said that South African teenagers have a 50% chance of contracting HIV over the course of their lives, because they indulge in high-risk sex (loveLife national survey report 2003).

According to loveLife's report on South Africa's National HIV Prevention Program for Youth (2005) half of South Africa's new HIV infections occur before the age of 25.

The numbers of young people infected with HIV increase, as they get older. LoveLife (2003) confirms this by putting the prevalence rate for fifteen year olds at 2.3% for males and 4.1% for females and 31.2% for 21year old females and 5.8% for males of the same age. These statistics highlight the fact that high school learners fall into a particularly high risk group for HIV and AIDS infection.



1.1 Background

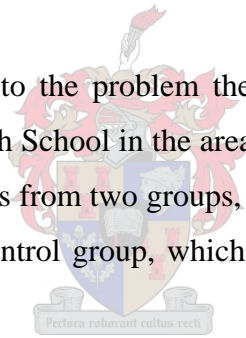
Peer education has been a staple of HIV prevention for the past decade. Designers of prevention projects assumed that one of the best ways to reach people with information about HIV/AIDS and to influence their behavior would be through their peers. Research also suggests that people are more likely to hear and personalize messages, and thus to change their behavior and attitude if they believe that the messenger is similar to them and faces the same concerns and pressures.

To respond to this the Eastern Cape Department of Education has introduced the use of peer education in some schools, as a tool to combat the spread of the virus and also to prevent new infections amongst high school learners. The project started in 2005. The Masixole High School was one of the schools that participated in the pilot project and was where the research took place. The study aimed to determine whether the use of peer education has an influence in providing learners with correct information about HIV/AIDS and other related health issues such as sexually transmitted infections.

Issues related to HIV/AIDS should be taught in schools because this is where young people are beginning to engage in activities such as sex and drugs that usually endanger their lifestyles. Levels of perceived vulnerability among this group are low and unprotected sex is common (Campbell and MacPhail 2003). This is also an age where most young people face tremendous pressure from their peers and the study aims to determine whether peer education can be part of the solution by giving learners the correct information and facts about HIV/AIDS so that they can make informed choices.

Schools in the disadvantaged areas, particularly in Mdantsane in the Eastern Cape where the research study is focused in, are faced with many challenges, for instance a high pregnancy rate amongst female learners. The question can thus be asked as to whether the use of peer education will increase their knowledge of HIV/AIDS so that they make informed decisions regarding their sexual lifestyles. The research study aims to establish to what extent does peer education (as opposed to teacher education) influence learners' knowledge about HIV/AIDS so that they are able to change their behaviors and make informed decisions as well.

In order to provide a possible answer to the problem the study made use of the peer education program that is running at Masixole High School in the area of Mdantsane in the Eastern Cape. Data was collected by means of questionnaires from two groups, the experimental group, which is the one that received peer education and the control group, which is the one that did not receive the peer education intervention.



1.2 Research Objectives

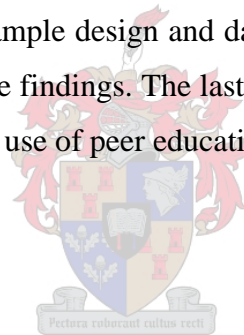
From the researcher's experience as a teacher in a high school, there has been and continue to be female learners, who are in their teenage years becoming pregnant. This sends a signal that despite having life skills education and awareness, which is predominantly conducted by educators; there still exists a huge problem that might lead to the spread of HIV/AIDS if other alternative and drastic measures are not taken.

The Eastern Cape Department of Education has introduced a peer education programme in some schools, which is facilitated by trained peer educators to inform, educate and empower the learners in HIV/AIDS and related issues.

The programme is run against the background that trained peer educators have accurate information to help their fellow young adults in dispelling myths they might have about HIV/AIDS and related topics, and also in making informed choices. Peer pressure is a strong influence in youth making unhealthy decisions. Strong pressure to become sexually active is part of being a teen, and with the accurate information, decision-making and prevention skills that are taught by peer educators, they have the ammunition to educate other youth on making healthy choices.

The objective of the study was to determine whether the use of peer education has an influence in increasing the level of knowledge of HIV/AIDS and thus to the ultimate reduction of HIV infection and transmission and also to the promotion of abstinence.

This mini-thesis is organized in five chapters. The first chapter is an introduction to peer education and it gives a background to the research problem and what drove the investigation. The second chapter discusses the literature review on peer education. Chapter three describes the research design and methodology including details of sample design and data collection method. The fourth chapter presents the results and discussion on the findings. The last chapter, which is chapter five, presents a conclusion and recommendations on the use of peer education in school communities.



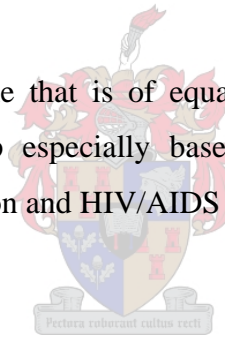
Chapter 2: The Literature Study

This chapter will review literature on the problem of HIV and AIDS amongst the youth and on the use of peer education and the success rate thereof both in South Africa and other countries as well. The discussion is limited to literature on the use of peer education in effecting a positive change amongst the youth, the benefits and advantages of peer education, the limitations or disadvantages and also discusses the lessons designed by Rutanang, a collaborative project of the South African Departments of Health, Education and Social Development. These lessons were administered to the pilot schools (schools where the peer education programme was implemented) in the Mdantsane area in the Eastern Cape.

2.1 Definition of concepts

2.1.1 Peer

The English term “peer” refers to “one that is of equal standing with one another; one that is belonging to the same societal group especially based on age, grade or status”. (Webster’s Dictionary 1985 quoted in Peer Education and HIV/AIDS 2004 Stellenbosch University).



2.1.2 Education

The term “education” (v. educate) refers to the “development,” “training” or persuasion of a given person or thing or the “knowledge” resulting from the educational process (Merriam Webster’s Dictionary, 1985 quoted in Peer Education and HIV/AIDS 2004 Stellenbosch University). McMillan & Schumacher (1993) maintain that educational practice centers on instruction and learning and includes practices that influence instruction, such as curriculum development, innovations, administration and policies. They maintain that education is an interdisciplinary field of inquiry that has borrowed concepts and theories from psychology, sociology, anthropology, political science, economics, and other disciplines. For the purpose of the study we limited education to refer to the training or persuasion of a given person or the knowledge resulting from the education process.

2.1.3 Peer education

Peer education involves the use of members of a given group to effect change among members of the same group. Peer education is often used to effect change at the individual level, attempting to modify a person's knowledge, attitudes, beliefs or behaviors. However, peer education may also effect change at the group or societal level by modifying norms and stimulating collective action that leads to changes in programs and policies.

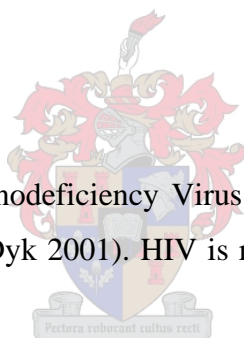
For the purpose of the research study the focus was on the influence peer education has in modifying knowledge of a group of Masixole High School learners in Mdantsane.

2.1.4 Level of knowledge

For the study, level of knowledge referred to how much accurate information do the learners have on HIV/AIDS and related information such as Sexually Transmitted Infections (STIs), condom use, and gender and HIV prevention.

2.1.5 HIV and AIDS

HIV- is an acronym for Human Immunodeficiency Virus. Viruses are kind of germs that require living cells in which to multiply (Van Dyk 2001). HIV is responsible for the global HIV pandemic raging today.



AIDS - Acquired Immune Deficiency Syndrome according to Van Dyk (2001) is a disease of the immune system. It is a collection of many different conditions that manifest in the body because HIV has so weakened the body's immune system that it can no longer fight the pathogen (disease causing agent) that invades the body.

2.1.6 The problem of HIV and AIDS.

HIV is rampant among young people in South Africa. According to loveLife (2003), at the current rate of infection, South African teenagers have a 50% chance of contracting HIV over the course of their lives. An annual survey conducted by the Department of Health (DOH) in South Africa on HIV prevalence trends in women attending antenatal clinics (1999-2002) found that HIV rates in teenagers have peaked. For example the prevalence rate in 1999 was 22.8%; in 2000 it was 24.5%

and in 2002 it was 26.5%. The survey has been able to give a good impression of how HIV prevalence has progressed in South Africa.

The UNAIDS (2006) report on the global AIDS epidemic points out that efforts to increase HIV knowledge among young people remain inadequate. According to the report, although the Declaration of Commitment on HIV/AIDS aimed for ninety percent of young people to be knowledgeable about HIV by 2005, surveys indicate that fewer than fifty percent of young people achieved comprehensive knowledge levels.

With the high prevalence of HIV in the 15-24 age groups, this has an impact on the education sector because this is predominantly school-going age group. The impact of HIV/AIDS on education systems is acute; substantial numbers of teachers are ill, dying or caring for family members. Young people, especially girls, are being withdrawn from school to assist in the caring of ill parents or siblings. The key challenge therefore is how to protect the education system from the ravages of the epidemic, and simultaneously adapt to the new needs that HIV/AIDS has created.

Education for prevention is the most effective tool currently available to halt the epidemic (UNAIDS 2001). Even if a cure is found, prevention will remain essential for protecting successive generations and those currently HIV free. Education also plays an important role in the fight against HIV/AIDS because it also addresses the underlying conditions that increase vulnerability, for example poverty, gender inequalities, and disregard of human rights.

2.2 Behavioral Theory and Peer Education

Peer education as a behavior change strategy is based on both individual cognitive as well as group empowerment and collective action theories. Deutsch and Swartz (2002) describe five theories underpinning peer education. For the purpose of the research study the researcher looked at the following theories:

Social Learning Theory asserts that people learn by observing the behavior of others and that some serve as models who are capable of eliciting behavior change in certain other individuals (Bandura 1986). Peer educators need to have credibility with others to be influential. In order to act as role models, according to this theory, peers would need to be able to observe peer role models practicing healthy behavior.

The Diffusion of Innovation Theory posits that certain individuals (opinion leaders) from a given population act as agents of behavior change by disseminating information and influencing norms in their community (Rogers 1983).

The Theory of Reasoned Action states that a person's perception of the social norms or beliefs that people important to them hold about a particular behavior can influence behavior change (Fishbein and Ajzen 1975). Deutsch and Swartz (2002) claim that as soon as people are made aware of their personal risk, and they accept that risk, they will go about acquiring specific skills to reduce that risk. There is therefore a continuum that leads from attitude change, to intention to reduce risk, to actual behavior change.

Peer education draws on elements of each of these theories in its assumption that certain members of a given group (peer educators) can be influential in eliciting individual behavior change among their peers.

The Theory of Participatory Education has also been important in the development of peer education (Freire 1970). "Participatory or empowerment models of education posit that powerlessness at the community or group level, and the economic and social conditions inherent to the lack of power are major risk factors for poor health" (Amaro 1995). Empowerment, according to Freire (1970), results through the full participation of the people affected; through such dialogue the affected community collectively plans and implements a response to the problem or health condition in question. Many advocates of peer education claim that this horizontal process of peers (equals) talking among themselves and determining a course of action is key to peer education's influence on behavior change.

2.3 Description of Peer Education intervention

Peer education has been a staple of HIV/AIDS prevention for the past decade. Designers of prevention projects assumed that one of the best ways to reach people with information about HIV/AIDS and to influence their behavior would be through their peers. Research also suggests that people are more likely to hear and personalize messages, and thus to change their attitudes and behaviors if they believe the messenger is similar to them and faces the same concerns and pressures.

Trained peers are a more credible source of information for some youth than are adult educators because they communicate in readily understandable ways and serve as positive role models while dispelling misperceptions that most youth have about sexual matters. A study comparing peer-led versus adult-led education programmes found that peer counselors produced greater attitude changes in teens' perception of personal risk of HIV infection (Rickert VI 1991). The same study indicated that adolescents who were counseled by peers were more likely to engage in interactive discussion following the education curriculum than those counseled by adult health care providers.

A study conducted by the AIDS Control and Prevention Project (AIDSCAP) (1996) on projects that use peer education found that peer educators in a number of countries are beginning to make this shift from raising awareness to supporting behavior change. The findings show that members of the target audience agreed unanimously that they were comfortable talking to peer educators about HIV and AIDS, and that talking to a peer educator was a good way to obtain HIV/AIDS information.

Although the use of peer education has its challenges, many countries and institutions of higher learning have used the programme with significant positive results. For example, an evaluated peer health education program in Cameroon showed increased use of modern contraceptive methods and increased condom use at most recent sex among participants versus comparison youth. The program was more effective among in than out of school youth (YouthNet Program 2002).

Evaluation of a sexual health peer education program in Peru found that, compared to controls, participating males had increased knowledge about pregnancy prevention and reported reduced incidence of sexual initiation and increased use of contraception at most recent sex. (YouthNet Program 2002).

A study by UNICEF in conjunction with the Namibian government (2002) came out with positive results. The study found that young Namibians who were reached by the programme delayed sexual intercourse longer, and when they became sexually active, more of them used condoms.

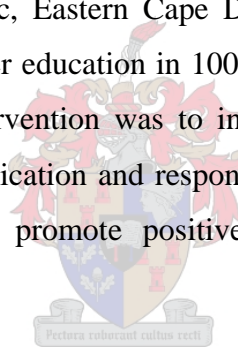
In South Africa, particularly in the Eastern Cape, institutions of higher learning like Border Technikon (now called Walter Sisulu University of Technology), have engaged in peer education although there is yet no report on the evaluation of the programme. The University of the Freestate has its own AIDS center that includes a peer education component.

2.4 Benefits of peer education

The benefits of peer education are widely recognized and can include positive changes in terms of knowledge, skills, attitudes and confidence. Boulton (1994) cites the following benefits of peer education as opposed to the conventional professional-led type:

- Efficacy: young people may be perceived as ready-made experts in communicating with other young people.
- Cost-effectiveness: peer education may be seen as a means whereby the effectiveness of a single trained educator may be multiplied
- Empowerment: it may be seen as right that young people should themselves control the process of education.

In response to the HIV/AIDS epidemic, Eastern Cape Department of Education embarked on a provincial programme to implement peer education in 1000 schools in the province (Department of Education 2005). The goal of the intervention was to increase knowledge and skills needed for healthy relationships, effective communication and responsible decision-making that would protect learners from HIV infection, and to promote positive attitudes towards people living with HIV/AIDS.



The study focused on the learners' level of knowledge of HIV/AIDS and the attitudes learners have on people living with the virus.

2.5. Background information on the Department of Education's peer education programme

The peer education programme is an initiative of the Eastern Cape Department of Education whose main objective is to combat the spread of HIV/AIDS among youth of school –going age. The theories that underpin the peer education programme are mainly the Social Learning Theory, the Theory of Reasoned Action and the Diffusion of Innovative Theory (see 2.2 above).

The programme was scheduled to run over a period of two years and it started from 2005 to 2006 (and is still running in some schools). The Department of Education has targeted 1000 schools to participate in the programme. Training started with the peer group trainers who then trained selected learners in piloted schools.

To implement the programme in schools the Department of Education contracted two service providers namely Youth for Christ and Planned Parenthood Association of South Africa to train the peer educators who in turn would train learners as peer educators in schools. These service providers made use of Rutanang Series (2002) to implement the programme. The Rutanang series is a collaborative project (they have published books) of the South African Departments of Health, Education and Social Development, the South African Vice Chancellors Association numerous South African NGOs and selected U.S. partners (Deutsch and Swartz 2002).

2.6 Content of the Rutanang peer education intervention

Two service providers, namely Youth for Christ and Planned Parenthood Association of South Africa were contracted by the Department of Education in the Eastern Cape to train the peer educators and to ensure the programme is implemented and supported in schools. These service providers made use of the Rutanang Series (2002): to develop guidelines for the content of the intervention. Ten lessons were provided because they take advantage of peer educator strengths as facilitators of small-group discussions; they emphasize and reinforce positive norms and behaviors whose prevalence young people often underestimate (Deutsch & Swartz 2002). The lessons together with their learning outcomes (Deutsch & Swartz 2002) are:

Lesson 1: Protection - How young people look after themselves and each other

The outcomes of this lesson were:

- Learners should be able to feel at ease with peer educators;
- Learners should be able to identify the kinds of protection they need as they are growing up
- Learners should be able to illustrate the ways in which people protect one another

From this lesson learners would learn skills such as decision-making, health advocacy and risk assessment.

Lesson 2: Influences - Making healthy choices and considering the things that influence us

The specific learning outcomes of this lesson were:

- Learners should be able to evaluate the various factors that influence them both negatively and positively and how these factors influence the decisions they make.
- Learners should be able to recall and state a basic decision making method.

- Learners should be able to consider how various factors influence decisions for example, values, alcohol, culture and goals.

Learners would learn skills such as assertiveness, critical thinking and decision-making from this lesson.

Lesson 3: Gender - Rediscovering gender respect for one another

The outcomes were:

Learners should be able to dispel the myths around gender roles.

Learners should be able to identify respect as the basis for relationships between genders.

Learners should be able to understand and therefore act against misusing power in gender relationships.

Learners should be able to seek help for any unacceptable behaviors.

Skills that learners would learn include critical thinking, decision-making and assertiveness.

Lesson 4: Respect - Putting the right foundation for relationships into place

The outcomes of the lesson:

- Learners should be able to describe why respect is important in relationships and what it looks like in relation to the other gender
- Learners should be able to list the actions and attitudes that show respect to the others who are different to them.
- Learners should be able to define Ubuntu and how they can show respect for others and for themselves.

From this lesson learners would acquire communication, health advocacy and self-assessment skills.

Lesson 5: Relationships - Skills for beginning, deepening and ending relationships

The specific learning outcomes of the lesson:

- Learners should be able to illustrate the factors that make a relationship work and what is acceptable and unacceptable behavior in a relationship.
- Learners should be able to provide tips to their friends on beginning, deepening and ending a relationship well.

- Learners should be able to discuss coping strategies for not being in a relationship and for developing friendships.

Skills that would be acquired include communication, decision-making, positive self talk and self-assessment.

Lesson 6: Pain - Dealing with problem of pain in our lives

Outcomes of the lesson:

- Learners should be able to discuss strategies to deal with pain.
- Learners should be able to display positive attitudes towards dealing with pain and helping others to deal with pain.
- Learners should be able to identify their own sources of pain and devise personal strategies to deal with it.

From this lesson learners would acquire communication, health advocacy, healthy self-management, positive self-talk and self-assessment skills.



Lesson 7: Getting involved - Practical advice to help people you care about

The outcomes of the lesson were:

- Learners should be able to describe strategies for helping friends even when help is not asked for.
- Learners should be able to display assertive (but not aggressive) ways in which to help friends.
- Learners should be able to articulate reasons for not being a bystander.
- This lesson would teach learners skills such as assertiveness, communication, health advocacy and risk assessment.

Lesson 8: Waiting for sex - Frank talk about virginity, waiting, delaying or not being sexually active at all

The following were the outcomes of the lesson:

- Learners should be able to evaluate the advantages of delaying sexual activity
- Learners should be able to demonstrate the skill of being able to say no to sex in an assertive but not aggressive manner.

- Learners should be able to talk about the maturity and responsibility needed to have sex and present counterarguments for being sexually active.

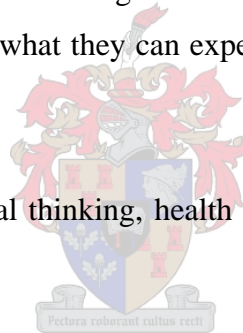
Learners would be taught skills such as assertiveness, critical thinking, risk assessment and self-assessment.

Lesson 9: You've got to know - Safer sex, treatment of Sexually Transmitted Infections (STIs) and getting tested for HIV/AIDS

The outcomes of the lesson:

- Learners should be able to describe the various methods for safer (or less risky) sexual intercourse.
- Learners should be able to recognize symptoms of sexually transmitted infections (STIs)
- Learners should be able to articulate the importance of knowing their HIV status, and acknowledge and address fears about being tested for HIV.
- Learners should be able to state what they can expect to happen at a visit to a clinic for STI treatment and HIV testing.

This would provide learners with critical thinking, health advocacy, healthy self-management, risk assessment and self-assessment skills.



Lesson 10: Emotional intelligence - Summarizing the mental health skill needed to live healthy lives.

The outcomes of the lesson were:

- Learners should be able to summarize the emotional intelligence skills they already had and those they needed to develop in the future in order to live happy healthy and productive lives.
- Learners should be able to articulate their own behavior expectations for the future.
- Learners should be able to identify the key skills and themes learnt over the past lessons.

From this lesson learners would apply the skills that they learned in previous lessons. These include assertiveness, communication, critical thinking, decision-making, health advocacy, healthy self-management, positive self-talk, risk assessment and self-assessment.

Chapter 3: Research design and methodology

3.1 Research problem

In order to organize the goals of the research study it is necessary to state the research problem. The research problem was initiated by the occurrence of teenage pregnancies and a high incidence of Sexually Transmitted Infections (STIs) of a high school where the researcher is working as a teacher. This suggests that the learners (both male and female) are engaging in high-risk behaviors such as unprotected sexual intercourse. Life Skills as a subject, has been taught by teachers in the past and despite that learners continue to engage in high-risk behaviors.

Review of current information suggests that learners are too afraid to ask sensitive questions and teachers are too ashamed to talk with their learners openly about sensitive matters (Youth Coalition 2004). With this background the Department of Education in the Eastern Cape introduced the peer education programme targeting 1000 schools. The researcher's school is one of those that have received the programme. The peer educators who were trained by the Department of Education in turn trained learners at the various schools. The scope of the training covered life skills, sexuality education, gender issues and leadership skills. Those learners who have been trained as peer educators would in turn share the knowledge and skills with others thus creating a ripple effect.

The research was carried out therefore to determine whether the use of peer education as opposed to teacher education would have an influence in the level of knowledge of learners about HIV/AIDS and related issues.

3.2 Research questions

The study aimed to find answers to these questions based on the peer education programme that is implemented at Masixole High School:

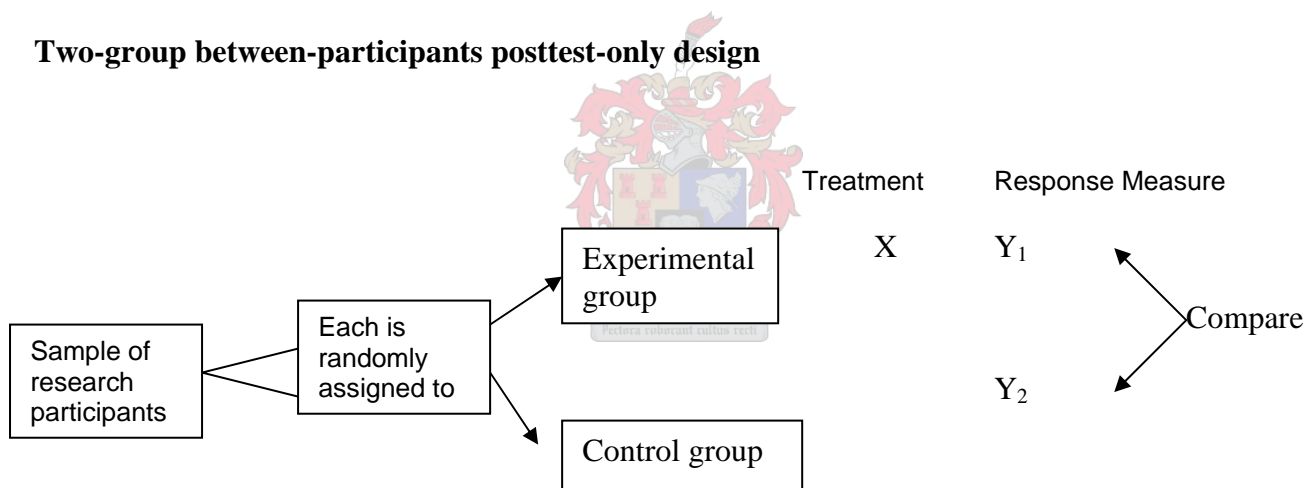
- Is there a difference in the knowledge level of HIV/AIDS as a result of peer education?
- Can peer education help in giving correct knowledge of HIV/AIDS amongst learners?
- Can peer groups have a significant impact on positive attitudes and behavior as a result of receiving peer education?
- Can peer education enable learners to know more about prevention and treatment of HIV/AIDS?

3.3 Research Design

The between- participants posttest only design was used for the research study. Christensen (2004) defines the posttest-only design as an experimental design in which the experimental and the control groups' posttest scores are compared to assess the influence of the treatment condition. The dependent variable, which is the level of knowledge of HIV/AIDS, is measured once and this measurement occurs after the experimental treatment condition, (which is peer education in this study), has been administered to the experimental group. In the between-participants posttest-only design the research participants are randomly assigned to the experimental and control group. Christensen (2004) maintains that the between-participants posttest-only design provides the necessary equivalence by randomly assigning participants to the two groups.

Figure 1

Two-group between-participants posttest-only design



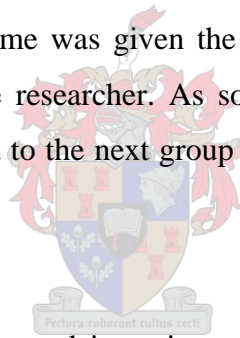
Source: Adapted from: Experimental Methodology by Christensen (2004)

This design was perceived as appropriate, as two groups, which were randomly chosen, participated in the study. A list of the experimental group (the learners in grade ten who have participated in the peer education programme), which is available at the school, was used to randomly choose those learners who were going to take part in the study. In selecting the research participants the researcher cut out the learners' names into pieces, folded them and put them in a box. Fifty learners were selected from the box and by using this method; each learner stood an equal chance of being selected. The same procedure and the same number of participants were used to select the control

group. The control group was identified as learners from the same grade as the experimental group but who did not participate in the peer education programme, which is the group that did not receive the treatment (peer education).

Randomization is said to be the most important and basic of all the control methods, which is designed to assure that extraneous variables, known or unknown, will not systematically bias the study results (Christensen 2004). Randomly selecting research participants from a population as Christensen (2004) states provides maximum assurance that a systematic bias does not exist in the selection process and that one has selected for the study a sample that is representative of the total population.

The researcher carried out the research on the same day for both groups but with a time difference of about 1 hour. The researcher conducted the research in the same environment, which was one of the learners' classrooms. One group at a time was given the questionnaires, which the learners were asked to answer in the presence of the researcher. As soon as the group finished answering the questionnaires, the researcher proceeded to the next group with similar questionnaires and the same procedure was followed.



The aim of doing this was to determine and investigate whether being taught by peer educators would have an influence in the level of knowledge of HIV/AIDS and related topics or whether there would be no difference when comparing the two groups.

3.4 Ethical issues

Ethical issues were observed by obtaining permission to carry out the research from the head and management staff of the school. Informed consent was also obtained from the participants and learners were told that they were not coerced into participating in the research; they were free to withdraw at any time if they so wish. The purpose of the study as well as the content of the questionnaire was fully explained prior to the research.

The principle of confidentiality was observed by assuring the participants that any information obtained from them will not be revealed to anyone outside the research group (Christensen 2004)

other than for reporting purposes of the research study. Anonymity was adhered to by keeping the identity of the participants unknown.

3.5 Population

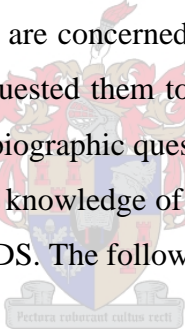
The population was all the learners of Masixole High School in Mdantsane in the Eastern Cape.

3.6 Sampling

The sample comprised of two groups of learners of Masixole. Fifty learners were randomly selected from the group that received peer education and another fifty from the group that did not receive peer education.

3.7 Questionnaire

The researcher made use of a questionnaire as a method of collecting data (see Appendix A). The research participants were not required to write their names on the questionnaire to allow for anonymity. As far as the ethical standards are concerned, the researcher first explained the purpose of the research to the participants and requested them to be as honest as possible in answering the questions. The questionnaire consisted of biographic questions such as gender, age and grade as well as scales assessing HIV/AIDS knowledge, knowledge of protective behavior and attitudes regarding HIV/AIDS and people living with HIV/AIDS. The following scales were included:



Scale 1: Knowledge of HIV/AIDS.

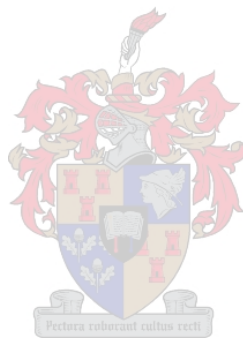
Fourteen knowledge questions from AVERT.ORG (2005) HIV/AIDS quiz package were included. Multiple-choice types of questions were used; and participants were given three possible answers from which they had to choose the correct one. True/False types of questions were used that assessed knowledge on the transmission of the HIV virus.

Scale 2: Knowledge about protective behavior

These questions were also obtained from AVERT ORG (2005) HIV/AIDS quiz package. The participants had to answer nine questions about protection from HIV/AIDS and STIs. The aim was to assess the participants' understanding and awareness of the means of protection from HIV infection.

Scale 3: Attitudes towards people living with HIV/AIDS

Five questions were used to assess participants' attitudes towards people living with HIV/AIDS. Questions relevant to the school and family situation were used. Open-ended types of questions were used where participants had to write down their opinions and reasoning behind the provided answers. The purpose of giving these types of questions was to assess participants' attitudes towards people living with HIV. This however was not done on a deeper level, as it did not constitute the main aim of the research.



Chapter 4: Results

The results of this research comprise the interpretation of the descriptive statistics for the questionnaire by comparing the two groups. The group that received peer education is referred to as group 1 and the one that did not receive peer education is referred to as group 2. The responses of the two groups are analysed using the SPSS (ver 13.0) package.

The questionnaire consisted of biographic questions such as age, gender as well as scales assessing HIV/AIDS knowledge, knowledge of transmission, protective behaviour and attitudes towards HIV/AIDS and related sexual matters. The main emphasis is on Section B of the questionnaire that deals with the knowledge of HIV/AIDS because it is the main objective of the research. Questions in this section have been categorized into general knowledge, transmission and prevention and treatment of HIV/AIDS. Please refer to appendix B for the tables for detailed information on the statistics.

4.1 Summary of biographic information



Table 4.1

Summary of Biographical Information for Group 1

GENDER	FREQUENCY	%	AGE	FREQUENCY	%
Males	22	44	16 yrs	14	28
Females	28	56	17 yrs	36	72
Total	50	100		50	100

Table 4.1 above shows the distribution of the participants in terms of age, gender and grade. For group 1 a total of 50 participants, which were randomly assigned so that every participant had an equal chance of being selected out of a pool of learners, took part in the research study 1. It is worth noting that in terms of gender this group was fairly represented, as gender inequality has been a problem in the management of HIV/AIDS. If males constituted 44% of the participants this might suggest that quite a significant number of male learners (who did not take part in the program) will benefit from the peer education program as a result of their colleagues taking part in the study.

Sharing of information even informally could be one of the ways in which they will acquire the knowledge. As far as age is concerned the distribution ranges from 16 years to 17 years.

Table 4.2

Summary of Biographical Information for Group 2

GENDER	FREQUENCY	%	AGE	FREQUENCY	%
Males	23	46	15 yrs	9	18
Females	27	54	16 yrs	17	34
			17 yrs	24	48
Total	50	100		50	100

Group 2 in Table 4.2 above shows that less than half of males (46%) participated in this group but the number is quite higher when compared to with group 1. The same argument as in the first group holds true, because inclusion of males in these programmes might address issues of gender roles and gender inequalities. The ages of participants in this group are slightly lower than in group 1 with participants as young as 15 years participating in the study.

The grade of the participants is not shown here since all the participants are in grade 10.

4.2 Summary of correct responses given by the two groups.

Table 4.3

Summary of correct responses given by group 1 and group 2.

No	Questions	Group 1		Group 2	
		Frequency	%	Frequency	%
1	Is HIV a virus, bacterium or a fungus?	50	100	49	98
2	HIV attacks which body system?	38	76	43	86
3	In which fluid is HIV not present?	34	68	18	36
4	How can you become infected with HIV	24	48	26	52
5	How many people worldwide are newly infected with HIV everyday?	28	56	28	56
6	What is the difference between HIV and AIDS?	39	78	34	68
7	How can you tell if somebody has HIV?	27	54	17	34
8	Can HIV be passed by sharing needles used for injecting drugs?	41	82	44	88

9	HIV can be passed to people by mosquitoes?	34	68	35	70
10	Only men who have sex with another man can get HIV	32	64	28	56
11	A person can pass HIV on to others only when they have obvious signs of the infections that can occur when the immune system is weakened	23	46	24	48
12	It is safe to have sex just once without a condom	47	94	45	90
13	All people who have aids have the same symptoms	34	68	30	60
14	HIV can be transmitted from a pregnant mother to an unborn baby	45	90	45	90
15	Using protection such as Latex barrier when performing sex (vaginal, oral, anal) lowers the risk of HIV transmission.	21	42	32	64
16	New drugs are now available that can cure HIV/AIDS.	37	74	19	38
17	Women will not get HIV if they use birth control pills and/or a diaphragm.	30	60	32	64
18	Not having sex is a good way to prevent.	47	94	37	74
19	The best way to prevent getting HIV during sex is to wash carefully after having sex	35	70	36	72
20	Safe sex is only having sex with someone you love	36	72	31	62
21	One size condom fits all	12	24	18	36
22	Condoms can be used more than once if they are washed	40	80	43	86
23	Condoms provide total protection from all sexually transmitted diseases	34	68	34	68



4.3 Section B General knowledge of HIV/AIDS

Q 1 - Is HIV a virus, bacterium or a fungus

Group 1 performed better (100%) than group 2 in this question (98%). Although the performance of both groups can be said to be excellent in this question it is worth noting that there are learners (2%) who do not know that HIV is a virus. This suggests that there could be other learners albeit a small percentage, in the same predicament so assuming that all learners know these basic facts could be misleading.

Q 2 - HIV attacks and weakens which body system?

Group 2 scored better in this question (86%) as opposed to its counterpart (76%). The fact that there are learners who do not understand the basic facts about the virus suggests that education about the virus has not reached the whole target school population and therefore more education is needed on the basic facts of the virus and how it works.

Q 3 - In which fluid is HIV not present?

Only 36% of the participants in group 2 achieved the correct answer in this question while 68% in group 1 got the correct answer. It seems that as the questions begin to probe deeper about HIV the number of participants who seem to have an understanding become less. This might suggest a bigger challenge lays ahead in informing and educating learners in schools about HIV/AIDS.

Q 4 - How can you become infected with HIV?

In group 1 only 48% whilst in group 2 52% of the participants achieved the correct answer in this question. This may seem a rather easy question but it is surprising to note that almost half of the participants in each group could not provide a correct answer to this question.

Q 5 - How many people worldwide are newly infected with HIV and AIDS?

Both groups performed equally with 56% of the participants in this question giving the correct answer.

Q 6 - What is the difference between HIV and AIDS?

Table 4.3 shows that 78% of the participants in group 1 as compared to 68% in group 2 gave the correct answer. The responses of the groups in this question are surprising as it would be easily assumed that a grade ten learner would know the difference between HIV and AIDS.

Q 7 - How can you tell if somebody has HIV?

Group 1 performed better in this question than group 2, with 54% of participants giving the correct answer than 34% in group 2. The average performance of the groups can be said to be lower (44%) than average.

Questions 1-7 were aimed at testing the general knowledge of the participants in as far as what is and how the virus works. It can be said that group 1 performed better (68.6%) than group 2 (61.4%) in this part of the section and the difference is significant.

4.4 Transmission of HIV

Questions 8-14 constitute questions on the transmission of HIV. The objective of giving these questions was to assess how much the participants know about how the virus is transmitted. The questions were presented in a True/False type format.

Q 8 - HIV can be passed by sharing needles used for injecting drugs

82% of participants in group 1 provided the correct answer to this question whilst the other group performed better (88%).

Q 9 - HIV can be passed to people by mosquitoes.

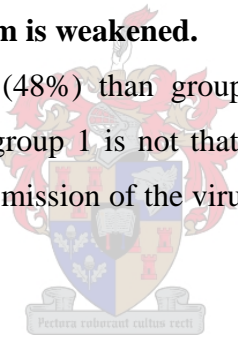
Again in this question group 2 performed better than group 1 70% of participants in group 2 got this question right whilst 68% of participants in group 1 responded correctly.

Q 10 - Only men who have sex with other men can get HIV

64% of participants in group 1 got this question correctly whilst 56% in group 2 got the right answer to the question.

Q 11 - A person can pass HIV on to others only when they have obvious signs of the infections that can occur when the immune system is weakened.

Group 2 fared better in this question (48%) than group 1 (46%). It is worth noting that the performance of both groups especially group 1 is not that good. It is to be expected that group 1 would have basic knowledge on the transmission of the virus as it was exposed to the peer education programme.



Q 12 - It is safe to have sex just once without a condom

94% of participants in group 1 got the correct answer as opposed to 90% in group 2. This might indicate some degree of understanding of the use of a condom.

Q13 - All people who have AIDS have the same symptoms

Participants in group 1 (68%) performed better than their counterpart (60%).

Q14 - HIV can be transmitted from a pregnant mother to an unborn baby

As shown in table 4.3 above, participants in both groups fared equally (90%) and this shows a relatively high level of understanding of one of the modes of HIV transmission.

4.5 Prevention and treatment

Questions 15-23 were on prevention and treatment of HIV/AIDS. The objective of using these questions was to determine the level of understanding of the participants in as far as prevention and treatment is concerned.

Q 15 - Using protection such as latex barrier when performing sex (vaginal, oral, and anal) lowers the risk of HIV transmission.

Only 42% of the participants in group 1 achieved the correct answer whilst group 2 participants performed better (64%). The researcher assumes that there might have been a problem in the understanding of the language. The word latex barrier might have been substituted with a commonly used word (condom).

Q 16 - New drugs are now available that can cure HIV/AIDS

74% of participants in group 1 elicited correct responses than those in group 2 (38%). This shows a significant difference in the performance of the two groups and might suggest that there is little understanding of availability of drugs that can cure HIV/AIDS.

Q17 - Women will not get HIV if they use birth control pills and/or a diaphragm.

Participants in group 2 performed better (64%) than in group 1 (60%). The difference is not significant in this question although the average performance of both groups can be said to be just above average.

Q18 - Not having sex is a good way to prevent HIV

94% of participants gave the correct answer as compared to 74% in group 2. This might raise some questions as to what do young people think is the best way of preventing HIV as it could be expected that all the participants would concur with this statement.

Q19 - The best way to prevent getting HIV during sex is to wash carefully after having sex.

70% of participants in group 1 gave the correct answer whilst more (72%) in group 2 got the question right. It is surprising to note that the group that received peer education performed poorly when compared to their counterparts. This might suggest that there are learners who still hold the myths about HIV and thus more education is needed.

Q20 - Safe sex is only having sex with someone you love

72% of participants in group 1 and only 62% in group 2 gave the correct response to this question. This suggests that there are quite a few learners (28% in group1) and (38% in group2) who still think that this is true. This could pose a problem of neglecting the use of condoms for prevention if young people do not understand fully the meaning of safe sex.

Q21 - One size condom fits all

A small percentage of learners in both groups gave the correct answer (24% for group1 and 36% for group 2).

Q22 - Condoms can be used more than once if they are washed.

The performance of group 2 in this question was better (86%) than of their counterpart (80%). This response is rather surprising given that group1 participated in the programme.

Q23 - Condoms provide total protection from all sexually transmitted diseases

Both groups performed equally (68%) in this question. This might suggest that the participants are on the same level of understanding in as far as condom use and protection is concerned.

The performance of group 1 in this section is again better when compared to that of group2, although there were surprising responses in some questions, (e.g. Q22) where the group showed low levels of understanding

4.6 Attitudes towards HIV and AIDS

This section of the questionnaire aimed to assess the participants' attitudes towards HIV/AIDS, and sexual relations. As mentioned earlier, the researcher will not dwell not much on the findings of this section, as they do not form the basis of the research. Discussion will focus only on observed trends in each question.

Table 4.4**Attitudes towards HIV and AIDS - Group 1**

No	Questions	SD	D	A	SA
24	It is okay for a girlfriend to suggest condom use			26%	72%
25	A girl should leave her boyfriend if he hits her	14%	18%	26%	40%
26	It is okay for a boyfriend to force his girlfriend to have sex	66%	22%	6%	4%
27	A man feels proud if he has multiple partners	14%	46%	34%	2%
28	I must have sex to keep my boyfriend/girlfriend	38%	38%	16%	4%
29	HIV/AIDS is the disease of promiscuous people	34%	22%	30%	10%

SD= Strongly Disagree; D= Disagree; A= Agree; SA= Strongly Agree.

Table 4.5**Attitudes towards HIV and AIDS - Group 2**

No	Questions	SD	D	A	SA
24	It is okay for a girlfriend to suggest condom use	10%	10%	24%	56%
25	A girl should leave her boyfriend if he hits her	10%	18%	50%	22%
26	It is okay for a boyfriend to force his girlfriend to have sex	60%	30%	4%	6%
27	A man feels proud if he has multiple partners	18%	42%	22%	16%
28	I must have sex to keep my boyfriend/girlfriend	46%	16%	2%	8%
29	HIV/AIDS is the disease of promiscuous people	19%	32%	12%	8%

SD= Strongly Disagree; D= Disagree; A= Agree; SA= Strongly Agree.

In their response to whether it is okay for a girlfriend to suggest condom use all the participants in group 1 agreed (26%) and some strongly agreed (72%) to the statement whereas in group 2 a mixture of responses is observed. Only 56% of the participants in group 2 strongly agreed and 24% agree. The fact that some participants agree to the statement shows an understanding that negotiating safe sex does not rely only on males. The minority (20%) who do not agree with this statement suggest the opposite and this could make females more vulnerable to HIV transmission if they cannot negotiate safe sex.

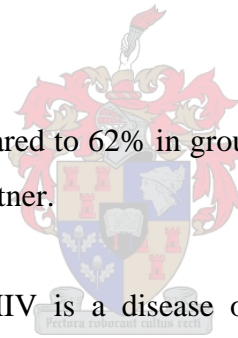
A variety of responses in both groups were given to the statement that a girl should leave her boyfriend if he hits her. But a larger percentage (68% in group 1) and (72% in group 2) show agreement with this statement. It is surprising to note that there are learners who would stay in an abusive relationship at their young age.

Comparison of the responses of the two groups in question 26 shows that a large percentage in both groups strongly disagree/disagree with the fact that it is okay for a boyfriend to force his girlfriend to have sex with him. This might suggest some degree of assertiveness on some learners, especially female learners.

Responding to the statement that a man feels proud when he has multiple sexual partners, 60% of participants in both groups disagree. It is worth noting that there are still some learners who agree with this despite the fact that having multiple sexual partners drives the HIV pandemic. This might indicate that education and awareness campaigns on HIV/AIDS, relationships, and sexually transmitted diseases are still needed.

76% of participants in group 1 as compared to 62% in group 2 strongly/ disagree with the statement that one must have sex to keep one's partner.

The last statement, which says that HIV is a disease of promiscuous people elicited different responses, with 56% of participants in group 1 and 51% in group 2 disagreeing with this.



Chapter 5

5.1 Discussion

This study aimed at determining whether peer education can give correct factual knowledge to a group of learners as opposed to a group of learners that did not receive peer education.

In the groups as a whole learners' knowledge about HIV/AIDS, transmission and prevention and treatment ($p < 0.082$) was insignificant considering the fact that a significant value is $p < 0.05$ or $p < 0.01$. This implies that although group 1 displayed a better performance than group 2 the difference in the level of knowledge is not much. In all the three subsections of the questionnaire's section B the performance of group 1 compared to that of group 2 was slightly better. These subsections assessed the groups on the general knowledge of HIV/AIDS, transmission and prevention and treatment of HIV/AIDS. Because no control was built in for extraneous factors, it cannot be concluded that the better performance of group 1 was due only to peer education. The insignificant difference might imply that group 2 was not a control group after all; the group might have been exposed to some level of AIDS awareness.

The mean scores for group 1 was (15.52) and for group 2 (14.34). This shows that group 1 performed better than group 2 as the mean is a measure of the average performance of the group of numbers. It is noted here that the difference in the mean is slight, (1.18) implying that although group 1's performance is slightly better than that of its counterpart, the difference is not significant.

The t-value obtained was -1.75 which is very small. Since the t-test helps in comparing the difference between the group means, it therefore means that the difference is so small that there are no significant differences in the performance of the two groups. The responses of the two groups were similar in most instances.

If the results show that group 1's performance is not much better than group 2's it then cannot be said that peer education can be used as one of the strategies to combat the spread of HIV in schools. The results have raised more questions than providing answers regarding the use of peer education in schools. More research on a wider scale needs to be conducted on the benefits of using peer education to combat the spread of HIV/AIDS.

The small sample size and exposure to AIDS awareness could be other extraneous variables that could have influenced the performance of the control group making the group not a control group after all.

Regarding the questions that were formulated in the study, the group that received peer education has shown a better level of understanding in the facts about HIV/AIDS, transmission and prevention and treatment of the epidemic when compared to the group that did not receive peer education. The difference though is not significant.

On attitudes about HIV/AIDS the study aimed to find out whether peer education fostered positive attitudes regarding sexual behavior and lifestyles, and towards HIV/AIDS. Results show that the two groups differ in their opinions and hence their attitudes towards sexual behavior and HIV/AIDS. The opinions vary from those that agree that it is okay to have sex to keep a boyfriend or a girlfriend (10% in both groups) to those who think that AIDS is a disease of promiscuous people (42% agree in group 1 compared to 70% in group 2). Some participants did not agree with the statement that you should leave your boyfriend if he hits you (34% in group 1 and 32% in group 2). This might imply that some learners are prepared to subject themselves to abuse even at their young age.

Some of the responses given especially by group 1 (for example 32 % of participants in group 1 do not agree that a girl should leave her boyfriend if he hits her) were not expected of the group considering the fact that they were trained in lessons that teach them how to be assertive, how to respect their bodies and how to wait for sex.

5.2 Limitations of the study

The study was limited to one school out of four high schools in the area where the peer education programme was implemented by the Department of Education. Therefore the internal validity of the results cannot be confirmed. Internal validity of the results refers to the extent to which we can accurately infer that the independent variable (peer education in this study) caused the effect observed on the dependent variable, that is, knowledge level (Christensen 2004).

There could also be other extraneous variables that influenced the knowledge level of HIV/AIDS such as exposure to television and information from the school or nurses that come to school and conduct awareness campaigns on HIV/AIDS.

The sample size was small considering the fact that other neighboring schools took part in the programme. Extending the evaluation to larger groups might give more comprehensible picture on the influence of peer education to the knowledge level of HIV/AIDS. This would help in drawing a conclusion that could be generalized to a wider population.

5.3 Conclusion and Recommendations

From this study it was found that whilst the group that received peer education performed slightly better than the one that was not taught by peer educators, the knowledge of many learners was not correct. There were a number of questions from Section B that were not correctly answered from both groups.

Questions that required general understanding of HIV/AIDS, the transmission of the virus and also prevention and treatment were not answered as could be expected because these form the basis of the understanding of the virus and any further intervention would move from these assumptions. But it was clear from the results that education on the virus and how it works on humans still needs to be carried out.

This study has probably raised more questions than it has provided answers. For example it would be expected that a grade 10 learner would have the basic knowledge about HIV, how it is transmitted and ways to prevent its spread, since this forms part of the curriculum in Life Orientation. The key ingredient to managing the disease successfully is current and accurate information (Mandela 2002 cited in HSRC Study of HIV/AIDS). There is thus a need to carry out more extensive research on this topic.

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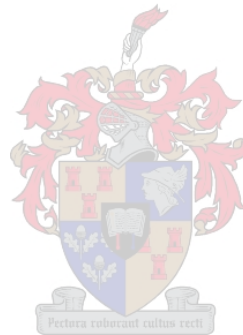
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Appendix A- Questionnaire

Please answer the questions as honestly as possible. Give full answers where possible.
Put a tick in the appropriate block.

SECTION A: DEMOGRAPHIC INFORMATION

1. In which grade are you?

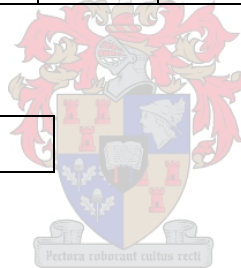
Grade 9		Grade 10	
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2. How old are you?

13		14		15		16		17 and above	
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3. Are you

Male		Female	
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SECTION B:-GENERAL KNOWLEDGE OF HIV/AIDS

1) HIV is a

- a) Virus
- b) Bacterium
- c) Fungus

2) HIV attacks and weakens which body system?

- a) The digestive system
- b) The immune system
- c) The circulatory system

- 3) HIV is not present in
- a) Semen and vaginal secretion
 - b) Sweat
 - c) Blood
- 4) You can become infected with HIV by
- a) Sharing utensils with or drinking from the same cup as someone with HIV
 - b) Mosquito bites
 - c) None of the above
- 5) How many people worldwide are newly infected with HIV each day?
- a) Fewer than expected
 - b) More than 5000
 - c) More than 15000
- 6) What is the difference between HIV and AIDS?
- a) HIV causes AIDS
 - b) There is no difference between HIV and AIDS
 - c) There is no cure for AIDS but there is cure for HIV
- 7) How can you tell if somebody has HIV?
- a) Because of the way they act
 - b) There is no way to tell
 - c) They look tired and ill



Transmission of HIV virus

8) **True or False:** HIV can be passed by sharing needles used for injecting drugs.

- a) True
- b) False

9) **True or False:** HIV can be passed to people by mosquitoes

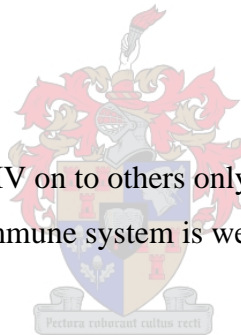
- a) True
- b) False

10) **True or False:** Only men who have sex with other men can get HIV

- a) True
- b) False

11) **True or False:** A person can pass HIV on to others only when she or he has obvious signs of the infections that can occur when the immune system is weakened

- a) True
- b) False



12) **True or False:** It is safe to have sex just once without a condom

- a) True
- b) False

13) **True or False:** All people who have AIDS have the same symptoms

- a) True
- b) False

14) **True or False:** HIV can be transmitted from a pregnant mother to an unborn baby

- a) True
- b) False

Prevention and Treatment

15) **True or False:** Using protection such as latex barrier when performing sex (vaginal, oral anal) lowers the risk of HIV transmission

- a) True
- b) False

16) **True or False:** New drugs are now available that can cure HIV/AIDS

- a) True
- b) False

17) **True or False:** Women will not get HIV if they use birth control pills and/or a diaphragm

- a) True
- b) False



18) **True or False:** Not having sex is a good way to prevent HIV

- a) True
- b) False

19) **True or False:** The best way to prevent getting HIV during sex is to wash carefully after having sex

- a) True
- b) False

20) True or False: Safe sex is only having sex with someone you love

- a) True
- b) False

21) True or False: One size condom fits all

- a) True
- b) False

22) True or False: Condom can be used more than once if they are washed

- a) True
- b) False

23) True or False: Condoms provide total protection from all sexually transmitted infections

- a) True
- b) False



Attitudes

Please answer this section by putting a “X” under the appropriate column.

		Strongly agree	Agree	Disagree	Strongly disagree
24)	It is okay for a girlfriend to suggest condom use				
25)	A girl should leave her boyfriend if he hits her				
26)	It is okay for a boyfriend to force his girlfriend to have sex				
27)	A man feels proud if he has multiple partners				
28)	I must have sex to keep my boyfriend/girlfriend				
29)	HIV/AIDS is the disease of promiscuous people				

Thank you for the time you spent answering this questionnaire

Appendix B - Tables

The questionnaire was divided into three scales, namely: demographic knowledge, HIV/AIDS knowledge and attitudes towards HIV/AIDS and related sexual matters. The main emphasis is on Section B of the questionnaire that deals with the knowledge of HIV/AIDS because it is the main objective of the research. Questions in this section have been categorized into general knowledge, transmission and prevention and treatment of HIV/AIDS.

Table 1

Group 1 - Gender

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid f	22	44.0	44.0	44.0
m	28	56.0	56.0	100.0
Total	50	100.0	100.0	



Group 2 - Gender

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
F	26	52.0	52.0	54.0
M	23	46.0	46.0	100.0
Total	50	100.0	100.0	

Table 2 indicates the gender of the participants in both groups. Females constituted 44% and males 56% in group 1, and group 2 females constituted 52% whilst males formed 46%. It must be noted here that each participant had an equal chance of being selected since random sampling was used. Since there are both genders the sample can be said to be representative of the population in terms of gender.

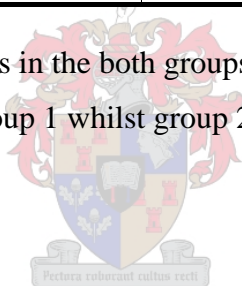
Table 2**Group 1 - Age**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 16	14	28.0	28.0	28.0
17	36	72.0	72.0	100.0
Total	50	100.0	100.0	

Group 2 – Age

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 14	2	4.0	4.0	4.0
15	7	14.0	14.0	18.0
16	17	34.0	34.0	52.0
17	24	48.0	48.0	100.0
Total	50	100.0	100.0	

Table 2 shows the ages of the participants in the both groups. The ages of the participants range from 16 years (28%) to 17 years (72%).for group 1 whilst group 2 the ages of the participants started from 14 (4%) to 17(48%).

**Table 3****Q1: is HIV a virus, bacterium or a fungus?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	50	100.0	100.0	100.0

Q1 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	49	98.0	98.0	98.0
b	1	2.0	2.0	100.0
Total	50	100.0	100.0	

All participants answered this question correctly in group 1(100%) whereas in group 2 98% gave the correct answer.

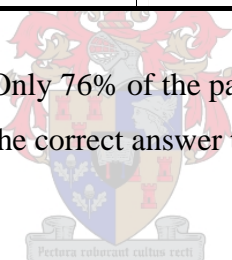
Table 4**Q2: HIV attacks and weakens which body system?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
a	8	16.0	16.0	18.0
b	38	76.0	76.0	94.0
c	3	6.0	6.0	100.0
Total	50	100.0	100.0	

Q2 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
a	6	12.0	12.0	14.0
b	43	86.0	86.0	100.0
Total	50	100.0	100.0	

The correct answer to this question is b. Only 76% of the participants achieved the correct answer in the first group whilst group 2 86% gave the correct answer to this question.

**Table 5****Q3: In which fluid is HIV not present?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
a	11	22.0	22.0	24.0
b	34	68.0	68.0	92.0
c	4	8.0	8.0	100.0
Total	50	100.0	100.0	

Q3 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	4.0	4.0	4.0
a	11	22.0	22.0	26.0
b	18	36.0	36.0	62.0
c	19	38.0	38.0	100.0
Total	50	100.0	100.0	

The correct answer to this question is b and 68% of the participants in group 1 elicited correct response whilst only 36% in group 2 gave the correct answer.

Table 6

Q4: How can you become infected with HIV?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	4.0	4.0	4.0
a	3	6.0	6.0	10.0
b	21	42.0	42.0	52.0
c	24	48.0	48.0	100.0
Total	50	100.0	100.0	



Q4 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	11	22.0	22.0	22.0
b	13	26.0	26.0	48.0
c	26	52.0	52.0	100.0
Total	50	100.0	100.0	

Table 6 shows that only 48% of the participants in group 1 got the correct answer, which is c, whilst group 2 52% of the participants got the question right.

Table 7**Q5: How many people worldwide are newly infected with HIV everyday?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	13	26.0	26.0	26.0
b	9	18.0	18.0	44.0
c	28	56.0	56.0	100.0
Total	50	100.0	100.0	

Q5 – Group2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	18	36.0	36.0	36.0
b	4	8.0	8.0	44.0
c	28	56.0	56.0	100.0
Total	50	100.0	100.0	

Just over half (56%) of the participants in both groups achieved the correct answer to this question, which is c.

**Table 8****Q6: What is the difference between HIV and AIDS?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	1	2.0	2.0	2.0
b	39	78.0	78.0	80.0
c	4	8.0	8.0	88.0
c	6	12.0	12.0	100.0
Total	50	100.0	100.0	

Q6 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	34	68.0	68.0	68.0
b	13	26.0	26.0	94.0
c	3	6.0	6.0	100.0
Total	50	100.0	100.0	

The correct answer to this question is a, and 78% in group 1 got it right compared to 68% in group 2.

Table 9

Q7: How can you tell if somebody has HIV?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
a	9	18.0	18.0	20.0
b	27	54.0	54.0	74.0
c	13	26.0	26.0	100.0
Total	50	100.0	100.0	

Q7 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	8	16.0	16.0	16.0
b	17	34.0	34.0	50.0
c	25	50.0	50.0	100.0
Total	50	100.0	100.0	

The correct answer to this question is b and only 54% of the participants achieved it. Group 2 performed even worse with only 34% getting the correct answer.

Table 10**Q8: T or F: HIV can be passed by sharing needles used for injecting drugs.**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
a	41	82.0	82.0	84.0
b	8	16.0	16.0	100.0
Total	50	100.0	100.0	

Q8 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	44	88.0	88.0	88.0
b	6	12.0	12.0	100.0
Total	50	100.0	100.0	

The correct answer to this question is a, and 82% got it right from group 1 whilst group 2 outperformed the first group. 88% of participants in the second group got the correct answer.

Table 11**Q9: T or F: HIV can be passed to people by mosquitoes.**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
a	15	30.0	30.0	32.0
b	34	68.0	68.0	100.0
Total	50	100.0	100.0	

Q9 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
a	14	28.0	28.0	30.0
b	35	70.0	70.0	100.0
Total	50	100.0	100.0	

Table 11 shows that 68% of the participants gave the correct answer, which is b, compared to 70% in group 2.

Table 12

Q10: T or F: Only men who have sex with other men can get HIV

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	18	36.0	36.0	36.0
b	32	64.0	64.0	100.0
Total	50	100.0	100.0	

Q10 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	22	44.0	44.0	44.0
b	28	56.0	56.0	100.0
Total	50	100.0	100.0	

64% gave the correct answer, which is b, in group 1 whilst only 56% in group 2 gave the correct answer.



Table 13

Q11: T or F: A person can pass HIV on to others only when they have obvious signs of the infections that can occur when the immune system is weakened.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	27	54.0	54.0	54.0
b	23	46.0	46.0	100.0
Total	50	100.0	100.0	

Q11 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	26	52.0	52.0	52.0
b	24	48.0	48.0	100.0
Total	50	100.0	100.0	

Results show that only 46% of the participants achieved the correct answer, which is b, compared to 48% in group 2.

Table 14.

Q12: Group 1. T or F: It is safe to have sex just once without a condom.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	3	6.0	6.0	6.0
b	47	94.0	94.0	100.0
Total	50	100.0	100.0	

Q12 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid A	5	10.0	10.0	10.0
B	45	90.0	90.0	100.0
Total	50	100.0	100.0	

The correct answer to this question is b, and 94% got it right whilst in group 2 90% of participants achieved the correct answer.

Table 15

Q13 T or F: All people who have AIDS have the same symptoms.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	16	32.0	32.0	32.0
b	34	68.0	68.0	100.0
Total	50	100.0	100.0	

Q13 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	20	40.0	40.0	40.0
b	30	60.0	60.0	100.0
Total	50	100.0	100.0	

68% of the participants gave the correct answer, b whilst only 60% in group 2.

Table 16

Q14: T or F: HIV can be transmitted from a pregnant mother to an unborn baby.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	45	90.0	90.0	90.0
b	5	10.0	10.0	100.0
Total	50	100.0	100.0	

Q14 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	45	90.0	90.0	90.0
b	5	10.0	10.0	100.0
Total	50	100.0	100.0	

Table 16 shows the responses to the above question. 90% of the participants in both groups gave the correct answer (a).

Table 17

Q15: T or F: Using protection such as latex barrier when performing sex (vaginal, oral, anal) lowers the risk of HIV transmission.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
a	21	42.0	42.0	44.0
b	28	56.0	56.0	100.0
Total	50	100.0	100.0	

Q15 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	32	64.0	64.0	64.0
b	18	36.0	36.0	100.0
Total	50	100.0	100.0	

Less than half of the participants gave the correct answer (a) in group 1 (42%) compared to 64% in group 2.

Table 18.

Q16: T or F: New drugs are now available that can cure HIV/AIDS.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	13	26.0	26.0	26.0
b	37	74.0	74.0	100.0
Total	50	100.0	100.0	

Q16 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	19	38.0	38.0	38.0
b	31	62.0	62.0	100.0
Total	50	100.0	100.0	

The correct answer to this question is b and it appears that 74% of the participants know that compared to 62% in group 2.

Table 19

Q17: T or F: Women will not get HIV if they use birth control pills and/or a diaphragm.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	4.0	4.0	4.0
a	18	36.0	36.0	40.0
b	30	60.0	60.0	100.0
Total	50	100.0	100.0	

Q17 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	18	36.0	36.0	36.0
b	32	64.0	64.0	100.0
Total	50	100.0	100.0	

This table shows that only 60% of the participants gave the correct answer to this question, which is b, compared to 64% in group 2.

Table 20

Q18: T or F: Not having sex is a good way to prevent HIV

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
a	47	94.0	94.0	96.0
b	2	4.0	4.0	100.0
Total	50	100.0	100.0	

Q18 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	37	74.0	74.0	74.0
b	13	26.0	26.0	100.0
Total	50	100.0	100.0	

A large percentage (94%) of participants gave the correct answer to this question, which is a, whilst 74% of participants in group 2 gave the correct answer.

Table 21

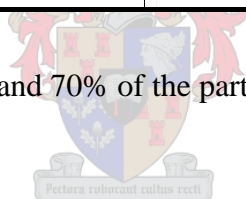
Q19: T or F: The best way to prevent getting HIV during sex is to wash carefully after having sex.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
a	14	28.0	28.0	30.0
b	35	70.0	70.0	100.0
Total	50	100.0	100.0	

Q19 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
a	13	26.0	26.0	28.0
b	36	72.0	72.0	100.0
Total	50	100.0	100.0	

The correct answer to this question is b, and 70% of the participants got it right in group 1 compared to 72% in group 2.

**Table 22**

Q20: T or F; Safe sex is only having sex with someone you love.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	14	28.0	28.0	28.0
b	36	72.0	72.0	100.0
Total	50	100.0	100.0	

Q20 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	19	38.0	38.0	38.0
b	31	62.0	62.0	100.0
Total	50	100.0	100.0	

Table 22 shows the responses to the above question and it seems that 72% of the participants in group 1 achieved the correct answer, which is b, compared to 62% of their counterparts.

Table 23

Q21: T or F: One size condom fits all

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
a	37	74.0	74.0	76.0
b	12	24.0	24.0	100.0
Total	50	100.0	100.0	

Q21 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
a	31	62.0	62.0	64.0
b	18	36.0	36.0	100.0
Total	50	100.0	100.0	

The correct answer to this question is b and it is surprising that only 24% of the participants got it right in group 1 compared to 36% in group 2.

Table 24

Q22: T or F: Condoms can be used more than once if they are washed.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	10	20.0	20.0	20.0
b	40	80.0	80.0	100.0
Total	50	100.0	100.0	

Q22 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	7	14.0	14.0	14.0
b	43	86.0	86.0	100.0
Total	50	100.0	100.0	

80 % of the participants gave the correct answer to this question, which is b in the first group compared to 86% in group2.

Table 25

Q23: T or F: Condoms provide total protection from all sexually transmitted diseases.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	34	68.0	68.0	68.0
b	16	32.0	32.0	100.0
Total	50	100.0	100.0	



Q23 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid a	34	68.0	68.0	68.0
b	16	32.0	32.0	100.0
Total	50	100.0	100.0	

Both groups fared equally in this question (68%) of the participants gave the correct answer.

Table 26

Q24: It is okay for a girlfriend to suggest condom use.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
A	13	26.0	26.0	28.0
SA	36	72.0	72.0	100.0
Total	50	100.0	100.0	

Q24 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid A	12	24.0	24.0	24.0
D	5	10.0	10.0	34.0
SA	28	56.0	56.0	90.0
Sd	1	2.0	2.0	92.0
SD	4	8.0	8.0	100.0
Total	50	100.0	100.0	

Group 1 participants show that they concur with this statement, none in the group disagree whilst in group 2 there seem to be some who do not agree with this (10%).

Table 28

Q25: A girl should leave her boyfriend if he hits her.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
A	13	26.0	26.0	28.0
D	9	18.0	18.0	46.0
SA	20	40.0	40.0	86.0
SD	7	14.0	14.0	100.0
Total	50	100.0	100.0	

Q25 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid A	25	50.0	50.0	50.0
D	9	18.0	18.0	68.0
SA	11	22.0	22.0	90.0
SD	5	10.0	10.0	100.0
Total	50	100.0	100.0	

Both groups elicited different views on this statement. A total of 66% in group 1 agree whilst the number is slightly more in group 2 (68%).

Table 29**Q26: It is okay for a boyfriend to force his girlfriend to have sex.**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
A	3	6.0	6.0	8.0
D	11	22.0	22.0	30.0
SA	2	4.0	4.0	34.0
SD	33	66.0	66.0	100.0
Total	50	100.0	100.0	

Q26 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid A	2	4.0	4.0	4.0
D	15	30.0	30.0	34.0
SA	3	6.0	6.0	40.0
SD	30	60.0	60.0	100.0
Total	50	100.0	100.0	

Only a total of 10% of participants in both groups agree to this statement.

Table 30**Q27: A man feels proud if he has multiple partners.**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
A	17	34.0	34.0	36.0
D	23	46.0	46.0	82.0
S	1	2.0	2.0	84.0
SA	1	2.0	2.0	86.0
SD	7	14.0	14.0	100.0
Total	50	100.0	100.0	

Q27 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
A	11	22.0	22.0	24.0
D	21	42.0	42.0	66.0
SA	8	16.0	16.0	82.0
SD	9	18.0	18.0	100.0
Total	50	100.0	100.0	

36% of participants in group1 agree whilst a total of 38% in group 2 concur to this statement.

Table 31

Q28: I must have sex to keep my boyfriend/girlfriend.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	4.0	4.0	4.0
A	8	16.0	16.0	20.0
D	19	38.0	38.0	58.0
S.D	1	2.0	2.0	60.0
SA	2	4.0	4.0	64.0
SD	18	36.0	36.0	100.0
Total	50	100.0	100.0	

Q28 – Group 2



	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
A	8	16.0	16.0	18.0
D	13	26.0	26.0	44.0
SA	4	8.0	8.0	52.0
Sd	1	2.0	2.0	54.0
SD	23	46.0	46.0	100.0
Total	50	100.0	100.0	

In group 1 the table shows that 20% agree, whilst a total of 74% do not agree. Group 2 on the other hand shows that a total of 84% disagree and 24% agree.

Table 32

Q29: HIV/AIDS is a disease for promiscuous people.

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
A	15	30.0	30.0	32.0
D	11	22.0	22.0	54.0
S	1	2.0	2.0	56.0
SA	5	10.0	10.0	66.0
SD	17	34.0	34.0	100.0
Total	50	100.0	100.0	

Q29 – Group 2

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2.0	2.0	2.0
A	6	12.0	12.0	14.0
D	16	32.0	32.0	46.0
SA	8	16.0	16.0	62.0
SD	19	38.0	38.0	100.0
Total	50	100.0	100.0	

The table shows that a total of 42% agree with the statement, whilst in group 2 only 28% agree. The percentage of those who disagree in group 1 is 56% compared to 70% in group 2.