

**The Knowledge, Attitudes and Practices (KAP) regarding  
HIV/AIDS of high school learners in the Cape Flats area**

**Rasheed Dien**

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



Study leader: Prof JB du Toit

April 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.

Signature:

Date: 3/3/2016

## SUMMARY

The youth of the Cape Flats may still have a distorted perception of HIV/AIDS. This is indicated by the findings of research conducted at five high schools in the Cape Town area. The study groups were selected from five different areas in the city to represent different sectors in the society.

The findings of this research project that emerged from the knowledge, attitudes and practices (KAP) test revealed that, while the high school learners might be exposed to a substantial amount of information on HIV/AIDS, this does not mean that they fully understand the basics about the disease. It is not clear just how much information the learners are exposed to, yet there is enough evidence to suggest that some learners are exposed to more than others.

The research was aimed at finding out if there were differences in knowledge, attitudes and practices on the basis of social, religious and economic diversity. Factors like language and religion were also considered, especially in relation to the groups' responses to HIV/AIDS.

Judging from the prejudiced responses of some of the respondents, it is clear that more intervention and awareness programmes are needed, especially in informal settlements. These programmes would have to cater for high school learners between the ages of 14 and 19. This group of respondent falls into the segment (ages 15-49) that is most at risk of being infected by HIV/AIDS.

One of the most telling findings of this study is the difference in attitudes towards the disease and people living with HIV/AIDS on the basis of religion. Of the respondents, 60.4% were Christians, 37.2% were Muslims and the remaining were members of other religions. The research seems to suggest that most of the stigma that is attached to HIV/AIDS can still be attributed to differences in religious norms and beliefs. Muslim respondents from Islamia College showed

the most reluctance in interacting and communicating with people infected with HIV/AIDS. This suggests that the stigma attached to the disease could be attributed to limited access to information and awareness programmes.

While some respondents seem to know more about the disease than others, there seems to be some misunderstanding about the transmission of the disease.

The respondents' knowledge about the disease also seems to be influenced by language. Xhosa and Afrikaans speakers were found to be marginalised, as most of the information on HIV/AIDS in the media is in English. There is a clear need for information and programmes in other languages in order to reach the youth in their homes and schools. The misconceptions of and poor knowledge on all aspects of HIV/AIDS that are prevalent in most of the respondents have to be addressed through effective awareness programmes to prevent the spread of HIV/AIDS. Indeed, it would be most effective if these programmes could be taken to the homes of the respondents. In this way, younger learners would also benefit from the programmes.

## OPSOMMING

Die jeug op die Kaapse Vlakte het heel moontlik nog 'n verdraaide persepsie van MIV/Vigs. Dit word onderskryf deur navorsing wat in vyf hoërskole in die Kaapstad omgewing gedoen is. Die groepe wat bestudeer is, was afkomstig van vyf verskillende areas in die stad wat verskillende sektore van die gemeenskap verteenwoordig.

Die bevindinge van hierdie navorsingsprojek wat ook 'n "knowledge, attitudes and practices (KAP)" toets behels het, het bewys dat leerders blootgestel word aan 'n wye spektrum van inligting, maar dat dit nie beteken dat hulle ten volle bewus is van hoe die virus werk nie. Daar is nie genoegsame bewys van hoeveel kennis die leerders oor beskik nie, maar aanduidings is dat sommige leerders meer blootgestel word aan inligting as ander.

Die navorsing wou vasstel of daar verskille in kennis, houdings en praktyke is op grond van sosiale, godsdienstige en ekonomiese diversiteit. Faktore soos taal en geloof is in ag geneem, veral met betrekking tot die respons van die groepe tot MIV/Vigs.

Dit het aan die lig gekom dat meer ingrypings- en bewusmakingsprogramme benodig word, veral in informele gebiede. Hierdie programme moet vir die behoeftes van leerders tussen die ouderdomme van 14 en 19 voorsiening maak. Hierdie leerders val in die hoë-risiko kategorie, d.w.s die kategorie tussen die ouderdom van 15-49 wat 'n hoër waarskynlikheid het om deur die virus besmet te word.

Een van die sprekende bevindings was die verskil in houdings teenoor die virus op grond van die respondente se geloof. 'n Totaal van 60.4% van die leerders was Christene, 32.2% was Moslems en die res was van ander geloofsgroepe. Die navorsing het bevind dat die stigma teenoor die virus toegeskryf kan word

aan geloofsnorme en dit waarin mense glo. Moslemleerders van 'n Islamitiese kollege het baie min vrywilligheid getoon om met leerders te kommunikeer wat MIV positief is. Dit bewys weereens die stigma teenoor die virus wat die gevolg kan wees van beperkte toegang tot inligtings- en bewusmakingsprogramme.

Terwyl sommige leerders meer weet as ander, is daar 'n algemene wanpersepsie oor hoe die virus oorgedra word.

Die leerders se kennis oor die virus word ook deur taal beïnvloed. Xhosa- en Afrikaans sprekers word gemarginaliseer, omdat die meeste inligting in die media oor MIV/Vigs in Engels aangebied word. In die lig hiervan is dit belangrik dat programme in verskillende tale aangebied moet word om die jeug in hulle huise en skole te bereik. Wanpersepsies en swak kennis in verband met alle aspekte van die virus kom baie algemeen voor. Hierdie probleem moet aangespreek word deur programme wat daarop gerig is om die verspreiding van die virus te voorkom. Hierdie programme moet na die huise geneem word, waar dit suksesvol kan wees. Op hierdie manier kan jonger leerders ook aan die inligting blootgestel word en sodoende kan die wanpersepsies op 'n baie jong ouderdom aangespreek word.

**TABLE OF CONTENTS**

1.	BACKGROUND .....	1
2.	INTRODUCTION .....	2
3.	PURPOSE OF THE RESEARCH .....	3
4.	AIM AND OBJECTIVES .....	4
4.1	Aim .....	4
4.2	Objectives .....	4
4.2.1	Knowledge objectives .....	4
4.2.2	Attitude objectives.....	4
4.2.3	Practice objectives.....	4
5.	METHODOLOGY .....	4
5.1	Methods employed .....	5
5.2	Definition of terms.....	5
6.	FINDINGS.....	7
6.1	Demographic data .....	7
6.2	Knowledge about HIV/AIDS.....	9
6.3	Knowledge and school.....	10
6.4	Correlation between level of knowledge about HIV/AIDS and gender.....	11
6.5	The influence of religion.....	12
6.5	Link between knowledge about HIV/AIDS and home language.....	12
6.7	Attitudes and perceptions .....	13
7.	DISCUSSION .....	17
8.	CONCLUDING REMARKS .....	20
9.	BIBLIOGRAPHY .....	22
	ANNEXURE A .....	25

## 1. BACKGROUND

The following report is based on a study of learners in high schools where intervention programmes relating to HIV/AIDS have not taken place. The aims and objectives of the study were to determine the knowledge, attitudes and practices (KAP) amongst high school children in some areas of the Western Cape. It also determined their knowledge regarding the prevalence of HIV/AIDS and their knowledge of methods of protection, as well as assessed their understanding of modes of transmission and highlighted trends in this understanding.

A further focus was the assessment of high school learners' attitudes towards people with HIV/AIDS to ascertain what information about HIV/AIDS they receive within their families and within the community, and to determine whether they attend any awareness campaigns.

The schools were selected in areas that display a wide range of socio-economic backgrounds: Khayelitsha, Manenberg, Lansdowne, Athlone and Grassy Park. High school learners who attend the schools in these areas hail from diverse backgrounds – from urban to rural areas, informal settlements and sub-economic areas to medium and upper-class areas.

The intervention programme was a verbal interview guided strictly by a pre-written questionnaire completed by a member of the interview team as part of the survey. Due to time constraints and the fairly large number of schools in the Western Cape, the stratified sampling method was applied. Schools were stratified according to socio-economic gradients. The required sample for this study was 100 pupils from grade 8 to 12 in each socio-economic area. This selection was done proportionately within each grade, which means that about 20 pupils were selected from each grade.



## 2. INTRODUCTION

About a decade ago, South Africa was lagging behind some of its neighbours in the incidence of HIV/AIDS. With at least 1 500 new infections per day by 1998, the country has one of the highest and fastest growing infection rates on the continent (Department of Health, 1998).

Sufficient public knowledge about AIDS and HIV prevention measures is an essential requirement for any society trying to limit the spread of HIV. Although accurate information may not in itself be sufficient to entrench safe sexual behaviour, it is necessary as a bare minimum. People will not begin to think of protecting themselves (and their partners) until they have grasped the essential facts about the nature of AIDS, how it is spread, and how one can try to avoid infection. In South Africa, as elsewhere, interventions attempting to curb the spread of HIV have generally aimed at imparting knowledge about AIDS and promoting condom use. AIDS education programmes have targeted younger people in particular.

There is good reason to focus on the youth. Youth under the age of 20 have the fastest increasing rate of HIV infection in the country; for example, among women attending antenatal clinics, the seropositivity rate increased from 12.7% in 1997 to 21.0% in 1998 (Department of Health, 1998). However, this group may be the most amenable to behavioural change, given that their sexual behaviour patterns are not yet entrenched. Many researchers have investigated the level of AIDS-related knowledge of young people in South Africa in an attempt to establish baseline levels of knowledge and to document associations between knowledge, attitudes and behaviour. These studies have used a wide range of methods and samples. Their varied results have not generated any consensus on the level of knowledge prevalent amongst the youth. To date there have been no comprehensive reviews of this research literature in South Africa.

School-based sex education programmes have been heralded as one of the most important interventions for young people. Of the South African adolescent population, 97% of those aged 10-14 years and 83% of those aged 15-19 years attend school (National Institute for Economic Policy, 1995). It is thus an important setting for adolescent and youth development. School is where many young people spend a substantial part of their time, and where they learn, love, work and play.

Evaluation is an integral part of school-based AIDS interventions. Evaluations are important to highlight whether the programmes are appropriate and acceptable, and whether they are achieving their objective and reducing the magnitude of the problem. For adolescents and the youth, who are at a critical phase of life, effective programmes should aim to shape the development of sexual behaviour, practices and attitudes, and to promote health.

Although knowledge, attitudes and practices (KAP) studies relating to HIV/AIDS have been undertaken amongst schoolchildren in some areas of the Western Cape, this study focuses on schools where intervention programmes have not taken place. A questionnaire was administered to learners to ascertain their KAP, after which an intervention programme focusing on HIV/AIDS awareness was conducted.

### **3. PURPOSE OF THE RESEARCH**

The purpose of this research was to gather detailed information on the HIV/AIDS knowledge, attitudes and practices of groups of high school learners studying at schools on the Cape Flats. This study will add to a growing body of South African HIV/AIDS research and may contribute to further studies targeting this age group.

## **4. AIM AND OBJECTIVES**

### **4.1 Aim**

The aim of this study was to determine the knowledge, attitudes and practices (KAP) regarding HIV/AIDS among high school learners in the Cape Flats area.

### **4.2 Objectives**

#### **4.2.1 Knowledge objectives**

- To determine their knowledge regarding the prevalence of HIV/AIDS.
- To determine their knowledge of methods of protection against HIV/AIDS.
- To assess their understanding of and highlight trends regarding modes of transmission.

#### **4.2.2 Attitude objectives**

- To assess their attitudes towards people with HIV/AIDS.
- To investigate their opinions regarding HIV in the religious context.

#### **4.2.3 Practice objectives**

- To assess what information about HIV/AIDS they receive within their families and within the community.
- To determine whether they attend any awareness campaigns.

## **5. METHODOLOGY**

This section aims to present the methods employed during this research study. To ensure clarity I have included a list of terms with definitions applicable to this study.

## 5.1 Methods employed

Five schools in the Cape Town area representing different socio-economic groups were contacted about participating in the study. The heads of the schools put me in contact with a teacher who was given responsibility for administering the questionnaires in the classroom situation. The teacher ensured that the questionnaires were completed, after which they were returned to me.

## 5.2 Definition of terms

**EPIDEMIOLOGY:** The investigation and control of the distribution and determinants of disease.

**KAP:** Knowledge, attitudes and practices.

**ATTITUDE:** A set way of thinking or feeling about a topic or person, typically reflected in practices.

**PREVALENCE:** The predominance of certain beliefs or attitudes regarding HIV at the time the study was performed. This is measured as a percentage of the population.

**VARIABLE:** A factor or characteristics of the respondent that may influence beliefs and attitudes as well as knowledge of the study.

**CROSS-SECTIONAL STUDY:** An epidemiological study design where data is collected at one point in time.

**DESCRIPTIVE STUDY:** A survey attempting to describe the current state of affairs regarding the study topic. It also identifies and subsequently quantifies the extent of a problem.

**POPULATION:** The total number of people living in a demarcated geographical area.

**SAMPLE:** A subset of the population selected to participate in the research study.

**MEASUREMENT INSTRUMENTS:** The research tools for data collection. For our study we have used a verbal interview guided by a pre-written questionnaire.

**RESPONDENT:** The person answering the questions in the interview; in this case, the high school learners.

**INTERVIEWER:** The researcher who poses the questions to the respondent during the interview.

**RELIABILITY:** The extent to which similar information is obtained when the measurement is repeated, or when there are different interviewers using the same questionnaire. This attempts to evaluate consistency and reproducibility.

**VALIDITY:** The extent to which the measurement measures what it is intended to measure. This improves the accuracy and relevance of the research study.

**QUALITATIVE METHODS:** Investigating in-depth information relating to people's attitudes, opinions, perceptions and motivations.

**QUANTITATIVE METHODS:** Measures the breadth of a problem's existence. This is representative and quantifiable data, e.g. knowledge regarding HIV.

## 6. FINDINGS

### 6.1 Demographic data

On the basis of the study, an indication was obtained about the level of knowledge that the students have about HIV transmission and prevention and about their personal attitudes towards HIV/AIDS. The demographic data of the respondents are presented in Table 1, after which each demographic is discussed.

**TABLE 1: Demographic data of participants in the study**

1. Age distribution	13-15 years = 41.60% 16-18 years = 34.40% 19-21 years = 10.60%
2. Gender	Female = 54.00% Male = 46.00%
3. Religion	Christians = 60.40% Muslims = 37.20% Other = 2.40%
4. Language	English = 48.80% Afrikaans = 21.60% Xhosa = 21.20% Bilingual = 8.40%
5. Siblings	Yes, the majority of respondents have siblings (76.4%) attending school.
6. Own house	85% of the respondents live in houses that are owned. 14% come from families that either rent or do not own a house.

#### The age distribution of the respondents in this study

According to the Department of Education (2003), most learners attending high school in grades 8 to 12 are 15-19 years old. The result for this sample show that 34.40% of respondents are between the ages of 16-18 and 10.60% are over the age of 19. The majority of the respondents (41.60%) attending high schools on

the Cape Flats currently are between 13 and 15 years old. This gives us an average age of 16.1 for learners in grades 8 to 12, with a standard deviation of 1.8.

### **Gender spread of respondents**

According to the Department of Statistics (2001), the gender spread in Western Cape schools for grades 8 to 12 (secondary school) is 53.14% female and 46.86% males. The results of this study show that 54% of high school learners are female and 46% are male. There is thus no significant difference between the data of the Department of Statistics and the results obtained in this study.

### **Religious denominations of respondents**

A total of 60.40% of the respondents claimed Christianity as their faith, Muslims accounted for 37.20% and the other religious groups made up 2.4%. This religious spread is not reflective of the wider community in Cape Town. The vast majority of learners attending Islamia College are Muslim as it is a Muslim school. Islamia College is one of the five schools in the sample, thus the distribution of Muslim students is increased disproportionately by the inclusion of an all-Muslim school.

According to the Department of Statistics, the South African census in 2001 showed that Christians account for 75.46% of the population, with believers in Islam accounting for 0.006%.

### **Language**

Almost half (48.8%) of all respondents noted that they spoke English at home, with 21.6% choosing Afrikaans and 21.2% choosing Xhosa as their home language. A small percentage of respondents (8.4%) identified themselves as bilingual speakers – that they speak both Afrikaans and English at home. This category has been included (as opposed to quantifying the speakers as both English and Afrikaans) because it is a unique category, which is self-designated.

According to the Department of Statistics, South Africa Census 2001, the spread of languages in the Western Cape is Afrikaans (41.8%), English (23.8%) and Xhosa (13.6%).

The difference between the results and the data from the Department of Statistics could be because Islamia, Windsor and Grassy Park High are all schools that have English as first language, whereas Phoenix High is only Afrikaans speaking and the learners at Bulumko Secondary High School have Xhosa as their first language.

### **Percentage of respondents with school-going siblings**

The results indicate clearly that the majority of the respondents have siblings (76.4%) attending school. This means that intervention programmes aimed at their schools would necessarily target one or more siblings in a family, increasing the likelihood that the intervention would have a ripple effect into the family.

### **Percentage of respondents whose parents own or rent the house**

The results show that 85.60% of the respondents have parents who own their house, while 14.4% either rent or do not own a house. The accuracy of the high percentage of owned houses is questionable because a large number of the respondents live in informal housing in the townships.

## **6.2 Knowledge about HIV/AIDS**

Table 2 provides details about the knowledge of the respondents regarding HIV/AIDS.



**TABLE 2: Knowledge about HIV/AIDS**

Score category	8	9	10	11	12	Total
Low Score = 0	21 42%	28 56%	24 48%	18 36%	9 18%	100 40.00
High Score = 1	29 58%	22 44%	26 52%	32 64%	41 82%	150 60.00
Total	50 100.0	50 100.00	50 100.00	50 100.00	50 100.00	250.00 100.00

The total score is out of 19. A score greater than 15 has been categorised as 1 (high score), while a score below 15 is categorised as 0 (low score)

There were 19 questions in this section. Respondents who answered more than 15 questions correctly were categorised as high score, while those answering less than or equal to 15 correctly were categorised as low score.

The results of the knowledge-based score of the respondents are given in percentage per grade (in low and high scores). The results show a direct correlation between the respondents' grades and their HIV/AIDS knowledge base. The lower the grade, the lower the knowledge base of the respondent, i.e. the lower grade has the lowest score. Low scores for grade 8 is 42%, for grade 9 is 56%, for grade 10 is 48%, grade 11 is 36% and grade 12 is 18%.

### 6.3 Knowledge and school

The relationship between the level of knowledge of the respondents and the schools they attend is illustrated in Table 3.

**TABLE 3: Knowledge and school**

Score category	B.SSS	GP.SSS	ISLAMIA	P.SSS	W.SSS	TOTAL
Low Score = 0	18 36.00	21 42.00	29 58.00	27 54.00	5 10.00	100 40.00
High Score = 1	32 64.00	29 58.00	21 42.00	23 46.00	45 90.00	150 60.00
TOTAL	50 100.00	50 100.00	50 100.00	50 100.00	50 100.00	250 100.00

In the table above, the low and high score percentage of the knowledge base is illustrated per school. The results show that Islamia High School and Phoenix High School have the lowest scores, while Windsor High School has the highest score, at more than 90%. The difference between the scores in Islamia, Phoenix (lowest score) and Windsor (highest score) as reflected in the above table could possibly be partly the result of part-time sustained awareness programmes, e.g. at religious institutions.

#### 6.4 Correlation between level of knowledge about HIV/AIDS and gender

The correlation between gender and the level of knowledge about HIV/AIDS is illustrated in Table 4.

**TABLE 4: Level of knowledge about HIV/AIDS and gender**

Level of knowledge	Female	Male	Total
Score low = 0	53 39.26	47 40.87	100 40.00
Score high = 1	82 60.74	68 59.13	150 60.00
Total	135 100.00	115 100.00	250 100.00

Chi-squared test,  $P = 0.796$

The results indicate that there is no significant association between the level of knowledge about HIV/AIDS and gender. All five schools are coeducational, and the awareness campaigns or lack thereof would affect both genders equally. However, as other studies show, women and girls are more susceptible to the effects of HIV/AIDS.

### 6.5 The influence of religion

The possible role played by religion in terms of knowledge about HIV/AIDS in the low and high score groupings is illustrated in Table 5.

**TABLE 5: Religion in terms of knowledge about HIV/AIDS in low and high scores**

Level of knowledge	Christian	Muslim	Total
Low Score = 0	57 37.75	43 46.24	100 40.98
High Score = 1	94 62.25	50 53.76	144 59.02
Total	151 100.00	93 100.00	244 100.00

Chi-squared test,  $P = 0.190$

There seems to be no significant association between knowledge and religious groupings. As the table shows, Christians had a high score of 62.25 and the Muslims a high score of 53.76. The knowledge base of those respondents in the "other" category was not considered because of the low percentage of respondents in this group.

### 6.6 Link between knowledge about HIV/AIDS and home language

The link between knowledge about HIV/AIDS and home language is shown in Table 6.

**TABLE 6: Knowledge about HIV/AIDS and home language**

Score category	Afrikaans	English	Bilingual	Xhosa	Total
Low Score = 0	30 55.56	41 33.61	11 52.38	18 33.96	100 40.00
High Score = 1	24 44.44	81 66.39	10 47.62	35 66.04	150 60.00
Total	54 100.00	122 100.00	21 100.00	53 100.00	250 100.00

English- and Afrikaans-speaking pupils have the highest knowledge base on HIV/AIDS, at 66%, whereas the bilingual respondents have a high score of 47.62%. The results show clearly that the Afrikaans speakers have the lowest knowledge base. According to the Department of Education (2003), the main languages in the Western Cape are Afrikaans (41.8%), English (23.8%) and Xhosa (13.6%).

There is a difference between the results of this study and official statistics, because each sample was chosen according to an area, and the different areas are representative of different language groups. For example, Phoenix High School is for Afrikaans-speaking learners, Bulumko High School is for Xhosa-speaking learners; while Grassy Park High School represents both English and Afrikaans speakers, and Islamia College and Windsor High School represent English speakers.

## 6.7 Attitudes and perceptions

Table 7 below provides a summary of the attitudes and perceptions of the respondents regarding HIV/AIDS. The various points are discussed after the table.

**TABLE 7: Attitudes towards HIV/AIDS**

	<b>B.SSS.</b>	<b>GP.SSS.</b>	<b>ISLAMIA</b>	<b>P.SSS.</b>	<b>W.SSS.</b>
1. Percentage of respondents willing to speak to HIV/AIDS-positive people	84%	78%	52%	64%	80%
2. Percentage of respondents willing to hug HIV/AIDS-positive people	84%	74%	38%	68%	66%
3. Percentage of respondents willing to kiss HIV/AIDS-positive people	58%	52%	14%	44%	44%
4. Percentage of respondents who avoid speaking to HIV/AIDS-positive people	16%	22%	48%	36%	20%
5. Percentage of respondents who expect HIV/AIDS-positive people to leave their company	72%	66%	52%	58%	76%
6. Percentage of respondents who avoid physical contact with HIV/AIDS-positive people	66%	60%	38%	48%	50%
7. Percentage of respondents who would consider not changing their jobs	66%	76%	58%	58%	62%
8. Percentage of respondents who would visit HIV/AIDS-positive people	66%	66%	26%	58%	52%
9. Percentage of respondents who would allow their children to play with the children of HIV/AIDS-positive people.	50%	54%	18%	40%	34%
10. Percentage of respondents who would allows HIV/AIDS-positive people to enter their	62%	64%	34%	58%	54%

homes					
11. Percentage of respondents who expect others to tell them their HIV/AIDS status	46%	64%	20%	48%	62%

The various responses are grouped and discussed below. A listing of the relevant points precedes each discussion.

**1. Percentage of respondents willing to speak to HIV/AIDS-positive people, according to school**

**2. Percentage of respondents willing to hug HIV/AIDS-positive people**

**3. Percentage of respondents willing to kiss HIV/AIDS-positive people**

An interesting result of this survey, as illustrated in points 1 to 3 in the table, is the clear difference in attitudes of the respondents at Islamia College and Bulumko SSS. Islamia respondents showed the strongest hesitation in speaking, hugging and kissing HIV/AIDS-positive people, particularly in contrast to respondents from Bulumko SSS. One reason for this could be the lack of HIV/AIDS efficacy programmes at Islamia College as opposed to the other schools.

**4. Percentage of respondents who avoid speaking to HIV/AIDS-positive people**

The above table shows that Islamia College had the highest score in terms of avoiding speaking to HIV/AIDS-positive people.

**5. Percentage of respondents who expect HIV/AIDS-positive people to leave their company**

**6. Percentage of respondents who would avoid physical contact with HIV/AIDS-positive people**

**7. Percentage of respondents who would consider not changing their jobs**

Points 5 to 7 illustrate that pupils from Bulumko Senior Secondary School showed the lowest score in respect of attitudes towards HIV/AIDS-infected and affected people. Bulumko SSS respondents were least likely to speak or have physical contact with HIV/AIDS-positive people, expected HIV/AIDS-infected people to leave their company and were more likely to consider leaving their jobs to avoid contact with HIV/AIDS-positive people.

**8. Percentage of respondents who would visit HIV/AIDS-positive people**

**9. Percentage of respondents who would allow their children to play with the children of HIV/AIDS-positive people**

**10. Percentage of respondents who would allow HIV/AIDS-positive people to enter their homes**

In points 8 to 10, Islamia College respondents again show the lowest scores. The Islamia respondents were least likely to go to the homes of HIV/AIDS-positive people, allow their children to play with the children of HIV/AIDS-positive people, and allow HIV/AIDS-positive people to enter their homes. They would also be less likely to expect HIV/AIDS-positive people to inform them about their status. This may be due to the limited amount of HIV/AIDS awareness programmes to which these learners are exposed.

## **11. Percentage of respondents who expect others to tell them their HIV/AIDS status**

The above table shows that Grassy Park SSS showed the highest score of respondents who expected people to tell them their HIV/AIDS status, compared to Islamia College, with the lowest response. Two discourses may be in effect here – on the one hand, the learners at Islamia may feel that HIV/AIDS is a shameful disease and that disclosure of status would invoke rejection and stigmatisation. On the other hand, the learners may be invoking a rights-based discourse that prioritises the HIV/AIDS-infected person's right to disclose their status in their own time. The first option is the most realistic given the levels of prejudice shown by Islamic learners in other questions.

## **7. DISCUSSION**

The youth are an important target group for AIDS education. Adolescence is a time of sexual experimentation, which places young people at risk of being infected with HIV. It is the stage at which sexual behaviour is formulated and decisions about life-style and identity are made (Brooks-Gunn and Furstenberg, 1989). The role of education is less to change entrenched or established behaviour, but to shape the development of sexual behaviour and attitudes. This increases the likelihood that education may have a positive impact on behaviour.

The intervention in this study appears to have had a favourable impact in terms of improving student knowledge and shifting certain key attitudes. Its impact on behavioural intention is, however, more disappointing. While overall levels of knowledge about HIV transmission, prevention and the course of the disease improved, many misconceptions persisted. Attitudes towards people with AIDS, although markedly improved, remained largely hostile. Previous evaluations of AIDS education programmes among school students have shown similar results. Interventions, even if brief, are able to prove certain key attitudes in relation to AIDS. These improvements are not necessarily sustained over time and, most



importantly, education has been shown to have a limited, if at all noticeable, impact on students' intentions to protect themselves from AIDS (Brown *et al.*, 1989, 1991; Huszti *et al.*, 1989; Ruder *et al.*, 1989; Chandarana *et al.*, 1990).

These results indicate the persisting need for the development and evaluation of AIDS education programmes that will have a more incisive impact on adolescent behaviour. However, gradual rather than immediate changes in behaviour are to be expected with prevention efforts. Realistic short-term objectives have to be set for interventions based on models that define the precursors or determinants of behaviour change (Petosa & Wessinger, 1990). If more substantial gains are to be achieved, prevention programmes will need to be ongoing and followed up or repeated regularly. Ways of ensuring the continuity and sustainability of programmes need to be built into their design.

It has repeatedly been emphasised that AIDS education programmes need to be developed and evaluated in close consultation with the target audience to ensure that they are appropriate and acceptable (Cullen, 1989). The target group should be involved not as passive recipients of education, but as active participants in the design and organisation of AIDS programmes (Van Dam, 1988). Facilitating the participation of the school community (parents, teachers and students) was a key principle in the development of this programme. This is commensurate with a community empowerment model of AIDS education, geared towards community control over education and prevention efforts (De la Cancela, 1989). Parents, particularly, were not successfully involved. The process of gaining future participation may result in some loss of interest, and momentum for the project may be lost. Teachers supportive of the project seem to both resist and lack the confidence to take responsibility for the design of future programmes. Realistic expectations are needed about the degree of motivation and potential for different groups to contribute. Despite the partial nature of participation, the programme appeared to have been successful in promoting a sense of collective ownership of the programme within the schools.

Teachers will be the main educators in future programmes. They will occupy an intrinsic position as educators in schools and have relative power in this context, but studies of their knowledge of AIDS have highlighted their need for training (Wilson *et al.*, 1989; Ballard *et al.*, 1990; Bowd, 1989; DiClemente, 1989). The selection of teachers to be responsible for AIDS education is also important, as not all teachers are necessarily equally skilled or motivated. However, all teachers need to be reached by AIDS education and training programmes to ensure their support. Peer-based education [such as the Zambian AIDS clubs (Baker, 1988) or peer counsellors programme (Bell, 1990)], which is increasingly being recognised as an effective means to promote behaviour change, will also need the support of teachers if implemented in the school environment.

Successful AIDS education needs to address behavioural skills such as decision making, assertiveness and refusal (Kerr, 1990; Franzini *et al.*, 1990); involve students as active learners through interactive activities to make learning enjoyable (Amer-Hirsch, 1989); and address the complex social and psychological issues around sexuality (DiClemente & Houston-Hamilton, 1989; Schinke *et al.*, 1990). This makes heavy demands on the skills of the educators. In this study, the activities that required the least amount of preparation or follow-up were most successful. This does not bode well for a more intensive, sensitive and in-depth process built up within the curriculum. We believe that strengthening and developing existing internal resources of schools, particularly focusing on teacher training and support, is a key priority for school-based AIDS education.

The programme required the participation of the entire school community and involved a range of activities, but students were not necessarily uniformly involved or touched by the programme/ project/research. The assessment of students' exposure to different components of the programme/project/research may have been useful. The study design is limited in the extent to which change can be attributed to the intervention, and future search should consider ways to

match students, while maintaining confidentiality and other experimental designs. The baseline questionnaire was conducted after planning for the programme was already underway. This demonstrated change in student knowledge and attitudes may, therefore, underestimate the programme's effect.

It appears that the communities in general are not dealing very well with the AIDS epidemic, by not confronting and dealing with the issues posed by AIDS and eliminating them. This could point to feelings of vulnerability and fear and a high level of denial in the community.

## **8. CONCLUDING REMARKS**

South Africa lags behind both the developed and the developing worlds in implementing AIDS education in its schools. While there is receptiveness to the idea of AIDS education in schools, the potential for AIDS education initiatives is limited by a lack of skilled educators, a lack of resources and the absence of a sense of the urgent need for such initiatives. Also, considerable disagreement and conflict exists within different sectors involved in school education about the appropriate approach to AIDS education. This study showed that it was possible, with limited resources, to successfully implement an AIDS education programme in an urban, African school despite existing educational and social disadvantages.

Further resources need to be allocated to develop, adapt and evaluate educational materials and approaches appropriate to the local context, and disseminate concrete materials more widely.

As more experience with school-based AIDS education is accumulated, successful programmes can be developed and implemented. Although many elements for successful interventions have already been identified, there is no AIDS education *magic bullet* to change young people's sexual behaviour on a

wide scale or in a sustained way. Participation and involvement of the school community is necessary to practically implement AIDS education in schools, and is important in the development of appropriate and feasible materials and approaches. Furthermore, participation, through facilitating a process of school ownership, may, in the long term, contribute to a climate supportive of behaviour to prevent the spread of HIV.

## 9. BIBLIOGRAPHY

Ajzen, I. (1999). The theory of planned behaviour. *Organisational Behaviour and Human Decision Processes*, 50, 79-211.

Ayo-Yusuf, I., Naidoo, S., & Chikte, U.M. (2001). The role of primary school teachers in HIV prevention in South Africa. *Journal of the South African Dental Association*, 56(9), 596-598.

Bandura, A. (1986). *Social foundations of thought and action: A Social Cognitive Theory*. New Jersey: Prentice-Hall.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.

Beyer, C.E., & Ogletree R.J. (1998). Sexual coercion content in 21 sexuality education curricula. *J Sch Health*, 68(9), 370-5.

Beyer, C.E., Ogletree, R.J., Ritzel, D.O., Drolet, J.C., Gilbert, S.L., & Brown, D. (1996). Gender representation in illustrations, text, and topic areas in sexuality education curricula. *J Sch Health*, 66(10), 361-4.

Brown, L.K., Fritz, G.K & Barone, V.J. (1989). The impact of AIDS education on junior and senior high school students, *Journal of Adolescent Health Care*, 10, 386-392.

Campbell, C. (2003). "Letting them Die". How HIV/AIDS prevention programmes often fail. Cape Town: Double Storey.

Chandarana, P.C., Conlon, P., Noth, S & Field, V.A. (1990). The impact of AIDS education among elementary school students, *Canadian Journal of Public Health*, 81, 285-289.

Comer, J.P., Haynes N.M., Joyner E.T., & Ben-Avie M. (1996). Rallying the whole village: The Comer process for reforming education. New York: Teachers College Press.

Coyle, K.K, Kirby, D.B., Martin, B.V., Gomez, C.A., & Gregorich, S.E. (2004). Draw the line/respect the line: A randomised trial of a middle school intervention to reduce sexual risk behaviours. *American Journal of Public Health*, 94, 843-851.

Department of Education (2003). Education Statistics at a Glance 2001.

Department of Health: The HIV/AIDS and STD Directorate. South African HIV/AIDS Lifeskills Education Materials Edition. South Africa; 1999. ISBN 0-620-24825-4.

DiClemente, R.J. (1989). Prevention of HIV infection among adolescents: The interplay of health education and public policy in the development and implementation of school-based AIDS education programs, *AIDS Education & Prevention*, 1, 70-78.

Doyle, P. (1991). *The impact of AIDS on the South African Population* (Centre for Health Policy, University of the Witwatersrand).

Haynes, N.M., Emmons, C.L., Ben-Avie, M., & Comer, J.P. (1996). The school development program - student, staff, and parent school climate surveys. Yale Child Study Centre: USA.  
*Health Policy and Planning*, 5, 123-131.

Kirby D. (2002). The impact of schools and school programs upon adolescent sexual behaviour. *J Sex Res*, 39:27-33.

Mathews, C., Kuhn, L., Metcalf, C.A., Joubert, G & Cameron, N. (1990). Knowledge, attitudes, and beliefs about AIDS in township high school students. *South African Medical Journal*, 78, 511-516.

Mathews, C., Everett, K., Binedell, J., & Steinberg, M. (1995). Learning to listen: formative research in the development of AIDS education for secondary school students. *Social Science and Medicine*, 41, 1715-24.

McCormick, L.K., Steckler, A.B., & Mcleroy, K.R. (1995). Diffusion of innovations in schools: study of adoption and implementation of school based tobacco prevention curricula. *Am J Health Promot*, 9(3), 210-9.

Petosa, R. & Wessinger, J. (1990). The AIDS education needs of adolescents: a theory based approach. *AIDS Education and Prevention*, 2, 127-136.

Statistics South Africa (Census) 2001.

UNAIDS. (1997a). Impact of HIV and sexual health education on the sexual behaviour of young people: A review update. Geneva, UNAIDS.

UNAIDS (1997b). Learning and teaching about AIDS at school (UNAIDS Best Practice Collection: Technical Update). Geneva: UNAIDS.

Zwi, A. & Bachmayer, D. (1990). HIV and AIDS in South Africa - What is an appropriate public health response?

## ANNEXURE A QUESTIONNAIRE

### DEMOGRAPHY

### SOCIO-ECONOMIC AREA

Age: \_\_\_\_\_

School: \_\_\_\_\_

Grade: \_\_\_\_\_

where do you live: \_\_\_\_\_

M  F

\_\_\_\_\_

Religion: \_\_\_\_\_

Home language: \_\_\_\_\_

Are there any school going children in your house:            Y             N

No. Of years living in this area: \_\_\_\_\_

### **GENERAL QUESTIONS ABOUT HIV/AIDS**

**Please say whether you agree, disagree or don't know the answers to the following questions.**

- |   |   |                          |   |                          |    |                          |
|---|---|--------------------------|---|--------------------------|----|--------------------------|
| 1) Is there a cure for AIDS?  | Y | <input type="checkbox"/> | N | <input type="checkbox"/> | DK | <input type="checkbox"/> |
| 2) Is there a difference between AIDS and HIV?                          | Y | <input type="checkbox"/> | N | <input type="checkbox"/> | DK | <input type="checkbox"/> |
| 3) Does RSA have the highest incident of HIV/AIDS in the world?         | Y | <input type="checkbox"/> | N | <input type="checkbox"/> | DK | <input type="checkbox"/> |
| 4) Can you tell, just by looking at them, that someone is HIV positive? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> | DK | <input type="checkbox"/> |
| 5) Can a person live longer than 5 years with HIV?                      | Y | <input type="checkbox"/> | N | <input type="checkbox"/> | DK | <input type="checkbox"/> |



**THE TRANSMISSION OF HIV/AIDS**

**1) By which of the following modes can HIV be transmitted:**

	Y	N	DK
Kissing on the lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet seats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sharing needles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unprotected sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drinking from same cup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shaking hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A mosquito bite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A swimming pool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
By breathing on a person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If a person has a Sexually Transmitted Disease (e.g. Genital ulcers/discharge) are they more likely to get AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2) Which of the following methods can protect you from HIV?**

	Y	N	DK
Condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sterilization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contraceptive pill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PERSONAL ATTITUDES REGARDING HIV/AIDS**

Please say how strongly you feel about the following statements:

(1 = Strongly Disagree, 2 = Disagree, 3 = Agree, 4 = Strongly Agree)

**1) If a member of your family were HIV positive, you would be willing to:**

Speak to them	1	2	3	4
Hug them	1	2	3	4
Kiss them	1	2	3	4

**2) If you found out that a colleague of yours was HIV positive, you would:**

Avoid speaking to them	1	2	3	4
Expect them to leave	1	2	3	4
Avoid physical contact with them	1	2	3	4
Consider changing jobs	1	2	3	4

**3) If you found out someone in your street had HIV, you would:**

Still go to their house	1	2	3	4
Let your kids play with their kids	1	2	3	4
Let them into your house	1	2	3	4
Expect them to tell you	1	2	3	4