THE HIV/AIDS KNOWLEDGE OF GRADE 9 AND 10 LEANERS IN MABARHULE HIGH SCHOOL IN MPUMALANGA

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

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DECLARATION

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ABSTRACT

This research study examined teenagers' knowledge about HIV and AIDS with a questionnaire, eliciting both quantitative data, which was administered to grade 9 and 10 learners in Mabarhule High School in Mpumalanga.

The findings indicated that learners held generally positive knowledge about HIV/AIDS, how it is transmitted and how it can be prevented.

Recommendations were made for further studies. The importance of research to determine the role of education in order to determine behaviour change is strongly recommended. Behaviour change is the only real varialbe that can have an immense impact on the prevention of the virus.

OPSOMMING

Die doel van die studie was die bepaling van die MIV/vigs – kennis van graad 9 en 10 skoliere van Mabarhule Hoërskool in Mpumalanga.

Die resultate van die studie dui daarop dat die skoliere oor die algemeen kennis dra van MIV/vigs, hoe dit oorgedra word en hoe dit voorkom kan word.

Voorstelle vir verdere studies word gemaak. Die noodsaaklikheid van die ondersoeke ten einde die rol van opvoeding in uiteindelik gedragsverandering van te stel, word sterk aanbeveel. Gedragsverandering is die enigste werklike veranderlike wat ‘n beduidende impak kan hê op die voorkoming van verdere verspreiding van die virus.

ACKNOWLEDGEMENTS

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To the grade 9 and 10 learners of Mabarhule High School in the Mpumalanga Department of Education, my boundless gratitude is due for your co-operation and voluntary participation in the study.

DEFINITION OF CONCEPTS

Knowledge - is defined as the basic information and understanding of HIV/AIDS. This is whether the learners understand the difference between HIV and AIDS, risk factor, modes of transmission, care and support for PLHA.

AIDS (An acronym for Acquired Immune Deficiency Syndrome) – is the final stage of HIV infections.

HIV (An acronym for Human Immuno Deficiency Virus) – is the initial stage of a disease that may develop into AIDS.

STDs – are sickness passes from one person to another during an unprotected sexual intercourse. Gonorrhoea, Syphilis and HIV are examples of STDs.

An epidemic – is the uncontrollable outbreak of a disease which affects many people at the same time.

ABBREVIATIONS

HIV- Human Immunodeficiency Virus

AIDS- Acquired Immune Deficiency Syndrome

PLHA – People living with HIV and AIDS

STI's - Sexual Transmitted Infection

STD - Sexual Transmitted Disease

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CHAPTER 1: BACKGROUND OF THE STUDY

1.1. INTRODUCTION

According to UNAIDS (2009: 7) the number of people living with HIV worldwide continued to grow in 2008, reaching an estimated 33.4 million (31.1 million–35.8 million). Sub-Saharan Africa remains the region most heavily affected by HIV. In 2008, sub-Saharan Africa accounted for 67% of HIV infections worldwide, 68% of new HIV infections among adults and 91% of new HIV infections among children. The region also accounted for 72% of the world's AIDS-related deaths in 2008 (UNAIDS, 2009: 21). The epidemic continues to have an impact on households, communities, businesses, public services and national economies in the region. Southern Africa is the epicenter of the worldwide AIDS pandemic. South Africa has over five million people living with HIV/AIDS. This figure is more than any other country in the world (UNAIDS, 2009: 21).

According to UNAIDS (2008: 33) and Garcia – Callej*a et al* (2006) women and girls continue to be affected disproportionately by HIV in sub-Saharan Africa .In this region as a whole, women account for approximately 60% of estimated HIV infections. UN (2005) declare that due to high prevalence of HIV among the youth aged 15- 24 years various governments have diverted their strategies to emphasize social behavioral change other than the focus on curative and hospitalization measures. In the same vein Shisana *et al* (2005) adds that the HIV/AIDS knowledge among young people is of great concern in South Africa, where HIV prevalence among 15-24 year-olds is 10.3%. With the constant rise of HIV/AIDS and pregnancies amongst teenagers in South Africa, it is important for research to investigate and evaluate attitudes held by teenagers towards their sexuality education. In the light of the above this study investigates the knowledge of the youth about HIV/AIDS specifically those in secondary school.

1.2. SIGNIFICANCE OF THE STUDY

The study will equip the learners (youth), educators, education circuits, parents, regions, health officials, the Department of Education and the community at large with relevant and information pertaining to HIV/AIDS. Schools will be equipped with skills and knowledge on how to treat, accommodate, support, teach and guide learners and colleagues infected and affected by HIV/AIDS. The youth will adequately know the real facts about the epidemic. The study will also contribute towards demystifying myths, misconceptions, uncertainties, fears, denial, discrimination and stigma surrounding HIV/AIDS that the teenagers may have.

Behavioural change especially among the youth may emanate from the gained knowledge if it is known what the level of knowledge is.

1.3. PROBLEM STATEMENT

The prevalence of teenage pregnancy at the school has reached unprecedented proportions. For the first time in as many years the number of pregnant learners exceeded fifty (50) during 2009. The increasing number of teenage pregnancies is an indication that there are underlying causes which warrant attention. In addition to teenage pregnancy, many learners, both boys and girls more often than not ask permissions to visit clinics and doctors. A closer scrutiny into these visits show that they mostly suffer from sexually transmitted infections (STIs). The majority of these infections occur in learners between the ages of 15 and 25. Learners as little as 14 and 15 years of age fall pregnant. There is large number of drop- outs each year. As a consequence of this, the performances of the pupils at school are declining. The school now channels human and non – human resources into dealing with the situation.

From the above argument it is clear that teenage pregnancy among the youth is a problem. It may be caused by a lack of the necessary knowledge and proper attitudes. This also may suggest that the learners are not well conversant with HIV/AIDS. Therefore, this brings us to the research question: What is the grade 9 and 10 learners' knowledge about HIV/AIDS?

1.4. AIM OF THE STUDY

To establish learners' HIV/AIDS related knowledge in order to supplement them with other information and improve the knowledge presented at the school.

1.5. OBJECTIVES OF THE STUDY

The objectives of the study are:

- To identify knowledge on HIV/AIDS being presented at the school.
- To provide guidelines for improving training.

CHAPTER 2: LITERATURE REVIEW

2.1. INTRODUCTION

According to Abdool Karim *et al.* (2008: 143) sexual behaviour is the main driver of the South African HIV epidemic. They claim that the median age at first sexual intercourse among South Africans is 18 years, and that 8% of women who have ever had sexual intercourse have done so by the age of 15. They further allege that among sexually active men aged 15 to 24 years, 23% reported multiple partners in the preceding 12 months, and that among sexually active women and men, condoms were not used during 43% - 80% of the most recent incidents of sexual intercourse. Most individuals in these age groups are still attending secondary schools. The education sector is thought to be particularly hard hit by HIV/AIDS because both the demand for and supply of education are affected. Not only do children drop out of school because of HIV/AIDS, thus reducing demand for educators, but educators, school managers and education policy – makers are themselves dying of AIDS, thus reducing supply (Shisana *et al.*, 2005: 2).

Levels of pregnancy are very high among teenage and young adult women in South Africa (Abdool Karim*et al.*, 2008: 267). The rates of teenage pregnancy and sexually transmitted disease (STD) have long indicated that adolescents are a population vulnerable to HIV infection (Murphy, Rotheram – Borus& Reid, 1998). According to Haffajee (1996) one in three teenagers planned their pregnancies, and half of them were still at school when they conceive. The most recent South African Demographic and Health Survey showed that by age 19, 35% had been pregnant (Abdool Karim *et al.*, 2008: 256).

Young people have a right to the knowledge and means by which to protect themselves and their partners against infection (UNESCO, 2002). However, a multitude of factors can be a stumbling – block in their quest for knowledge about HIV/AIDS. Abdool Karim *et al* (2008: 143) aver that sexual behaviour is shaped by personal, interpersonal, environmental, cultural and structural forces. This section will therefore seek to look into the learners' HIV/AIDS related knowledge as well as factors which hinder them from accessing such knowledge by reviewing information from relevant journal articles, magazines, policies, books and previous research.

The literature review will focus on the following aspects: HIV/AIDS as part of the Life Orientation learning area, secondary school teachers' comfort in teaching adolescents about

sexuality and HIV/AIDS, teacher knowledge about HIV/AIDS, and culture of silence about HIV/AIDS.

2.2. SECONDARY SCHOOL TEACHERS' COMFORT IN TEACHING ADOLESCENTS ABOUT SEXUALITY AND HIV/AIDS

In some cases, educators feel that they cannot discuss sexual issues with young children. This is borne out by Dawson *et al* (2001) when they aver that among teachers with sufficient knowledge, many feel uncomfortable discussing these issues with students, especially topics related to safer sex and homosexuality.

2.3. TEACHER KNOWLEDGE ABOUT HIV/AIDS

Peltzer (2000) points out that the role of teachers in disseminating HIV/AIDS information seems critical for the success of school-based programmes but that teachers often lack adequate knowledge of the disease. In the same vein Abdool Karim *et* al (2008: 148) state that teachers lack training and they feel uncomfortable taking HIV discussions beyond the biomedical sphere to discuss relationships, sexuality and emotions. This argument cannot be dismissed as untrue as many educators teaching Life Orientation did not receive formal training in the learning area. Most educators only attended a few days' workshops which were insufficient to enable them to acquire in-depth knowledge and skills to impart to the learners. In – service training can play a role in expanding the knowledge of educators about HIV/AIDs related knowledge. Teachers who had received types of in-service training had significantly higher levels of knowledge and more tolerant attitudes regarding HIV/AIDS (Doherty-Poirier, Munro & Salmon, 1994).

2.4. CULTURE OF SILENCE ABOUT SEX AND HIV/AIDS

Among the various dimensions of family social support, parent-adolescent communication on issues of sexual behaviour and childbearing has received considerable attention (Camlin & Snow, 2008). Positive, open and frequent family communication about sex is linked to postponement of sexual activity, increased contraceptive use and fewer sexual partners (Blake, Simkin, Ledsky, Perkins & Calabrese, 2001). Similarly, parent-child communication is vital for the prevention and reduction of teenage pregnancy (Hollander, 2003). Many adolescents concur that it would be easier for them to avoid teen pregnancy if they were able to have more open and honest conversations about these topics with their parents (Albert, 2004). Parent-child communication about sex increases the likelihood that sexual risk will be discussed with partners and can mediate negative peer norms about sexual behaviour

(Whitaker & Miller, 2000). Communication between parents and adolescents about sexual risk behaviour represents a missed opportunity in South Africa. According to Kaiser Family Foundation & SABC, (2006) 79% of adolescents regard parents as a trusted source of information about HIV than their friends. Only 4% of adolescents report learning the most about HIV from their parents (Pettifor *et al.*, 2004). Adolescents in SA report poor communication with parents about sexual matters in that parents refuse to hold conversation with them about sex, provide only vague indications rather than direct and correct information, and may even punish them for bringing up the topic (Lesch & Kruger, 2005).

2.5. POVERTY

Poverty has been identified in the social science literature on the epidemic as one of a few crucial structural variables with a direct impact on various facets of the epidemic (Fredland, 1998; Whiteside, 2002). Girls in poor communities often get pregnant than those in economic viable areas. Kirby in Abdool Karim*et al* (2008: 148) declare that girls in schools with high rates of poverty and social disorganization are more likely to become pregnant.

In South African research, poverty, unemployment, overcrowding, and low levels of education appear to be linked to higher levels of adolescents' sexual activity and less knowledge about HIV and AIDS (Du Plessis et al., 1993:34). Poverty is often seen as the reason for the co modification of sex, in which women in dire economic circumstances agree to sexual relationships with men in exchange for financial support (Adams & Marshall, 1998:59). Socio economic status is also related to the likelihood of young people experiencing physical abuse and sexual coercion within relationships.

2.6. THE INSTITUTIONAL CLIMATE OF BOTH HEALTH SERVICES AND SCHOOL

The negative attitudes of health and teaching staff can bar young people from accessing much – needed assistance regarding HIV/AIDS. There have been reports of verbal abuse of young people who attempt to access condoms and contraceptive medication by health workers. Abdool and colleagues have shown that young people’s access to free condoms provided by clinics is restricted by negative attitudes of clinic staff, or by clinics running of supplies (Abdool Karim & Abdool Karim, 2008: 148). Of special concern is the way in which services are delivered. Young people are very sensitive to privacy and confidentiality, and do not want their dignity to be stripped away. Adolescents are more likely than older people to be deterred by long waiting times and administrative procedures, especially if they are made to feel

unwelcome. Unfriendly health care providers who do not listen or are judgmental, make it difficult for young people to reveal concerns. They may not return for follow up care (WHO, 2002: 21).

2.7. CULTURAL BARRIERS

In many countries a culture of shame discourages adults and children from talking about their bodies or sexual activity.Cultural inhibitions put a distance between young people and their parents with whom they have regular contact. It is considered a taboo for parents to talk to children about sexual matters including sexually transmitted diseases (STDs) in schools and at home because of cultural and religious barriers. Many adults are wary of their children being given sex education because of fear that it will encourage young people to be promiscuous. As a result adolescents tend learn about sexuality on their own from books, magazines and films. The information offered through radio or TV is not detailed enough because of cultural and religious reasons (National AIDS Control Program, 2000). Caldwell (1994) argues that silence in relation to the HIV/AIDS pandemic among Africans owes a great deal to suspicions that AIDS is more than an ordinary disease, that it has supernatural elements or that it is caused or manipulated by witchcraft.

2.8. EFFECT OF RELIGIOSITY ON ATTITUDES

Research has consistently shown for many decades that religious involvement and adolescent sexual behaviour and attitudes are strongly correlated (Thornton & Camburn, 1989). Lefkowitz *et al.*, (2004) found religious behaviour to be the strongest predictor of sexual behaviour. The analyses of the effect of religiosity on attitudes about safe sex behaviour yielded somewhat inconsistent results. On the one hand, the study of Afro-American teenagers (who were predominantly Baptist) revealed that those teenage women who participated regularly in religious or spiritual activities were less likely to engage in sexually risky behaviours than their non-religious colleagues were (Hollander, 2003). On the other hand, found that young people who attended church frequently and who valued religion in their lives had the least permissive attitudes and were less experienced sexually than their non-religious counterparts (Thornton and Camburn, 1989).

Furthermore, differences based on religious affiliation or religious identities have been inconsistent (Lefkowitz *et al.*, 2004). For example, the Roman Catholic Church is opposed to the use of condoms by its members. The Roman Catholic Church has continued to promote

an abstinence and faithfulness-only approach to HIV prevention in Africa, despite the evidence that confirms that this strategy cannot work within such a context. (Sangonet, 2009).

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter three outlines the research design, research method used in the study, Population in terms of selection and sample size. It goes further to elaborate the research instruments used, the questionnaires, the manner in which data collection was conducted and the ethical issues considered by the researcher**.**

3.2. RESEARCH PARADIGM

For this study, the researcher I employed a quantitative research approach to measure objectively the variables involved and statistically analyse and interpret the data. In quantitative research, data is collected in a value-free manner and structured methodology is used to facilitate statistical analysis (Saunders, Lewis & Thornhill 2003:83). Most importantly the quantitative research approach is selected because generalizations can be made from sample to population. The researcher used a quantitative research approach to focus specifically on the research question, which seeks to determine the grade 9 and 10 learners' knowledge about HIV and AIDS. The respondents ticked the correct options on the first section of the questionnaire, and gave written responses in the second section of the questionnaire.

3.3. RESEARCH DESIGN

Thyer (1993:93), as cited by De Vos (1998:10), defined a research design as a blue print or detailed plan on how a research study will be measured. Activities such as selecting a sample for the study, collection of data to be used as a basis for testing hypothesis and analysing the results may be conducted. Huysamen (1993), De Vos (1998) and De Vos (2000:10-11) also offer a closely related definition of design as the plan or blue print showing how data are collected in order to investigate the research hypothesis, or questions, in the most economical manner possible.

This was a quantitative research. A quantitative research study is the one that emphasises the quantification of constructs, where the researcher believes that the duly way of measuring the properties of phenomena is through quantitative measurement (Babbie & Mouton, 2001:49).

3.4. POPULATION

A target population is defined as the population under study, the population to which the researcher wants to generalize the research findings (Talbot 1995:241).100 learners were selected from Mabarhule High School in Mpumalanga Province. 45 learners were selected from grade 9 and another 55 learners from grade 10. The selected learners constitute an age range of between 13 and 16.

This age group was chosen because the literature revealed that it is at this point in life that young people are more inclined to seek sexuality information and most recently started sexual activities. It is also at this stage that they are likely to receive inappropriate information that may lead to dire consequences (Nsengiyumva, 2000).

3.5 SAMPLING PROCEDURE

Sampling is described as "A useful shortcut, leading to the results that can almost be as accurate as that full census of the population being studied but for a fraction of the cost" (Gorald, 2001: 10). Sample is on the other hand stated as the people involved in the research that represents the population that the study is focusing on. (Siegel,) http://www.delsiegel.com further states that age, gender and number are important aspects of the sample.

The study used simple random sampling. Random sampling was used to select individuals within the selected factories to take part in the research. Random sampling enabled the study to pick up a representative group of learners from both grade 9 and 10; this is said to enable the generalization of the results. Random sampling reduces extraneous variables and also reduces the risk of biasness (Preece, 1964).

The sample was drawn from a population of grade 9 and 10 learners from Mabarhule High School in the Bushbuckridge Region of Mpumalanga. 100 learners were selected from Mabarhule High School in Mpumalanga Province. 45 learners were selected from grade 9 and another 55 learners from grade 10. The selected learners constitute an age range of between 13 and 16. Care was taken to avoid gender bias.

3.6. MEASURING INSTRUMENT

There are numerous tools available to researchers (observation. survey/questionnaire, interviewer and focus groups) who wish to collect data. For the purpose of this study a

questionnaire consisting of two sections was used. Gall et al (2007, 228-229) contend that the questionnaire is advantageous because they are cost effective and time saving but they cannot probe deeply into respondents' beliefs, attitudes and inner experience. The first part of the questionnaire will consist of a Likert scale type questionnaire with fifteen questions requiring category answers ranging from Agree, Disagree, and unsure. For the second part of the questionnaire five open-ended questions will be asked. Biographic information such as level of education, gender differentiation, and religious backgrounds will be collected in the first section. Open – ended questions include themes such as "yes or no and motivate", "explain" and "name" types of questions.

Questionnaires are suitable for research of this nature for various reasons: more than one respondent can be 'interviewed' simultaneously allowing for quick and efficient collection of data, it is easy to administer and offers greater anonymity. With proper construction and administration such a questionnaire is one of the best data gathering tools available to a researcher (Behr, 1988).

Open-ended questions allow participants to respond with a "wide range of possible answers" (Vadum & Rankin. 1998). Since there are no limitations placed on responses received by open-ended questions the researcher will be able to capture the richness of the participants' experience of and feelings about the programme. A self-administered questionnaire was given to the respondents and after completion, they will submit to the researcher (De Vos, 2006).

3.7. DATA ANALYSIS & INTERPRETATION

Quantitative analysis was used to assess their knowledge about HIV/AIDS. Grade 9 and 10 learners constitute an age group most vulnerable to HIV and AIDS owing to the fact that they have just entered the puberty stage of their life. As a result of this it is imperative to explore their level of knowledge about HIV/AIDS. Quantitative data was analysed using graphs and tables. "Data analysis is a process of bringing order, structure and meaning to the mass of collected data" (Marshall &Rossman, 1995). According to Blatex et.al (1996: 197) data analysis there is a critical issue, "...is arriving at your own assessment of what the results mean and how they relate to other relevant research." It assists the researcher to seek explanation and develop more understanding on the subject studied.

CHAPTER 4: PRESENTSTION AND DISCUSSIONS

4.1. INTRODUCTION

This chapter aims at presenting and analysis of findings. The respondents were given the questionnaire to read the instructions before completing. The respondents were assured of confidentiality and that the survey was voluntary. Those who were prepared to continue to participate in the survey were given the opportunity to complete. Questions were asked in the form of Attitudinal Scale in a three-point scale namely agree, disagree and unsure. Open-ended questions were asked at the end.

Total number of 100 learners participated in the study. All the learners who were given the questionnaire returned the completed questionnaire. The participation and response rate was 100%. The questionnaire had 03 sections, which included demographic details of respondents, their knowledge and open - ended questions on HIV/AIDS. The results expected in this study were as follows:

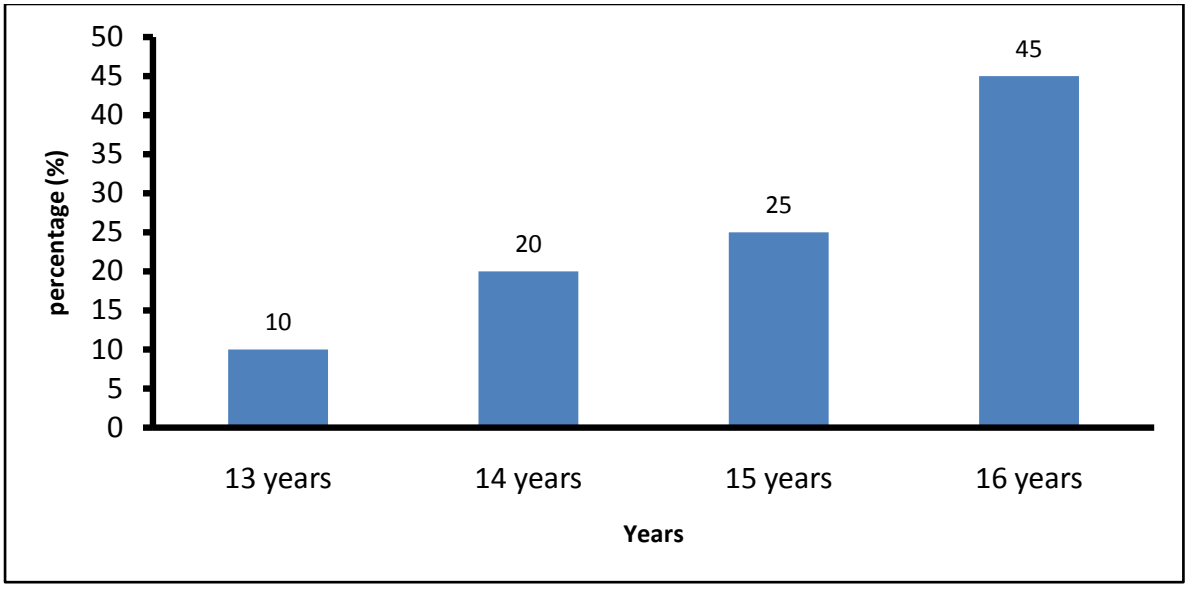
The knowledge on HIV/AIDS among the grade 9 and 10 learners in Mabarhule High School in Mpumalanga Province will be high (60%). They will also know what HIV is, how it is acquired and transmitted.

4.2 DEMOGRAPHIC DETAILS OF LEARNERS

This section presents the personal background of the respondents. It reflects the identifying particulars of the grade 9 and 10 learners in Mabarhule High School in Mpumalanga Province. The information gathered in this section included the following information: age, gender, marital status, religious status, Christian denomination, educational level of learners, and economic status of family and language proficiency of learners.

TABLE 4.1

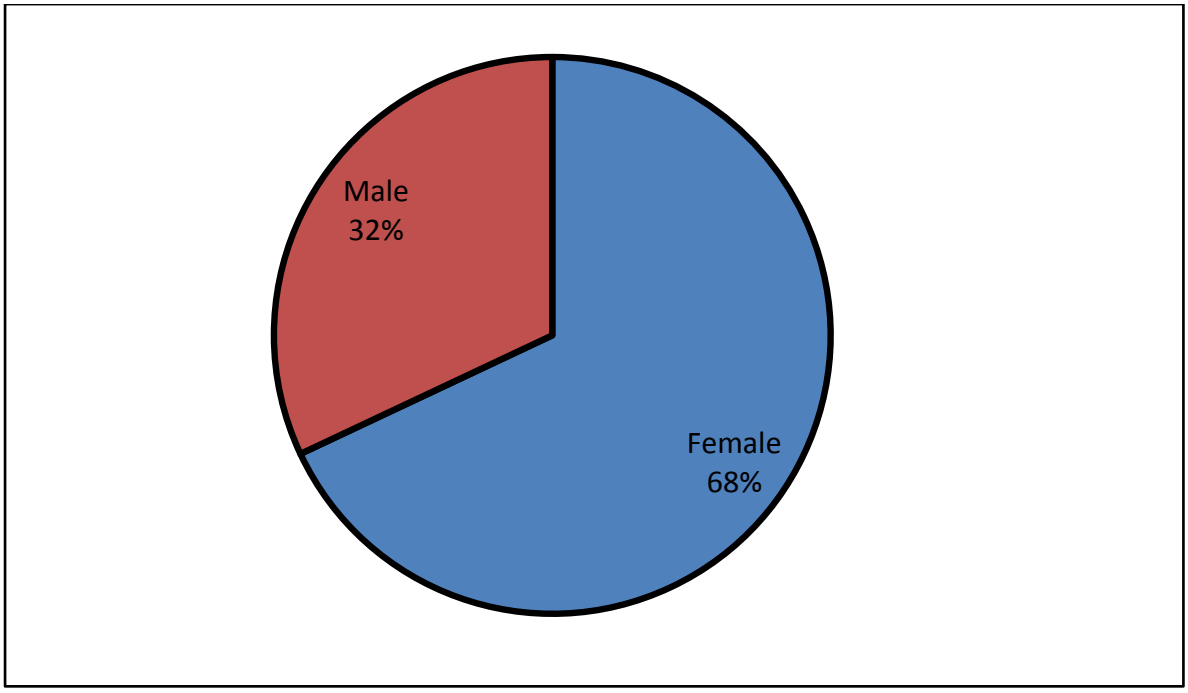
Age group



In terms of the age group, 45% of the respondents were 16 years old, 25% were 15 years old, 20% were 14 years old and 10% were 13 years old.

TABLE 4.2

Gender



It was found that 32% of respondents were male whereas 68% were female. The majority of the respondents were women. This shows that women are taking an interest in HIV/AIDS matters.

TABLE 4.3

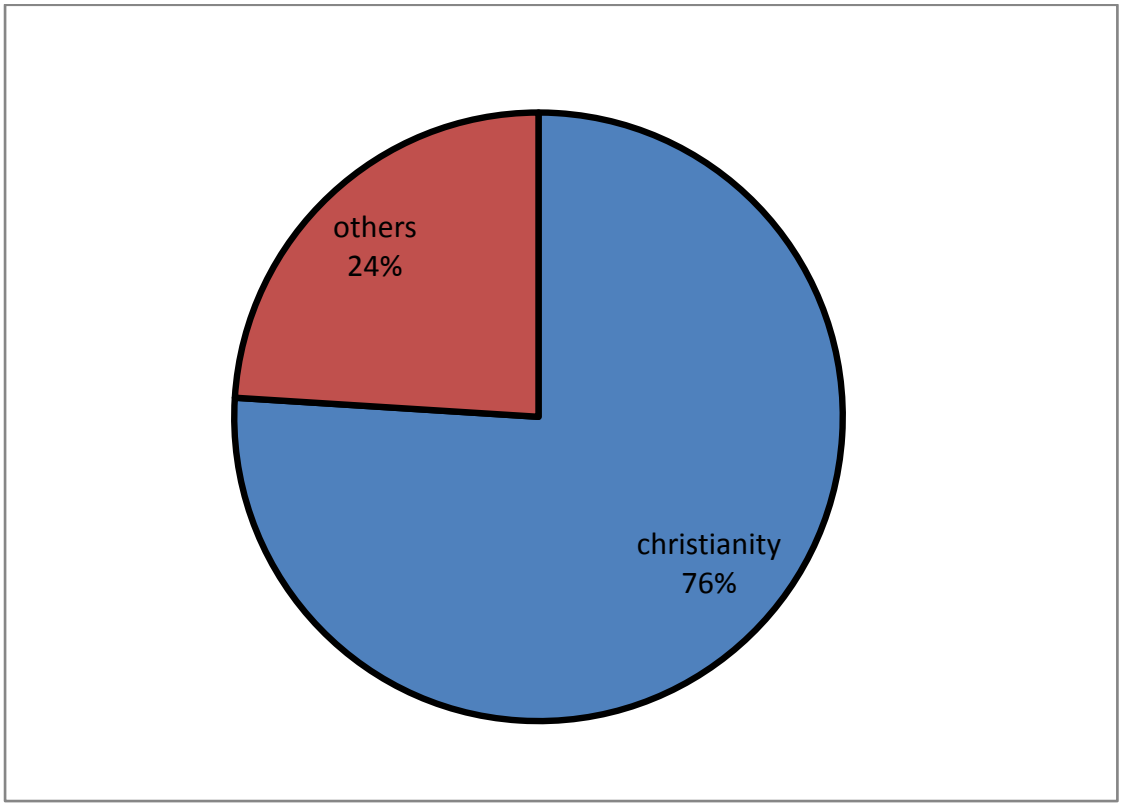
Marital status

MARRIED	**0**
NEVER MARRIED	**100**

100% of the respondents were not married or never married.

TABLE 4.4

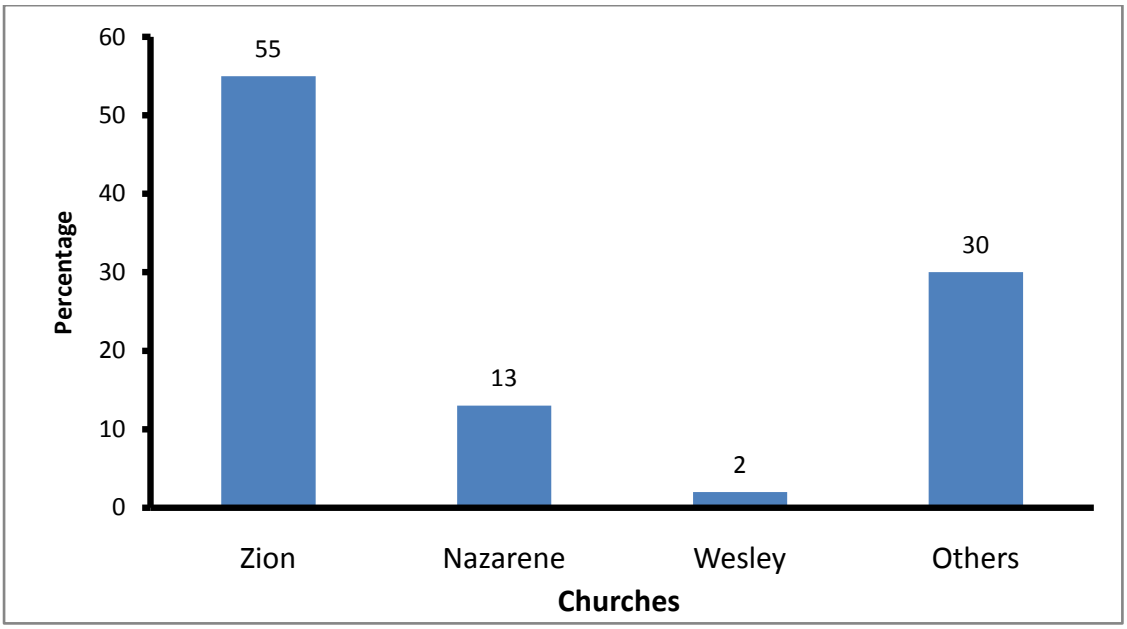
Religious status



76% of the respondents belong to Christianity and 24% to other religions.

TABLE 4.5

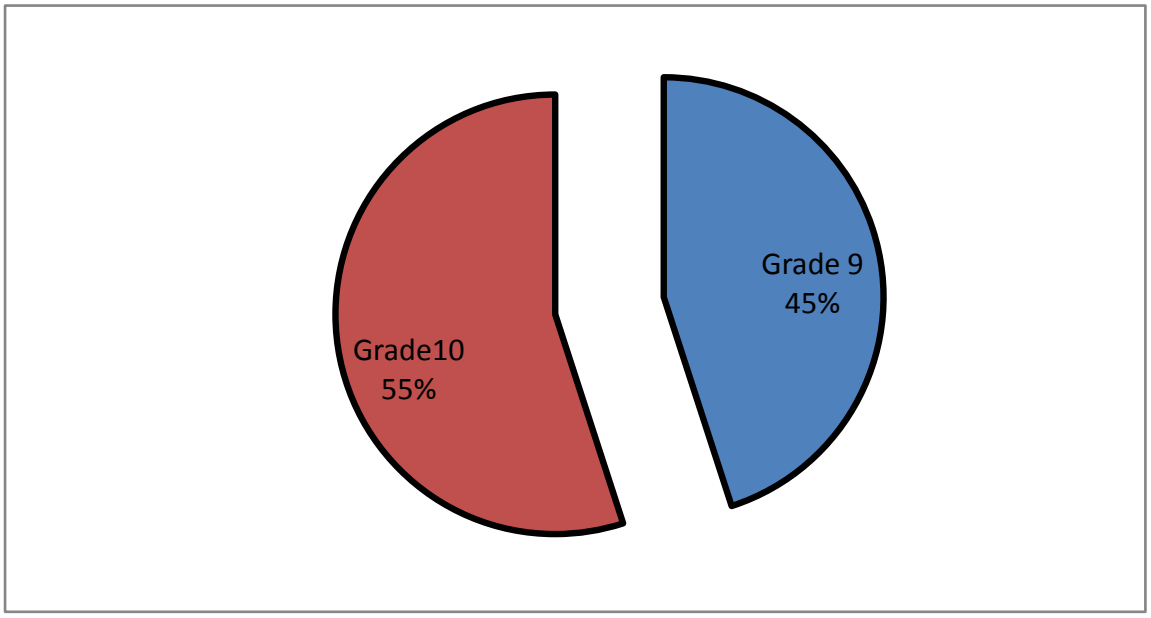
Christian denomination



55% of the respondents belong to the Zionist church, 13% to the Church of the Nazarene, 2% to the Wesley church and 30% to other churches.

TABLE 4.6

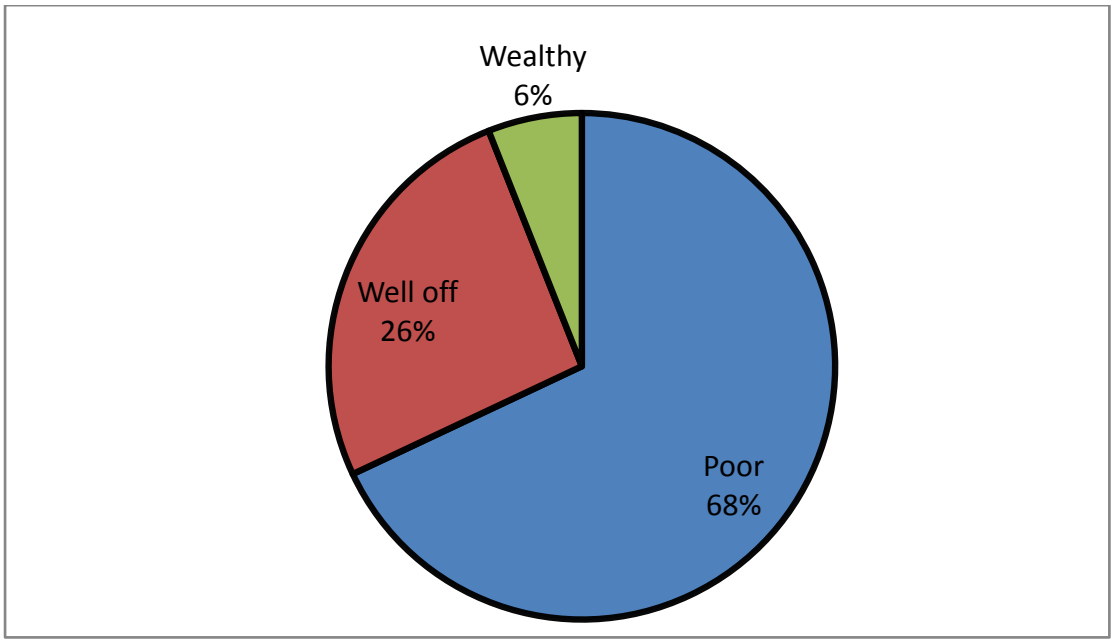
Educational level



55% of the respondents are doing grade 10 while 45% are doing grade 9.

TABLE 4.7

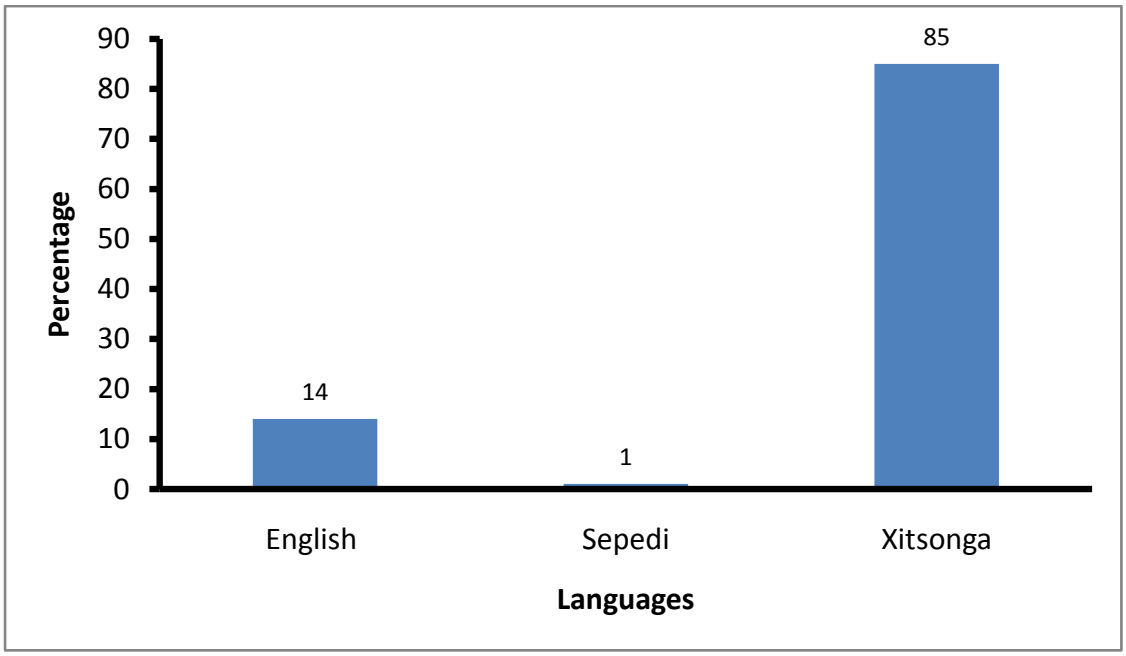
Economics status of the family



68% of the respondents are poor, 26% well – off and 6% wealthy.

TABLE 4.8

Language Proficiency of learners



85% of the respondents are proficient in Xitsonga, 14% in English and 1% in Sepedi.

4.3. KNOWLEDGE

This section focuses on the basic knowledge respondents have in terms of HIV/AIDS. The main purpose is to assess the level of knowledge in terms of modes of HIV transmission, prevention, treatment and care and support.

TABLE 4.9

A person who is strong and healthy cannot be infected with the HIV virus.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	17	17	17	17
	Disagree	62	62	62	79
	Unsure	21	21	21	100
	Total	100	100	100	

The majority of the respondents [62%] disagree with the fact that a person who is strong and healthy cannot be infected with the HIV virus. 17% of the respondents agree with the fact that a person who is strong and healthy cannot be infected with the HIV virus while 21% of them are unsure.

TABLE 4.10

People with HIV/AIDS should not come near other people

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	12	12	12	12
	Disagree	69	69	69	81
	Unsure	19	19	19	100
	Total	100	100	100	

The majority of the respondents [69%] disagree that people with HIV/AIDS should not come near other people while 12% of the respondents agree. The remaining 19% of the respondents are unsure.

TABLE 4.11

Parents should talk about HIV/AIDS with their children.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	87	87	87	87
	Disagree	2	2	2	89
	Unsure	11	11	11	100
	Total	100	100	100	

The highest number of respondents [87%] agrees that parents should talk about HIV/AIDS with their children while 2% disagree. 11% of the respondents are unsure about whether parents should talk about HIV/AIDS with their children or not.

TABLE 4.12

The HIV virus can be spread by mosquitoes or other insects.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	14	14	14	14
	Disagree	58	58	58	72
	Unsure	28	28	28	100
	Total	100	100	100	

The majority of the respondents [58%] disagree that the HIV virus can be spread by mosquitoes or other insects. 14% of the respondents agree that the HIV virus can be spread by mosquitoes or other insects while 28% of them are unsure.

TABLE 4.13

People of my age are too young to get the HIV virus.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	18	18	18	18
	Disagree	62	62	62	80
	Unsure	20	20	20	100
	Total	100	100	100	

A large number of the respondents disagree that people of their age are too young to get the HIV virus whereas 18% of them agree. 20% of the respondents are unsure if people their age are too young to get the HIV virus.

TABLE 4.14

I cannot eat from the same plate as someone with HIV/AIDS.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	46	26	26	26
	Disagree	26	46	46	72
	Unsure	28	28	28	100
	Total	100	100	100	

The majority of the respondents [46%] disagree that they cannot eat from the same plate as someone with HIV/AIDS while 26% agreed that they cannot. 28% of the respondents are unsure if they cannot eat from the same plate as someone with HIV/AIDS.

TABLE 4.15

People with HIV/AIDS have only themselves to blame.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	39	39	39	39
	Disagree	57	57	57	96
	Unsure	4	4	4	100
	Total	100	100	100	

The highest number of the respondents [57%] disagrees that the people with HIV/AIDS have only themselves to blame while 39% of the respondents agree people with HIV/AIDS have only themselves to blame. 4% of the respondents are unsure if people with HIV/AIDS have only themselves to blame.

TABLE 4.16

Young people have proper books, videos, and information on how to protect themselves from HIV/AIDS.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	78	78	78	78
	Disagree	4	4	4	82
	Unsure	18	18	18	100
	Total	100	100	100	

A huge number of the respondents [78%] agree that young people have proper books, videos, and information on how to protect themselves from HIV/AIDS while 18% disagree. 4% are unsure whether young people have proper books, videos, and information on how to protect themselves from HIV/AIDS.

TABLE 4.17

I can talk to my friend about HIV/AIDS and sex.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	78	78	78	78
	Disagree	12	12	12	90
	Unsure	10	10	10	100
	Total	100	100	100	

The highest number of the respondents agrees that they can talk to my friend about HIV/AIDS and sex. 12% of the respondents disagree that they can talk to my friend about HIV/AIDS and sex while 10% of them are unsure.

TABLE 4.18

Condoms are a good way to prevent infection with the HIV virus.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	83	83	83	83
	Disagree	6	6	6	89
	Unsure	11	11	11	100
	Total	100	100	100	

The majority of the respondents [83%] agree that condoms are a good way to prevent infection with the HIV virus while 6% think they are not. 11% of the respondents are unsure if condoms are a good way to prevent infection with the HIV virus.

TABLE 4.19

People on the farms and small villages are safe from HIV/AIDS.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	24	24	24	24
	Disagree	54	54	54	78
	Unsure	22	22	22	100
	Total	100	100	100	

The majority of the respondents disagree that the people on the farms and small villages are safe from HIV/AIDS while 24% of them agree. 22% of the respondents are not sure if people on the farms and small villages are safe from HIV/AIDS.

TABLE 4.20

I can tell that someone has HIV by looking at them.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	22	22	22	22
	Disagree	55	55	55	77
	Unsure	23	23	23	100
	Total	100	100	100	

Most of the respondents [55%] disagree that they can tell that someone has HIV by looking at them while 22% of them agree. 23% of the respondents are unsure if they can tell that someone has HIV by looking at them.

TABLE 4.21

You can get infected with HIV by having sex once with someone who is HIV positive.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	69	69	69	69
	Disagree	14	14	14	83
	Unsure	17	17	17	100
	Total	100	100	100	

The highest number of the respondents [69%] agrees that a person can get infected with HIV by having sex once with someone who is HIV positive while 14% of them disagree. 17% of the respondents are unsure if a person can get infected with HIV by having sex once with someone who is HIV positive.

TABLE 4.22

You should trust your partner if he/she tells you that he/she is not HIV positive.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	20	20	20	20
	Disagree	57	57	57	77
	Unsure	23	23	23	100
	Total	100	100	100	

Most of the respondents [57%] disagree that they should trust their partners if they tell that they are not HIV positive while 20% of the respondents agree that they should trust them. 23% of the respondents are unsure if they should trust their partners if they tell that they are not HIV positive.

TABLE 4.23

If I get tested for HIV a few weeks after having unprotected sex and the results are negative it means that I am out of danger.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Agree	27	27	27	27
	Disagree	51	51	51	78
	Unsure	22	22	22	100
	Total	100	100	100	

The majority of the respondents [51%] disagree that if they get tested for HIV a few weeks after having unprotected sex and the results are negative it means that they are out of danger. 27% of the respondents agree that if they get tested for HIV a few weeks after having unprotected sex and the results are negative it means that they are out of danger while 22% of them are unsure about this.

TABLE 4.24

Would you feel free to ask your partner to use a condom? Explain.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	97	97	97	97
No		3	3	3	100
	Total	100	100	100	

The highest number of the respondents [97%] feels that they would ask their partners to use a condom while 3% of them feel they would not. More than 90% of the respondents explain that a condom is the safest method to protect them from contracting HIV, and therefore they would ask their partners to use it.

TABLE 4.25

Can HIV/AIDS cured?

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Yes	37	37	37	37
	No	63	63	63	100
	Total	100	100	100	

Most of the respondents [63%] state that HIV/AIDS cannot be cured while 37 of them say it can. More than 60% of the respondents understand that a cure for HIV/AIDS is not yet available.

TABLE 4.26

Name two ways in which HIV can be spread.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Correct responses	75	75	75	75
	Incorrect responses	25	25	25	100
	Total	100	100	100	

The highest number of the respondents [75%] understands the ways in which HIV can be spread while just 25% of them have misconceptions about how it can be spread.

TABLE 4.27

Name three ways in which you can protect yourself from HIV and other infections

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Correct responses	66	66	66	66
	Incorrect responses	34	34	34	100
	Total	100	100	100	

The majority of the respondents [66%] know the ways in which they can protect themselves from HIV and other infections. 24% of the respondents have misconceptions about the ways in which they can protect themselves from HIV and other infections.

TABLE 4.28

What do you know or understand by HIV/AIDS? Explain.

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	Appropriate responses	60	60	60	60
	Inappropriate responses	40	40	40	100
	Total	100	100	100	

The majority of the respondents [60%] were able to offered appropriate responses about what HIV/AIDS are all about while 40% of them were not able to provide appropriate responses.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 RECOMMENDATIONS

More research in this area is necessary. While this study has created a platform for dialogue and interest towards learners' knowledge about HIV/AIDS, a larger scale research would have a much better impact in enhancing their knowledge.

Teachers should augment HIV/AIDS information covered in the textbooks by inviting people who work directly with HIV/AIDS to come and teach learners. This would bring more insight and different dimensions to the HIV and AIDS information often provided in academic, formalistic and to a certain extent in a monotonous manner by the educators.

5.2 DELIMITATIONS OF THE STUDY

The subjects were drawn from the learners at Mabarhule High School in Bushbuckridge Region in Mpumalanga Province. These are grade 9 and 10 learners. The findings of the study have been generalized based on the total population of the number of learners. All learners were given equal opportunity to participate in the study. Learners from grades other than 9 and 10 were excluded from the study.

5.3 LIMITATIONS

The respondents were only drawn from one school which means that these results cannot be generalized to the whole Mpumalanga High School population. A sample including more schools could have been considered. However a larger sample would require funding, traveling and other basic requirements.

The language limitation was not taken into account, as it might have impacted on the responses. The researcher believes that a translation of the questionnaire might have made a difference in responses and final findings.

Most of the research conducted regarding the learners' knowledge about HIV/AIDS used closed question questionnaires and did not actually focus on what the participants revealed about regarding experiences. As a result some of the findings in this study could not be interrogated, supported or refuted by existing literature. These might thus be possible hypotheses for further study.

5.4 CONCLUSION

An initial concern motivating this study was that adolescents especially those in rural schools lack the necessary knowledge about HIV/AIDS. However, from the results of this study it is evident that adolescents from rural schools have positive knowledge about HIV/AIDS. In contrast to some studies that suggest that children from low HIV prevalence areas report less knowledge of HIV and more negative attitudes towards people with HIV (e.g. Ndeki et al., 1994), this specific population revealed a high level of HIV knowledge and a reasonably high level of acceptance of safe-sex behaviours. For example, 83% of the respondents think condoms are a good way to prevent infection with the HIV virus, 62% of them disagree that people of their age are too young to get the HIV virus, and 69% of them disagree that people with HIV/AIDS should not come near other people. These are but few of the responses of the participants clearly pointing to fact that their knowledge about HIV/AIDS is at an acceptable level.

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APPENDIX A

QUESTIONNAIRE

1. You are not required to write your names or attach your signatures on the interview Schedule.

2. You are requested to feel free in answering the questions.

3. Please answer all questions as honest as possible

4. Please write your answers in the space provided and make a cross where there are alternative answers in their own words.

5. Your confidentiality is guaranteed.

6. Please note that there are no right or wrong answers.

7. You are requested to answer all the sections.

SECTION A: DEMOGRAPHIC FACTORS OF LEARNERS

1. Age

13	14	15	15

2. Gender

Male	Female

3. Marital Status

Never Married	Married

4. Religious Status

Christianity	Others

5. Christian Denomination

Nazarene	Zion	Wesley	Non-Affiliation	Other

6. Education level of learners

Grade	9
Grade	10

7. Economics status of the family

Poor	Well of	Wealthy

8. Language Proficiency of learners

Xitsonga	Swati	English	Sepedi	Others

SECTION B: CLOSED QUESTIONS

	Agree	**Disagree**	**Unsure**
1. A person who is strong and healthy cannot be infected with the HIV virus.			
2. People with HIV/AIDS should not come near other people.			
3. Parents should talk about HIV/AIDS with their children.			

4. The HIV virus can be spread by mosquitoes or other insects.			
5. People of my age are too young to get the HIV virus.			
6. I cannot eat from the same plate as someone with HIV/AIDS.			
7. People with HIV/AIDS have only themselves to blame.			
8. Young people have proper books, videos, and information on how to protect themselves from HIV/AIDS.			
9. I can talk to my friend about HIV/AIDS and sex.			
10. Condoms are a good way to prevent infection with the HIV virus.			
11. People on the farms and small villages are safe from HIV/AIDS.			
12. I can tell that someone has HIV by looking at them.			
13. You can get infected with HIV by having sex once with someone who is HIV positive.			
14. You should trust your partner if he/she tells you that he/she is not HIV positive.			
15. If I get tested for HIV a few weeks after having unprotected sex and the results are negative it means that I am out of danger.			

SECTION C: OPEN - ENDED QUESTIONS

1. Would you feel free to ask your partner to use a condom?

Yes	
No	

Explain:

.....

.....

.....

2. Can HIV/AIDS cured?

Yes	
No	

3. Name two ways in which HIV can be spread.....

.....

.....

4. Name three ways in which you can protect yourself from HIV and other infections

.....

.....

.....

5. What do you know or understand by HIV/AIDS?

Explain.....

.....

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