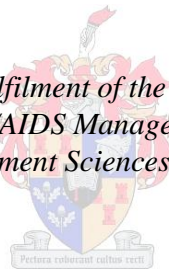


# **The perceptions of learners and educators at Malibu High School on the provision of condoms to schools**

by  
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*Assignment presented in fulfilment of the requirements for the degree of  
Master in Philosophy (HIV/AIDS Management) in the Faculty of Faculty  
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## **Declaration**

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: March 2013

## **Abstract**

In the light of the roll-out of the national combined school-health program which will include the availability of condoms to learners, this study was undertaken to determine what the perceptions of learners and educators are regarding the provision of condoms to learners at Malibu High School in Eerste River, Cape Town as a prevention strategy. The learners' knowledge levels on HIV and AIDS were also tested. Questionnaires were handed out to learners as well as Life Orientation educators.

The findings of the study revealed that the learners' knowledge levels on HIV and AIDS are reasonably high and that parents are more involved as originally perceived to be. Learners seem to think that the provision of condoms by schools is a good idea. The educators' views differ. The educators feel that the knowledge levels are low and that there is no visible parental or community involvement regarding HIV and AIDS. They see this as separate to their function. Educators are unanimous in their response that the provision of condoms by schools is not a good idea at all. They feel that it would send out the wrong message to learners.

From the study, it became apparent that the Education department still needs to do a lot to get schools on board for the roll-out of the school-health program. A lot needs to be done regarding the training of and support to the educators. A few recommendations are listed in order for the school to effectively address the HIV and AIDS issues at the school in order to reduce its impact.

## Opsomming

Die toekomstige uitrol van die nasionale gekombineerde skole-gesondheidsprogram sluit die verskaffing van kondome aan leerders in. Hierdie studie was dus hiervolgens onderneem om juis uit te vind wat die persepsies van leerders sowel as die opvoeders van Malibu Hoërskool in Eersterivier, Kaapstad is rakende die verskaffing van kondome aan leerders. Die leerders se kennisvlakke rakende MIV en VIGS was ook getoets. Vraelyste was uitgehandig aan beide die leerders en die Lewensoriëntering-opvoeders.

Die bevindinge van die studie weerspieël egter dat die kennisvlakke van leerders taamlik hoog is en dat ouers eintlik meer betrokke is as wat aanvanklik waargeneem was. Leerders is van mening dat die voorsiening van kondome aan hulle deur skole eintlik 'n goeie idee is. Die opvoeders se menings verskil egter. Die opvoeders is van mening dat die leerders se kennisvlakke laag is en dat daar egter geen sigbare ouer- en gemeenskapsbetrokkenheid bestaan nie. Opvoeders sien hierdie as apart van hul opvoedingsfunksie. Opvoeders voel dat die verskaffing van kondome aan leerders by skole nie 'n goeie idee is nie. Volgens hulle sal dit egter die verkeerde boodskap aan leerders deurgee.

Volgens die bevindinge van die studie is dit dus baie duidelik dat die Onderwysdepartement nóg baie moet doen om skole aan boord te kry rakende die uitrol van die skole-gesondheidsprogram. Baie moet gedoen word rakende die opleiding van en ondersteuning aan opvoeders in hierdie verband. 'n Paar aanbevelings word voorgelê om die skool in staat te stel om die MIV en VIGS-kwessies effektief aan te spreek om sodoende die impak daarvan by die skool te verminder.

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## **CHAPTER 1**

### **INTRODUCTION**

#### **1.1 INTRODUCTION**

Despite national awareness campaigns and integrating HIV and AIDS knowledge into the school curriculum, the disease has become a threat to our youth. The statistics show how vulnerable the youth of South Africa is to HIV due to unsafe sexual intercourse. This study aims to determine what the perceptions of the learners and educators' of Malibu High School are with regards to the provision of condoms to schools. It also aims to look at the challenges learners are currently experiencing regarding their own sexual well-being as well as their own level of knowledge on HIV prevention.

#### **1.2 BACKGROUND OF THE STUDY**

According to the World Bank (2000) individuals between 15-49 years are worst affected by HIV and AIDS. The infection rate for this group in 2009 in South Africa was 17.8% (Department of Health, 2011). The age group 15-24 years is most vulnerable to high risk sexual behaviour. According to an article on 'Teenagers Health at tremendous risk', it was found 40% of teenagers already had sex, 13% had sex under the age of 13 years, 41% already had sex with more than one partner and 16% had sex after consuming alcohol. Fourteen per cent had sex after taking drugs and less than a third practiced consistent condom use (Palitza, 2010). It is thus apparent a significant number of teenagers are experimenting with sex. Risky sexual behaviour such as having unsafe sexual intercourse increases their risk of HIV infection. The pregnancy rate at a school is an indicator of the level of learners engaging in unprotected sex. According to Advocates for Youth (2001) and an article by Palitza (2010) it would appear the lack of sexual health knowledge is not the problem but rather the lack of access to services. Many persons between 15-24 years feel they are discriminated against for being sexually active when they visit the local clinics; thus a reluctance to provide condoms to the youth. The National Strategic Plan for 2012-2016 aims to address this problem by focusing mainly on prevention and behaviour change. An integrated school health program is suggested which will be a collaboration between the Department of Education and the Department of Health and Social Development. Schools are regarded as places of learning and providers of information and all schools will be provided with a package containing condoms for learners. The package will contain information on sexual

health. Access to condoms and information to correct and consistent use without any discrimination will thus be provided by all schools to learners.

This study aims to determine what the perceptions of the learners and educators' of Malibu High School are with regards to the provision of condoms to schools. The aim is to look at the challenges that learners are currently experiencing regarding their own sexual well-being as well as their own level of knowledge on HIV prevention.

Malibu High School is located in a previously disadvantaged area called Blue Downs, Eerste River. The school serves the surrounding communities such as Kleinvlei, Melton Rose, Tuscany Glen, Blackheath, Silversands and Mfuleni. Learners come from predominantly coloured and black communities and also from different religious, cultural and socio-economic backgrounds. Malibu High School was established in 1990 and is known for its academic excellence and discipline. The learner enrolment is approximately 1 500 learners per annum with a staff complement of 50 educators. The school focuses on the holistic development of the learners and is proud to offer a variety of sports activities and cultural activities. The matriculation pass rate of the school is on average 85%. Many learners are exposed to poverty, single parent households, unemployment and domestic violence. They are exposed to alcohol, drug abuse and gangster activities close to where they live. Learners aged 15-18 years are most vulnerable to risky behaviour such as unprotected sex, unsafe sexual practices and alcohol- and drug abuse. They are at the age where they are naturally curious and keen to experiment. These learners have already been through puberty and perceptions and beliefs around sexuality have already been shaped. Peer pressure, media influences such as television and magazines coupled with an absence of proper adult supervision due to working parents create the opportunity for engaging in risky behaviour. Many learners experiment with alcohol and TIK accompanied with peer pressure often leading learners engaging in unprotected sexual behaviour. The lack of accurate sexual health education and parents' reluctance to talk about sexuality contributes to the creation of misconceptions around sexual health. Learners obtain their information on perceived appropriate sexual behaviour from peers; is not always correct and often sensationalized.

Sexual health education forms part of the Life Orientation curriculum for grade 8-12 learners at Malibu High School with 9 educators. The subject head is a specialist in this field and has since been promoted to a Curriculum Advisor. Life Orientation is offered for 4 periods per seven day

cycle on average to learners. Sexual health education takes up a small percentage of the curriculum and is covered mostly with grades eight and nine learners. It appears learners are receptive to sexual health education in the class. It appears educators feel uncomfortable to teach the prescribed subject matter; many of them are not Life Orientation educators. Life Orientation teaching periods are added to their teaching package to fill up their prescribed teaching time. There is a general reluctance from learners to speak to educators individually about respective sexual health matters; however, they prefer to speak up in the class. The pregnancy rate at Malibu High school is approximately five per annum and mostly amongst girls from grades ten to twelve. These grades receive limited sexual health education but it would appear Malibu High School is doing something right to keep its pregnancy rate relatively low.

### **1.3 MOTIVATION OF THE RESEARCH PROJECT**

The findings of the proposed study will give a clear indication of the level of knowledge of the learners and educators on HIV prevention as well as their perceptions on the provision of condoms. The study should also aim to highlight gaps in HIV related knowledge and challenges as experienced by these target groups.

The Department of Health and Social Development will benefit because HIV prevention and behaviour change programs can be adapted and tailored to the needs of young people. A great amount of insight will also be gained on the perceptions of these target groups with regard to the provision of services i.e. condoms to schools. The school itself will benefit greatly because the study will provide information on their learners' and parents' level of knowledge with regard to HIV prevention and services. The school will thus be in a favourable position to adapt their programs to suit the needs of the learners. Further collaboration with the Department of Health and Social Development can be initiated to address challenges. Successful programs can then be lodged by schools to equip both the learners and parents with sufficient and accurate knowledge on HIV prevention. Parents will benefit greatly from such an initiative because they will be given the opportunity to provide input regarding their own challenges, fears and misconceptions with regard to their role in educating their children on HIV prevention as well as their approval or lack thereof on condom provision to schools. Department of Health and Social Development should be able to incorporate the information obtained from parents into future programs. The school should be able to use the information from parents to lodge programs specifically aimed

at parents in order to equip them with sufficient knowledge to educate their children on HIV prevention. Educators will benefit greatly because they will be able to determine whether their own level of knowledge is sufficient and whether they are effectively addressing the needs of learners on HIV prevention as prescribed by the Life Orientation curriculum. They will thus be in a position to increase their knowledge through educator workshops and relay their findings to the Department of Education for the review of the Life Orientation curriculum on HIV prevention. HIV prevention and behaviour change researchers will benefit greatly with the findings of this study this will provide them with a dipstick of the challenges as perceived by learners and educators relating to HIV prevention and related services offered such as condoms to schools. The findings of the proposed study will be shared with the school and it will be recommended the school shares the findings with the learners, educators, parents, Department of Health and Social Development and the Department of Education. Support networks with community programs, faith-based- and non-governmental organizations will also be recommended to assist the school in its task to educate in HIV prevention.

#### **1.4 PROBLEM STATEMENT**

The problem statement of the study is:

What are the perceptions of learners and educators on the provision of condoms to schools?

#### **1.5 AIMS AND OBJECTIVES**

The aim of the study is to determine what the perceptions of learners and educators are on the provision of condoms to schools in an attempt to reduce or prevent HIV infection.

The objectives of the study are:

- To determine what the learners' perceptions are on the provision of condoms to schools.
- To establish the level of knowledge of learners on HIV and AIDS.
- To establish what the educators' perceptions are on the provision of condoms to schools.
- To provide guidelines to ensure that educators' and learners' challenges regarding HIV and AIDS awareness, sexuality education and condom provision are addressed.

## **1.6 RESEARCH METHODOLOGY**

The paradigm in which the proposed research was conducted is a quantitative study using descriptive statistics to provide meaning to the data. The research design took the form of a survey for learners and educators to collect information that will be expressed as percentage. The two target groups chosen for this study comprised of 100 grades 8-12 learners at Malibu High School and 9 Life Orientation educators at Malibu High School. Each learner was provided with a self-administered questionnaire consisting of closed-ended questions which was completed within a pre-arranged time-slot and venue (school hall) under supervision. Self-administered open-ended questionnaires (quantitative) were provided to all Life Orientation educators by means of non-random convenience sampling.

## **1.7 LIMITATIONS OF THE STUDY**

The sample size for both the learners and educators were small. Sixty learners of the 100 selected participated in the study due to absenteeism and refusals from parents. There were nine educators in the Life Orientation learning area, only five agreed to participate in the study. Time constraints played a major role because the grade 12 learners were busy with their mock examinations. According to the WCED stipulations, the research data had to be collected by the end of August. Since receiving the go-ahead from the Ethical Committee, the time was limited to collect the data.

## **1.8 OUTLINE OF CHAPTERS**

The literature review in Chapter 2 aims to highlight the current HIV statistics of our youth, the challenges that they face which contributes to HIV infection, the impact of HIV prevention programs as well as the promise of future collaborative prevention programs aimed at our youth.

Chapter 3 describes the research method. The paradigm in which the proposed research was conducted was a quantitative study using descriptive statistics to provide meaning to the data. The research design took the form of a survey for learners and educators collecting information that is expressed as percentage. The two target groups chosen for this study comprised of 100 grades 8-12 learners at Malibu High School and 9 Life Orientation educators at Malibu High School.

The results of the findings from the survey regarding the perceptions of the learners and the educators on the provision of condoms to learners by schools are revealed in Chapter 4.

Chapter 5 aims to conclude what the perceptions of the learners and the educators are from the results obtained from the survey. Further recommendations are suggested in an attempt to protect our youth against HIV infection.

## **1.9 CONCLUSION**

This study should provide more clarity on what the needs of the learners and educators are with regards to sexual health education and HIV prevention and also to establish whether they think that the provision of condoms to schools will address these needs. The incidence and intensity of HIV and AIDS globally and in South Africa, the effects of the disease on our youth, the contributions of health workers and the use of condoms are explored in the following chapter.



## CHAPTER 2

### LITERATURE REVIEW

#### 2.1 INTRODUCTION

There is evidence more young people aged 15-18 years are experimenting with sex. It is assumed that many learners receive adequate sexual health education at school. Yet many of them engage in unprotected sex thus increasing their risk for HIV infection. The literature review aims to highlight the current HIV statistics of the South African youth, the challenges they face which contributes to HIV infection, the impact of HIV prevention programs as well as the promise of future collaborative prevention programs.

UNAIDS (2011) reveals the global promise made to reduce the HIV prevalence amongst youth and to increase their access to prevention information, skills and services. This promise commits to the sixth Millennium Development Goal which is to halt and reverse the spread of HIV. So far progress has been made regarding knowledge and positive changes in sexual behaviour in young people with the help of schools, families, health workers, communities and political leaders. Globally there has been a reduction of 12% in the number of 15-24 year olds since 2001. The Government and policymakers thus have a major role to play to ensure young people are equipped with knowledge and services to reduce their HIV risk. The aim is to empower young people from as young as 10 years old to protect themselves against HIV infection in order to live healthy lives.

#### 2.2 WHAT IS HIV AND AIDS?

HIV is short for Human Immunodeficiency virus. The HIV virus enters and remains in the body mainly through infected body fluids such as blood, semen, vaginal fluids and breast milk (Andersson, 2012). The virus attacks the cells of the immune system called CD4 cells progressively. Over time the body's immune system is weakened to such an extent where the body cannot defend itself against harmless infections anymore. The HIV virus increases as the disease progresses inside the body and the infected person experiences the following stages; the acute retroviral syndrome which are flu-like symptoms and occurs two to four weeks after exposure, the asymptomatic phase where the person displays no symptoms which can last from one to up to fifteen years, followed by symptomatic HIV infection (persistent night sweats, diarrhoea, weight loss, swollen glands and fever) until the full-blown AIDS (Acquired Immune

Deficiency Syndrome) stage which displays very specific infections, malignancies and a combination of prolonged fever, diarrhoea and severe weight loss. This process can take 2 to 15 years to completely destroy the body's immune system. The most common opportunistic infections are tuberculosis, thrush, diarrhoea, meningitis, pneumonia, viral infections of the eyes and the oesophagus and intestines as well as herpes and shingles. These infections cannot be overcome by the body's weakened immune system and the person eventually dies (Stellenbosch University, 2012).

The virus is mainly spread by heterosexual transmission (unprotected vaginal or anal sexual intercourse). The virus can also be transmitted through blood-to-blood transmission such as the sharing of needles, home tattooing and body piercing, accidental needle-stick injuries, organ transplantation and blood transfusions (HIV Insite, 2011). HIV infection via blood transfusions is rare because donors' blood gets screened. The virus is also transmitted from mother to child. Pregnant mothers can pass the virus on to their unborn babies or during delivery and breastfeeding mothers can pass the virus on through lactation (Andersson, 2012).

Anyone is at risk to become infected with HIV when it is spread mainly by unprotected sexual intercourse. When a person has unprotected vaginal or anal sexual intercourse with an infected person, with more than one partner or with sex workers there is a higher risk to become infected with HIV. Other factors which put people at risk are untreated sexually transmitted diseases, rape and sexual abuse and having sex under the influence of drugs and alcohol (HIV Insite, 2011).

UNAIDS (2011) states young people can prevent HIV infection by abstaining from sex and by not injecting drugs, through the use of correct and consistent male and female condoms, through medical male circumcision, through needle and syringe exchange programs, using antiretroviral drugs for treatment or post-exposure prophylaxis and through communication for social and behavioural change.

### **2.3 WHAT ARE CONDOMS?**

According to Medical News Today (2009) there are two types of condoms, namely male and female types; is a barrier contraceptive used to prevent pregnancy.

The Palo Alto Medical Foundation (n.d) explains a male condom as a thin sheath that covers the penis during intercourse and is made of either one of the following: rubber or latex, plastic or polyurethane and lambskin. The male condom protects against infection and pregnancy by covering the penis and preventing direct contact between the penis and the vagina. It also collects the semen and prevents the semen from entering the vagina. The latex condoms can protect against sexually transmitted infections (STIs). The use of condoms reduces the risk to contract STIs, allows men to share the responsibility to prevent pregnancies and also protects against contracting sexually transmitted diseases (STDs). The disadvantages are that some people are allergic to latex, others say the use of condoms lead to a loss of sensitivity and sexual pleasure, it interrupts sex by having to put on the condom and it may break if they are put on incorrectly. It is advised that condoms should not be used with oil-based lubricants because it can cause breakage. It should be kept away from heat because it can weaken it and cause breakage. Some has a shelf-life and usage after that causes breakage.

The article also states the female condom is a lubricated polyurethane sheath or pouch that has two ends, one end is closed and the other end is open. The female condom protects against pregnancy by catching the sperm in the pouch thus preventing it from entering the vagina. The closed end of the condom is placed inside the vagina while the open end stays outside the vaginal opening. There are limited proof female condoms can protect against STIs but they do guard against pregnancy. Insertion of the female condom is easy and stays in place in her body if inserted correctly. It allows the woman to take responsibility to protect herself against pregnancy and STIs. The disadvantages are that the condom can slip into the vagina during intercourse, the outer ring may irritate the female vagina, the inner ring may irritate the man's penis and some complain that sexual pleasure is lost or that it can become noisy. The female condom cannot be used with a male condom.

The use of male condoms is still more popular than the female ones. Male condoms also appear to be easier accessible than those for females. According to the HSRC report (2009) both male and female condoms are available in South Africa. However, male condoms are more widely

available than the female ones due to costs and other logistical concerns. Condoms can be obtained free of charge at any public institution or can be purchased at any store.

According to UNAIDS (2011) the correct and consistent use of the male latex condom can effectively prevent the risk of HIV infection.

#### **2.4 INCIDENCE AND INTENSITY OF HIV AND AIDS GLOBALLY**

The HIV and AIDS epidemic remains a threat to the health of everyone globally. According to UNAIDS (2010) it is estimated 33.3 million people are currently living with HIV; a 27% increase since 1999. Sub-Saharan Africa accounts for 11.3 million of people living with HIV. Globally 2.6 million people were newly infected with HIV since 2009 and 1.8 million people died of AIDS. UNAIDS (2011) reveals an estimated 5 million young people in low- and middle-income countries aged 15-24 years are globally living with HIV and 2.5 million children under 15 years old are also living with the virus. Young people aged 15-24 years account for 41% of these HIV infections. Globally 60% of women are currently living with HIV compared with 71% in Sub-Saharan Africa. The statistics reflect women are more vulnerable to HIV infection. HIV and AIDS is still a reality.

#### **2.5 HIV AND AIDS STATISTICS IN THE SOUTH AFRICAN CONTEXT**

According to UNAIDS (2007) Southern Africa alone accounted for more than one third (32%) of all new infections and AIDS deaths globally and South Africa has the largest number of HIV infections. According to the World Bank (2000) 15-49 year olds are worst affected by HIV and AIDS. The infection rate for this group in 2009 in South Africa was 17.8% (Department of Health, 2011). According to UNAIDS (2011) an estimated 2 million adolescents aged 10-19 years were globally living with HIV in 2009. An estimated 1.5 million were in Sub-Saharan Africa with 1.2 million in Eastern and Southern Africa. The highest number was found in South Africa and Nigeria where one out of every three young people were newly infected. In South Africa it is projected adolescents (ten year olds) living with HIV will increase to 3.3 per cent in 2020. These infections are due to vertical transmissions (mother to child transmission) but due the prevention of mother to child transmission through treatment, the number of infections will decrease. According to the Western Cape Education Department (WCED, 2012) 5.5 million South Africans were infected with HIV and three-quarters of all new infections were among 15-

24 year olds. The WCED is concerned that a growing number of children can become infected with HIV whilst still at school.

The reality is young people are currently either living with HIV or are vulnerable to become infected with the virus. According to UNICEF (2010) programs therefore need to be tailored to the needs of young people who need greater access to service, information, skills development and anti-stigma and –discrimination action.

## **2.6 SOUTH AFRICAN CHALLENGES WHICH CONTRIBUTE TO THE SPREAD OF HIV**

The South African HIV epidemic is mainly driven by heterosexual transmission (unprotected vaginal or anal sexual intercourse). South Africa is faced with many challenges such as cultural practices, poverty, gender inequity, resistance to the use of condoms and low perceptions of risk which still contribute to the spread of HIV. The lower status of women, the traditional subordinate role they play, myths and ignorance of knowledge about HIV and AIDS, their disrupted family life due to migrant labour contribute to women being at a higher risk to contract HIV (Mswela, 2009). Women in general are subjected to many forms of violence within or outside the marriage which includes sexual violence. The risk for young girls to contract HIV is higher during vaginal sex because their vaginal tracts are prone to tear (Seeley, Grellier & Barnett, 2004). Young people still lack skills to negotiate abstinence or condom use, are fearful and embarrassed to talk about sex and there is a lack of open discussion and guidance about sexuality at home. They receive their knowledge about sexuality from peers and are generally misinformed (Health24, undated).

## **2.7 HIV AND AIDS AND THE YOUTH**

HIV and AIDS has now become a serious threat to South African youth aged 15-24 years. The HSRC report (2009) suggests this age group is vulnerable to HIV infection due to engaging in early sexual debut, having intergenerational sex, having multiple sexual partners and low condom use. The use of alcohol and recreational drugs leads to an impairment in judgment and decision-making which leads to risky sexual behaviour. Risky sexual behaviour increases the risk of HIV infection.

The HIV prevalence rate amongst pregnant women aged 15-24 years old was 30% in 2005 and 29% in 2006. The HIV prevalence rate in this age group has decreased from 10.3% in 2005 to 8.6% in 2008. The report also reveals that condom use and the awareness of HIV status have increased since 2005 to 2008.

It would appear as if the prevalence rate is declining but clearly not fast enough. The slight decrease in the prevalence rate in South Africa could be ascribed to prevention programs aimed at behaviour change. A more determined and aggressive drive to initiate prevention programs aimed at youth should attempt to have a greater impact on their knowledge on HIV prevention and behaviour change.

## **2.8 CHALLENGES CONTRIBUTING TO ON-GOING HIV INFECTION AMONGST THE YOUTH**

The youth are faced with many challenges which make them vulnerable to HIV infection. These challenges include factors which lead to early sexual debut which could be due to their socio-economic backgrounds, a lack of access to information and services due to stigma and discrimination, a lack of accurate sexuality education from educators and parents as well as the existence of gender inequality which makes young women more vulnerable to HIV infection.

### **2.8.1 EARLY SEXUAL ACTIVITY AND TEENAGE PREGNANCY**

According to Health Statistics (2007) young people aged 15-24 years old seem to become sexually active and pregnant at a younger age. Sexual activity increases their risk of HIV infection (Love Life, 2007). Socio-economic backgrounds such as poverty, no adult supervision during the day, peer pressure, value systems and alcohol- and drug abuse contribute to young people engaging in unprotected and risky sexual practices (Advocates for Youth, 2001). This leads to an increase in unwanted pregnancies. According to Health Statistics (2007) one in every five pregnant teenagers is infected with HIV and according to the Medical Research Council's study in 2007, 16% of all pregnant teenagers under 20 years old tested positive for HIV. The UNAIDS Global report (2010) states high pregnancy rates indicate high levels of unprotected sexual activity thus increasing the risk of HIV infection.

### **2.8.2 LACK OF ACCESS TO INFORMATION AND SERVICES**

The article on Advocates for Youth (2001) suggests young people experience a lack of access to sexual health information and services. Many health professionals at clinics are not willing to provide condoms to young people and discriminate against them engaging in sexual activity and who require related health services; hampers young people's decision to practice safe sex. According to a study by Oni, Prinsloo, Nortje, and Joubert conducted at a high school in Jozini, Kwazulu-Natal in 2005 some learners responded they had unprotected sex because their partner did not want to use condoms, condoms were not available at the time, they were not thinking of condoms at the time of sexual activity, sex would be less enjoyable using a condom and some of them were ignorant about the use of condoms.

### **2.8.3 LACK OF KNOWLEDGE**

The UNAIDS Global report (2010) suggests young people still lack the knowledge and skills as well as access to condoms to prevent HIV infection. The study by the Medical Research Council (2007) suggests sex education should be incorporated in the school curriculum before the age of 14. Health professionals should also be trained not to discriminate against young people seeking access to sexual health services. Thus far, sexual health education and HIV prevention is part of the Life Orientation curriculum (WCED, 2012). It is unclear whether educators feel equipped with their own level of knowledge and whether they feel they are effectively addressing the needs of learners on HIV prevention as prescribed by the Life Orientation curriculum. Love Life (2007) also highlights the importance of sex education in schools. Schools are seen as places of learning and sometimes young people's only source of information.

### **2.8.4 GENDER INEQUALITY**

According to UNAIDS (2010) it is estimated 13.6% of young women aged 15-24 years are living with HIV compared to 4.5 % of young men in the same age category in South Africa. It is thus apparent young women are more at risk for HIV infection than young men. According to UNAIDS (2009) the percentage of young women who have boyfriends more than 5 years older than them increased from 18.5% in 2005 to 27.6% in 2008. Many times they are unable to negotiate condom use during sexual activity due to power imbalances. This increases their risk for HIV infection. According to the UNAIDS Global report (2010) they are also more at risk to HIV infection due to the exposure to sexual violence. A study in Swaziland on violence against

children as cited by UNICEF in 2007 indicated 33% of women aged 13-24 years old were exposed to sexual violence before the age of 18. Younger women are also biologically more susceptible to HIV infection (UNAIDS, 2010).

## **2.9 SUCCESSFUL HIV PREVENTION PROGRAMS AIMED AT YOUNG PEOPLE**

The UNAIDS Global Report (2010) reports there is a shift towards adopting safer sex methods. In South Africa the HIV incidence for young people aged 18 years old declined from 1.8% in 2005 to 0.8% in 2008. The infection for young women aged 15-24 years old declined from 5.5% in 2003-2005 to 2.2% in 2005-2008. The downward trend is ascribed to the implementation of HIV prevention programs aimed at young people promoting behaviour change. Positive trends show increased condom use, delayed sexual debut and a decrease in multiple partners amongst young people aged 15-24 years old due to intensive awareness campaigns and education programs. An emphasis is placed on the correct and consistent use of condoms as this proved to be more than 90% effective in preventing HIV and sexually transmitted infections. Prevention programs in Namibia promoting behaviour change amongst young people aged 15-24 years old showed positive results for declines in HIV prevalence from 10% in 2007 to about 5% in 2009. However, young people still lack the knowledge and tools to practice HIV reduction strategies and also do not have easy access to condoms. According to UNAIDS (2009) young men aged 15-24 years old showed a delay in sexual debut from 13.1% in 2002 to 11.3% in 2008. However, young women of the same age showed an increase in sexual activity before the age of 15 from 5.3% in 2002 to 5.9% in 2008.

## **2.10 THE ROLE OF SCHOOLS**

According to an article by AVERT (2011) on 'AIDS education and young people' schools have an important role to play by providing HIV and AIDS education because they can reach a large number and because the institutions are regarded as places of learning. The article also reveals according to a UNESCO study in 2009 it was found learners from schools in Eastern and Southern Africa had low levels of HIV knowledge. This is attributed to the lack of teacher training, be deficient in testing learners' HIV knowledge and the unease of educators teaching the subject. Some schools prefer the abstinence-only approach in the hope young people will refrain from sex. The disadvantage of this approach is that learners are not skilled on how to protect themselves from HIV infection. The comprehensive approach is favored where young



people are educated on condom use and to delay sexual debut. In order for this type of teaching to take place, there should be adequate teacher training. It is suggested HIV and AIDS education are introduced to learners as young as 10 to 14 years as their HIV risk becomes greater the older they become. It is also recommended education on condoms is provided to children as young as nine years old. The HIV and AIDS education should be cross-curricular and involve active learning. Schools should also involve family, friends and the community in order to reach young people who are not attending schools anymore and also to break down stigma and negative cultural practices. Such a program should also be supported by legislation and cultural and religious beliefs should be considered. Greater sensitivity should be shown to young people affected by HIV and AIDS. In Kenya for example HIV and AIDS education was integrated in all school subjects. A weekly and compulsory lesson was introduced and teacher training was offered to transmit the knowledge effectively to learners. The subject knowledge included information on the different ways how HIV transmission occurs, prevention, skills building, health and sexuality, issues on stigma and discrimination and care for people living with HIV and AIDS. The program revealed increased condom use amongst boys and girls indicated a delayed sexual debut.

### **2.11 WCED HIV AND AIDS LIFE SKILLS PROGRAMME 2003**

The Western Cape Education Department (WCED) committed itself to effectively deal with HIV and AIDS through its Life skills 2003 program as a knowledge provider on HIV and AIDS through its curriculum and to ensure there is no discrimination against the infected. The HIV and AIDS as well as sexual health education were mandated by both the Tirisano and the National Curriculum. HIV and AIDS education as well as sexual health education should be taught at least half an hour per week and should also be time-tabled and mainstreamed. Learning support materials were supplied to both the educators and learners of all grades since 2003. Educators received extensive training in HIV and AIDS. Schools were encouraged to organize parent and educator workshops in collaboration with faith-based organizations and the community to assist parents with the necessary skills to teach their children effectively on HIV and AIDS and sexual health education and also to support the WCED in its HIV and AIDS program objectives (WCED, 2012).

## **2.12 DEPARTMENT OF HEALTH'S NATIONAL STRATEGIC PLAN FOR 2012-2016**

According to the Department of Health's National Strategic Plan (2011) South Africa's HIV epidemic is driven mainly by sexual transmission. The plan's vision is zero new infections, zero deaths and zero discrimination. It aims to effectively communicate social and behaviour change in order to change risk behaviours as well as social conditions contributing to HIV infection. One of the goals is to reduce new HIV infections by 50% using combination prevention programs. It plans to promote delayed sexual debut, to reduce multiple sexual partners, increased condom use, decrease in intergenerational sex, decrease in alcohol and substance abuse, increase in prevention knowledge and risk perception, increase in medical male circumcision, as well as the treatment and prevention of sexually transmitted infections. It also plans to focus on gender roles and norms as well as sexual abuse.

An integrated school health program between the Department of Health and Social development and the Department of Basic education is suggested including a package suitable for each phase. It will comprise of comprehensive education on sexuality, reproductive health and reproductive rights including life skills education which will be provided to schools through curriculum and co-curricular activities to build skills, increase knowledge and shift attitudes, change harmful social norms and risky behaviour and promote human rights values; will be made available in all schools. The package will contain condoms for learners as well as information on sexual health, access to condoms and information to correct and consistent condom use without any discrimination.

## **2.13 GLOBAL SUPPORT OF A SCHOOL-HEALTH PROGRAM**

UNAIDS (2011) reveals 11% of young girls globally becomes sexually active before the age of 15. Intervention at 10 to 14 years old in the form of prevention and access to services are imperative before they become sexually active and before gender norms and roles influence them thus increasing their risk for HIV infection. The report also states the HIV knowledge level for this age group is poor. The report acknowledges some parents might have a problem with age-appropriate sexuality education and access to services for 10 to 14 year olds and might withhold their children from such information. The knowledge and the provision of condoms to the age group for 12 to 14 year olds are supported by 60% of parents from four Southern African countries. The report also reveals evidence that age-appropriate sexuality education increases

knowledge and does not lead to young people having sex at an earlier age. This type of teaching content should, however, be supported by a policy. Older adolescents (aged 15 to 19 years) are more prone to become involved in risky sexual behaviours and interventions to address these behaviours are crucial. Laws and policies therefore need to be revised in order to better protect the health and rights of young people. Parental, community, church and non-governmental organisation involvement is strongly suggested to support this type of teaching by schools and assist in changing attitudes.

The report also reveals sexuality education which includes awareness-raising and skills development and access to services in partnership with service providers are important in improving knowledge, attitudes and self-efficiency. In HIV affected countries there is still a resistance to sexuality education which includes information on contraception and condoms. It is important to note children living with HIV also need sexuality education and support in order to grow up healthy. It is important that schools form networks with the community, churches, parents and non-governmental organizations in order to reach children who do not attend school anymore because they have been affected by AIDS. They require sexuality education in order to reduce their HIV risk and lead a meaningful life.

In Europe there have been 59 % fewer pregnancies, 61 % fewer abortions and the number of new HIV cases has decreased by 95 % among 15 to 19 year olds who have been exposed to a combined school-based sexuality education with youth-friendly sexual and reproductive health services. In Kenya educators were trained to transmit HIV and AIDS – related education to 12 to 14 year olds. It was found that less pupils were involved in sex, more were delaying sexual activities and especially more girls reported that they were using condoms. In Jamaica greater knowledge on HIV and AIDS to grade six learners led to a reduction in risky sexual behaviour and the refusal of sex.

#### **2.14 DIFFERENCES IN THE SOUTH AFRICAN LEGISLATION AND CHILDREN'S ACT REGARDING CONSENT TO SEX**

According to the South African Criminal Law Act, 2007 a child is capable and mature enough to consent to sex at the age of 16. Between the ages 12 to 16 a child may be capable but not mature enough to consent to sex. Therefore if two children between the ages of 12-16 have consensual sex with each other, they may be charged with 'statutory rape'. Any child under the age of 12 is

incapable to consent to sex and any person having sex with a child under 12 is committing a crime.

UNAIDS (2011) states the South African Children Act was passed in 2005 which lowered the age of consent for HIV testing and contraceptives to 12 year olds. It was found 11% of young men and six per cent of young women are already sexually active before the age of 15 years old.

From the above, it is thus apparent that there exists a conflict of interest between legislation and policy regarding consent to sex. According to legislation any person who is aware that a 12 year old is having sex should report it. Yet the Children's Act implies that a health worker should offer contraceptives to a 12 year old fully aware that the child is sexually active.

### **2.15 ARTICLE ON THE INTENDED SCHOOL HEALTH PROGRAM**

According to a newspaper article an opinion was expressed by Carien Kruger in the Rapport on "Veiliger seks nou deel van leerplan" on 21 October 2012, children as young as 12 years old will have access to condoms which will be issued to them by professional health workers at their respective schools. According to Dr Saadhna Panday, Director of Health promotion, the integrated school health program is targeted at grades 7-12 learners and he promises condoms will not be issued irresponsibly to learners. Private individual requested counselling will take place first and dependent on the outcome condoms will be issued to learners. According to Panday there is an agreement with educators, principals and school governing bodies they will arrange parental meetings in order for the mobile clinics to visit the schools. Participation in the school health program is voluntary and consent forms are required from both parents and children from 12 years old. The school governing body can, however, choose which part of the school health program will be allowed. The article further reveals that it is estimated that 37% of grades 8 – 11 learners are already sexually active. The sexual health program forms part of a wider health program where every learner ranging from grade 1-12 learners will be examined for problems with hearing, sight, teeth and diseases such as tuberculosis. The focus will be the poorest schools which will be expanded over the next five years. Dr Jaco Deacon, Deputy Principal of the Federation of Governing Bodies of South African Schools (Fedsas) supports the program in principle and says children must be healthy in order to learn. However, the program should be treated with caution because sexual and reproductive aspects may upset many parents and potentially divide these communities. It is suggested governing bodies take ownership of the

program at their school and they include churches, welfare- and non-governmental organizations. The two non-governmental organizations, namely Equal Education (EE) and Treatment Action Campaign (TAC) fear school governing bodies might hamper the program as well as learners' access to condoms. The article also mentions international research shows that access to sexual education and condoms do not lead to an increase in sexual activities amongst adolescents. Differences in legislation and the program were highlighted in the article mentioning the possible consequences. The argument is children younger than 12 years old break the law if they engage in sex with each other and anyone who is aware of such activities is legally obligated to report the matter. Yet children as young as 12 years old can obtain contraceptives from health workers. The Centre for Children's Rights at Tukkies went to the High Court to contest the constitution on criminalization of consensual sex between children aged 12 – 16 years old as well as being under an obligation to report. The fear is this legislation might stop children from requesting assistance and if they are reported where their exposure to the criminal system will be traumatic. The article highlights in the light of current legislation it becomes complicated for a health worker to provide condoms to a 12 year old who by law is not mature enough to have sex whilst that very same health worker is obligated to report such a matter.

## **2.16 CONCLUSION**

There is evidence young people are adopting safer sex methods and the HIV incidence in South Africa is showing a decline. It appears the prevention programs promoting behaviour change is working. Young people tend to use condoms more once shown how to correctly and consistently use them. However, there still seems to be a lack of knowledge amongst young people regarding HIV prevention as well as the lack of access to condoms. The National Strategic Plan (2011) to roll out an integrated school health program for all schools consisting of comprehensive sexual health education and the supply of condoms aims to address this problem. Yet the implementation of this program seems to be tricky considering the differences with legislation and the policy. Chapter 3 reveals the methodology chosen to obtain the data from learners and educators regarding their perceptions about the provision of condoms to schools.

## CHAPTER 3

### RESEARCH METHODOLOGY

#### 3.1 INTRODUCTION

The research was conducted at Malibu High School which is situated in Eerste River in the Northern Suburbs of Cape Town. The school draws learners from neighbouring communities and currently has a student enrolment of approximately 1 500 learners. The school is proud of its holistic approach and its motto is 'We learn for life'; upholds a good discipline and academic standard. The research took place in the form of a survey which included 100 learners (10 boys and 10 girls per grade) who were randomly chosen and nine Life Orientation educators were non-randomly chosen.

#### 3.2 PROBLEM STATEMENT

The literature indicates many 15-18 year old teenagers are already engaging in sexual activity. Addressing level of sexual health education incorporated in their Life Orientation curriculum at schools, they should be equipped with sufficient knowledge to make responsible decisions about their sexual health in order to prevent unwanted pregnancies, sexually transmitted infections and HIV infection. However, when facing reality the statistical picture prove otherwise the opposite of what is envisaged in the ideal situation.

It is unclear what the learners' level of knowledge is on how to protect them against HIV infection. It is unclear whether educators feel confident with their own level of knowledge on HIV prevention they need to convey to learners. It is also unclear whether parents feel confident, knowledgeable and equipped to effectively teach their children about HIV prevention. This study aims to get a clearer understanding of the perceptions of the learners and educators at Malibu High School on condoms as a means of protection against HIV infection as well as on the provision of condoms to schools.

What are the perceptions of learners and educators on the provision of condoms to schools?

### **3.3 OBJECTIVES OF THE STUDY**

- To determine what the learners' perceptions are on the provision of condoms to schools.
- To establish the level of knowledge of learners on HIV and AIDS.
- To establish what the educators' perceptions are on the provision of condoms to schools.
- To provide guidelines to ensure that educators' and learners' challenges regarding HIV and AIDS awareness, sexuality education and condom provision are addressed.

### **3.4 RESEARCH APPROACH**

The paradigm in which the proposed research was conducted is a quantitative study using descriptive statistics to provide meaning to the data. According to Christensen, Johnson & Turner (2011) a quantitative study requires the collection of numerical data to answer a given research question. The research design took the form of a survey for learners and educators collecting information through the use of questionnaires that will be expressed as percentage. The two target groups chosen for this study comprised of 100 grades 8-12 learners at Malibu High School and 9 Life Orientation educators at the same institution. The advantage of a quantitative study using questionnaires it is easy for learners to complete and give responses that is required; they had to choose the close-ended option. The disadvantage of this approach is their view or opinion has not been taken into account as in the case of a qualitative study. Educators received a questionnaire with a few open-ended questions; were able to share their own views and opinions. When efforts were made to collect the completed responses from the educators created problems.

### **3.5 SAMPLING**

The learner population at Malibu High School consists of 1500 grades 8-12 learners. This study required a representative sample of 100 learners ranging from grade 8-12. Twenty learners (10 boys, 10 girls) per grade were randomly selected using the equal probability of selection method (EPSEM). According to Christensen et al. (2011) an EPSEM method ensures that each learner has an equal chance of being selected. The method of stratified random sampling was used where each grade was divided into two groups, namely males and females using a class or grade list. There are seven grade 8 groups, nine grade 9 groups, eight grade 10 groups, seven grade 11 groups and six grade 12 groups; identification numbers were issued to each name. A random

sample was drawn from each female and male group per grade (10 boys and 10 girls per grade). The final sample comprised of 100 learners (20 per grade) with an equal gender distribution for grades 8-12.

Each learner was provided with a self-administered questionnaire consisting of closed-ended questions which was completed within a pre-arranged time-slot and venue (school library) under supervision. Questionnaires for learners were designed with statements consisting of multiple choices and Yes/No responses to gather information about the level of HIV and AIDS awareness, their level of sex education and their perceptions on condoms as well as the provision of condoms to schools. The questions were explained before-hand and remained with the learners in the event of queries arising from the process. The questionnaires were anonymously completed by the learners and they had to place them in a sealed box.

Self-administered open-ended questionnaires (quantitative) were provided to all Life Orientation educators by means of non-random convenience sampling. According to Christensen et al. (2011) this type of sampling is based on individuals who are easily available or recruited. These questionnaires were collected from educators personally as pre-arranged. Questionnaires with open-ended questions for educators were designed to gather information about their role in HIV and AIDS awareness, sex education as well as their perceptions on condoms as well as the provision to schools. Educators completed these questionnaires anonymously and placed them in a sealed box. The data obtained from the questionnaires were logged into the Excel Program and it was processed. An analysis of the data follows where according to table 3.1 the number of girls and boys selected by means of random selection to participate in the study.



**Table 3.1**

**Number of girls and boys selected by means of random selection to participate in the research**

| <b>Grades</b> | <b>Column A: # of learners per grade</b> | <b>Column B: # of girls selected per grade</b> | <b>Column C: actual # of girls selected per grade</b> | <b>Column D: # of boys selected per grade</b> | <b>Column E: actual # of boys selected per grade</b> | <b>Total (Column A + B)</b> | <b>Actual total (Column C + E)</b> |
|---------------|--|--|---|---|--|-----------------------------|------------------------------------|
| <b>8</b>      | 297                                      | 10   | 5   | 10  | 5  | 20                          | 10                                 |
| <b>9</b>      | 254                                      | 10   | 5   | 10  | 5  | 20                          | 10                                 |
| <b>10</b>     | 342                                      | 10   | 6   | 10  | 0  | 20                          | 14                                 |
| <b>11</b>     | 273                                      | 10   | 10  | 10  | 10   | 20                          | 20                                 |
| <b>12</b>     | 259                                      | 10   | 5   | 10  | 5  | 20                          | 10                                 |
| <b>TOTAL</b>  | <b>1 529</b>                             | <b>50</b>                                      | <b>36</b>   | <b>50</b>                                     | <b>24</b>  | <b>100</b>                  | <b>60</b>                          |

Table 3.1 includes the total number of learners per grade from grade 8 to 12 (297 learners for grade 8, 254 learners for grade 9, 342 learners for grade 10, 273 learners for grade 11 and 259 learners for grade 12. The total number of learners for all grades amount to 1 529 learners. Ten boys and ten girls were randomly selected per grade. Only five boys and five girls for grade 8 and 9 respectively, only six girls and no boys for grade 10, ten boys and ten girls for grade 11 and only five girls and five boys for grade 12 participated in the study. Thirty six girls and 24 boys participated which amounts to 60 learners for all grades due to the sensitive nature of the study.

**Table 3.2**

**Number of Life Orientation educators selected by means of non-random selection to participate in the research**

| <b>Educators</b> | <b>Gender</b> | <b>Specialized Learning area</b> | <b>Qualified in Life Orientation</b> | <b>Life Orientation teaching experience</b> |
|------------------|---------------|----------------------------------|--------------------------------------|---|
| 1                | Female        | Life Orientation                 | Yes                                  | 4 years                                     |
| 2                | Female        | Life Orientation                 | Yes                                  | 8 years                                     |
| 3                | Female        | Afrikaans                        | No                                   | 8 years                                     |
| 4                | Female        | Afrikaans, History               | No                                   | 4 years                                     |
| 5                | Female        | Economic & Management Sciences   | No                                   | No experience                               |
| 6-9              | Males         | No participation                 | No participation                     | No participation                            |

Table 3.2 reveals that nine Life Orientation educators were approached to participate in the study. Of the nine educators, five are female and four are male. The male educators refused to participate in the study. Of the five female educators, only two are qualified to teach Life Orientation and have between four and eight years teaching experience. The other three female educators have been allocated with Life Orientation to fill up their packages. Two of the three educators have between four and eight years teaching experience whilst the one educator only started teaching Life Orientation this year. All five educators teach Life orientation across a number of grades. Due to confidentiality, the grades have not been included in the table.

### **3.6 ETHICAL CONSIDERATIONS**

According to Christensen et al. (2011) research ethics are a set of guidelines which assist how to conduct an ethical research. It is thus important the researcher gave consideration to the participants of the study. In this particular study, ethical considerations are important because the participants are school children and their HIV and AIDS as well as sexuality knowledge were tested which can be regarded as sensitive. Permission to conduct the study at Malibu High School was requested from the Western Cape Education Department (WCED). Ethical clearance to conduct the study was requested from the Stellenbosch University Ethical Committee to ensure that all the participants were protected from any physical or psychological harm. Informed consent forms were issued to all learners which required permission from parents for learners to participate in the study. It was communicated that any information obtained during the study would be treated with anonymity and confidentiality. Learners were also informed their participation would be voluntary and that they had the right to withdraw from the study at any point. Parents, learners and educators were informed of the purpose of the study before the study commenced.

### **3.7 CONCLUSION**

Sixty learners and five educators participated in the study. Chapter 4 reveals the reporting of the results obtained from the data questionnaires from learners and educators regarding their perceptions about the provision of condoms to schools.

## CHAPTER 4

### REPORTING OF RESULTS

#### 4.1 INTRODUCTION

The data from the responses of learners from the questionnaires are analysed and are expressed as percentages in tables and illustrated through the medium of bar and pie charts. The findings are analysed and placed in the context of the related literature. A view of the learners provides a profile of their perceptions and level of knowledge of HIV and AIDS.

The problem statement provides a roadmap for the direction of the solution namely, what are the perceptions of learners and educators on the provision of condoms to schools?

A total of 100 learners (10 girls and 10 boys per grade) were randomly selected to form part of the study. Consent forms were handed out to all the selected learners. Only 60 consent forms were returned. Forty students' parents indicated that their children will not form part of the study due to the sensitive nature of the study. The sixty learners who participated were 10 grade eight learners (5 girls and 5 boys), 14 grade nine learners (10 girls, 4 boys), 6 grade ten learners (6 girls only), 20 grade eleven learners (10 girls and 10 boys) and 10 grade twelve learners (5 girls and 5 boys). Thirty six girls and twenty four boys made up the final sample. For the purpose of this study, the learners' knowledge levels on HIV and AIDS were evaluated per grade and their sources of information, knowledge on condoms as a prevention strategy as well as their exposure to HIV and AIDS were evaluated as a whole group (Table 3.1).

## 4.2 GENERAL INFORMATION

The whole group from grades 8-12 had to answer the same questions on the questionnaire (Addendum 1). The questions tested their knowledge levels on HIV and AIDS. The first question tested how a person gets infected with HIV which included all the different modes of transmission such as having sex without a condom, sharing needles for drug use with a person with HIV and when a HIV + mother breastfeeds her baby. There are still a small percentage of students who are not aware that all the options mentioned can lead to HIV infection. The second question tested their knowledge on the myths of contracting HIV by kissing an HIV + person, sitting on a toilet seat or by touching a HIV + person. Some students are under the impression that you can become infected by kissing someone with HIV. The third question focused on whether learners thought that there is a cure for AIDS. Some students are under the impression that there is a cure for AIDS. The fourth question focused on whether one is able to see whether someone is HIV +. Although the majority of learners indicated that you cannot tell whether someone is HIV +, a small number of learners were unsure. The average percentage per grade for correct answers was 80.35 %.

The next eight questions tested the learners' sources of information on HIV and AIDS. It appears that parents are involved as a source of information regarding HIV and AIDS as well as community programs. Peers play a small role as a source of information to these learners. These findings are interesting and contrary to the literature. The findings indicate that although learners feel free to talk about sex-related topics at home whenever the need arises, they do not speak about it often which could be due to conservative views or strong moral values. A large number (60%) of learners indicated that their parents are quite knowledgeable on the topic of sex, HIV and AIDS and 40 % of the learners indicated that they are aware of community programs. Sixty per cent of the learners indicated that they receive sex education at school. It is clear that the school needs to play a more active role in order for the other 40 % who indicated that they do not receive sex education at school at all. The majority of learners feel comfortable to talk about sex in the classroom and they feel confident that their educators are competent to answer their questions. Half of the learners indicated that they are aware of community programs involved in HIV and AIDS awareness. It is safe to assume that the school is lacking community involvement.

The next six questions focused on learners' knowledge on whether condoms are a good prevention strategy for HIV. Sixty two per cent indicated that they feel that using condoms can prevent HIV infection. The rest were either unsure or unconvinced which is a reason for concern. Ninety three per cent of learners indicated that condoms are readily available and 98 % indicated that they feel comfortable to collect condoms at local clinics. Interestingly 73 % of learners felt that it is easy for a girl to negotiate condom use with a boy whilst 27 % felt that this was not the case. The school needs to address this problem as it reflects a degree of gender inequity. Ninety eight per cent felt that drugs and alcohol affect one's judgement and can lead to unsafe sex. Sixty seven per cent of learners felt that it is a good idea that condoms should be provided to learners by schools and 77 % felt that it can help prevent unwanted pregnancies, STDs and HIV infection.

The last two questions focussed on learners' exposure to HIV and AIDS. Sixty seven per cent of learners do not know anyone who is HIV +. Yet 33 % of the learners are exposed to HIV in one way or another. Eighty per cent of the learners do not know of anyone who has died of AIDS. It appears as if the majority of learners at the school is unaffected by HIV and AIDS. Yet 20 % know of someone who has died of AIDS and even though the impact at the school is still relatively low, the school needs to strengthen its focus on prevention.

Following are the questions posed to learners and the data/ responses received.

#### **4.3.1 LEARNER'S KNOWLEDGE LEVELS**

The first four questions test the learners' knowledge on HIV and AIDS and provide options for learners to choose from. The different grades' responses are illustrated in tables 4.1 to 4.4.

Table 4.1

## A person can get HIV when

|                 | Options   | Frequency | Percentage | Valid percentage | Cumulative percentage |
|-----------------|---|-----------|------------|------------------|-----------------------|
| <b>GRADE 8</b>  | You have sex without a condom with someone.               | 0         | 0          | 0                | 0                     |
|                 | You share needles when using drugs with someone with HIV. | 1         | 10         | 10               | 10                    |
|                 | A HIV + mother breastfeeds her baby.                      | 0         | 0          | 0                | 0                     |
|                 | All of the above.   | 9         | 90         | 90               | 90                    |
|                 | <b>TOTAL</b>  | <b>10</b> | <b>100</b> | <b>100</b>       | <b>100</b>            |
| <b>GRADE 9</b>  | Options   | Frequency | Percentage | Valid percentage | Cumulative percentage |
|                 | You have sex without a condom with someone.               | 3         | 21         | 21               | 21                    |
|                 | You share needles when using drugs with someone with HIV. | 0         | 0          | 0                | 0                     |
|                 | A HIV + mother breastfeeds her baby.                      | 0         | 0          | 0                | 0                     |
|                 | All of the above.   | 11        | 79         | 79               | 79                    |
|                 | <b>TOTAL</b>  | <b>14</b> | <b>100</b> | <b>100</b>       | <b>100</b>            |
| <b>GRADE 10</b> | Options   | Frequency | Percentage | Valid percentage | Cumulative percentage |
|                 | You have sex without a condom with someone.               | 0         | 0          | 0                | 0                     |
|                 | You share needles when using drugs with someone with HIV. | 0         | 0          | 0                | 10                    |
|                 | A HIV + mother breastfeeds her baby.                      | 0         | 0          | 0                | 0                     |
|                 | All of the above.   | 6         | 100        | 100              | 100                   |
|                 | <b>TOTAL</b>  | <b>6</b>  | <b>100</b> | <b>100</b>       | <b>100</b>            |

|                 | Options   | Frequency | Percentage | Valid percentage | Cumulative percentage |
|-----------------|---|-----------|------------|------------------|-----------------------|
| <b>GRADE 11</b> | You have sex without a condom with someone.               | 2         | 10         | 10               | 10                    |
|                 | You share needles when using drugs with someone with HIV. | 2         | 10         | 10               | 10                    |
|                 | A HIV + mother breastfeeds her baby.                      | 0         | 0          | 0                | 0                     |
|                 | All of the above.   | 16        | 80         | 80               | 80                    |
|                 | <b>TOTAL</b>  | <b>20</b> | <b>100</b> | <b>100</b>       | <b>100</b>            |
|                 | Options   | Frequency | Percentage | Valid percentage | Cumulative percentage |
| <b>GRADE 12</b> | You have sex without a condom with someone.               | 3         | 30         | 30               | 30                    |
|                 | You share needles when using drugs with someone with HIV. | 1         | 10         | 10               | 10                    |
|                 | A HIV + mother breastfeeds her baby.                      | 0         | 0          | 0                | 0                     |
|                 | All of the above.   | 6         | 60         | 60               | 60                    |
|                 | <b>TOTAL</b>  | <b>10</b> | <b>100</b> | <b>100</b>       | <b>100</b>            |

Table 4.1 reflects the learners' knowledge on how a person can become infected with HIV. The options given are that a person can get HIV when you have sex without a condom with someone, when you are sharing needles during drug use with someone who has HIV, when a mother with HIV breastfeeds her baby or all of the above. Ninety per cent of the grade eight learners, 79 % of the grade nine learners, 100 % of the grade ten learners, 80 % of the grade eleven learners and 60% of the grade twelve learners could answer the question correctly which was the last option for all of the above. It appears that the lower grades are more knowledgeable than the grade twelve learners. It is still worrying that a small percentage of learners (21 % of grade 9 learners, 10 % of grade 11 learners and 30 % of grade 12 learners) are still under the impression that you can only become infected with HIV when you have sex without a condom. More alarming is 10 % of grade 8, grade 11 and grade 12 learners respectively felt that you can only become infected with HIV when sharing needles with an infected person during drug use.



Table 4.2

## You can get HIV from

| GRADE 8  | Options                     | Frequency | Percentage | Valid percentage | Cumulative percentage |
|----------|-----------------------------|-----------|------------|------------------|-----------------------|
|          | Kissing an infected person. | 1         | 10         | 10               | 10                    |
|          | Sitting on a toilet seat.   | 0         | 0          | 0                | 0                     |
|          | Touching a HIV+ person.     | 0         | 0          | 0                | 0                     |
|          | None of the above.          | 9         | 90         | 90               | 90                    |
|          | <b>TOTAL</b>                | <b>10</b> | <b>100</b> | <b>100</b>       | <b>100</b>            |
| GRADE 9  | Options                     | Frequency | Percentage | Valid percentage | Cumulative percentage |
|          | Kissing an infected person. | 1         | 7          | 7                | 7                     |
|          | Sitting on a toilet seat.   | 1         | 7          | 7                | 7                     |
|          | Touching a HIV+ person.     | 0         | 0          | 0                | 0                     |
|          | None of the above.          | 12        | 86         | 86               | 86                    |
|          | <b>TOTAL</b>                | <b>14</b> | <b>100</b> | <b>100</b>       | <b>100</b>            |
| GRADE 10 | Options                     | Frequency | Percentage | Valid percentage | Cumulative percentage |
|          | Kissing an infected person. | 1         | 17         | 17               | 17                    |
|          | Sitting on a toilet seat.   | 0         | 0          | 0                | 10                    |
|          | Touching a HIV+ person.     | 0         | 0          | 0                | 0                     |
|          | None of the above.          | 5         | 83         | 83               | 83                    |
|          | <b>TOTAL</b>                | <b>6</b>  | <b>100</b> | <b>100</b>       | <b>100</b>            |
| GRADE 11 | Options                     | Frequency | Percentage | Valid percentage | Cumulative percentage |
|          | Kissing an infected person. | 2         | 10         | 10               | 10                    |
|          | Sitting on a toilet seat.   | 0         | 0          | 0                | 0                     |
|          | Touching a HIV+ person.     | 0         | 0          | 0                | 0                     |
|          | None of the above.          | 18        | 90         | 90               | 90                    |
|          | <b>TOTAL</b>                | <b>20</b> | <b>100</b> | <b>100</b>       | <b>100</b>            |
| GRADE 12 | Options                     | Frequency | Percentage | Valid percentage | Cumulative percentage |
|          | Kissing an infected person. | 2         | 20         | 20               | 20                    |
|          | Sitting on a toilet seat.   | 0         | 0          | 0                | 0                     |
|          | Touching a HIV+ person.     | 0         | 0          | 0                | 0                     |
|          | None of the above.          | 8         | 80         | 80               | 80                    |
|          | <b>TOTAL</b>                | <b>10</b> | <b>100</b> | <b>100</b>       | <b>100</b>            |

Table 4.2 reflected the learners' knowledge on the myths of contracting HIV. The options given are you can contract HIV by kissing an HIV + person, sitting on a toilet seat, touching an HIV + person or none of the options given. Ninety per cent of the grade 8 learners, 86 % of grade 9 learners, 83 % of the grade 10 learners, 90 % of the grade 11 learners and 80 % of the grade 12 learners could answer the question correctly on the myths of becoming infected by HIV which is none of the options given. There are still a small percentage of learners who feel that you can become infected by kissing someone with HIV (10 % of grade 8 learners, 7 % of grade 9 learners, 17 % of grade 10 learners, 10 % of grade 11 learners and 20 % of grade 12 learners. Seven per cent of grade 9 learners indicated that you can become infected by sitting on a toilet seat. It is thus evident that these myths surrounding HIV still exist.

Table 4.3

There is a cure for AIDS

| GRADE 8  | Options      | Frequency | Percentage | Valid percentage | Cumulative percentage |
|----------|--------------|-----------|------------|------------------|-----------------------|
|          | True         | 1         | 10         | 10               | 10                    |
|          | False        | 7         | 70         | 70               | 70                    |
|          | Unsure       | 2         | 20         | 20               | 20                    |
|          | <b>TOTAL</b> | <b>10</b> | <b>100</b> | <b>100</b>       | <b>100</b>            |
| GRADE 9  | Options      | Frequency | Percentage | Valid percentage | Cumulative percentage |
|          | True.        | 3         | 21         | 21               | 21                    |
|          | False        | 8         | 57         | 57               | 57                    |
|          | Unsure       | 3         | 21         | 21               | 21                    |
|          | <b>TOTAL</b> | <b>14</b> | <b>100</b> | <b>100</b>       | <b>100</b>            |
| GRADE 10 | Options      | Frequency | Percentage | Valid percentage | Cumulative percentage |
|          | True.        | 0         | 0          | 0                | 0                     |
|          | False        | 6         | 100        | 100              | 100                   |
|          | Unsure       | 0         | 0          | 0                | 0                     |
|          | <b>TOTAL</b> | <b>6</b>  | <b>100</b> | <b>100</b>       | <b>100</b>            |
| GRADE 11 | Options      | Frequency | Percentage | Valid percentage | Cumulative percentage |
|          | True.        | 1         | 5          | 5                | 5                     |
|          | False        | 13        | 65         | 65               | 65                    |
|          | Unsure       | 6         | 30         | 30               | 30                    |
|          | <b>TOTAL</b> | <b>20</b> | <b>100</b> | <b>100</b>       | <b>100</b>            |
| GRADE 12 | Options      | Frequency | Percentage | Valid percentage | Cumulative percentage |
|          | True.        | 0         | 0          | 0                | 0                     |
|          | False        | 8         | 80         | 80               | 80                    |
|          | Unsure       | 2         | 20         | 20               | 20                    |
|          | <b>TOTAL</b> | <b>10</b> | <b>100</b> | <b>100</b>       | <b>100</b>            |

Table 4.3 reflects learners' knowledge on the statement there is a cure for AIDS. The options given to learners were true, false or unsure. The correct option is that the statement is false. Seventy per cent of the grade 8 learners, 57 % of the grade 9 learners, 100 % of the grade 10 learners, 65 % of the grade 11 learners and 80 % of the grade 12 learners could answer the

question correctly. However 10 % of the grade 8, 21 % of the grade 9 and 5 % of the grade 11 learners believe that this statement is true. Twenty per cent of the grade 8 learners, 21 % of grade 9, 30 % of grade 11 and 20 % of the grade 12 learners are unsure whether the statement is true or false. A small degree of uncertainty therefore exists amongst the learners regarding the validity of the statement which is a reason for concern.

**Table 4.4****You are able to see if someone is HIV+**

| <b>GRADE 8</b>  | <b>Options</b> | <b>Frequency</b> | <b>Percentage</b> | <b>Valid percentage</b> | <b>Cumulative percentage</b> |
|-----------------|----------------|------------------|-------------------|-------------------------|------------------------------|
|                 | Yes            | 0                | 0                 | 0                       | 0                            |
| No              | 7              | 70               | 70                | 70                      |                              |
| Unsure          | 3              | 30               | 30                | 30                      |                              |
| <b>TOTAL</b>    | <b>10</b>      | <b>100</b>       | <b>100</b>        | <b>100</b>              |                              |
| <b>GRADE 9</b>  | <b>Options</b> | <b>Frequency</b> | <b>Percentage</b> | <b>Valid percentage</b> | <b>Cumulative percentage</b> |
|                 | Yes            | 2                | 14                | 14                      | 14                           |
| No              | 11             | 79               | 79                | 79                      |                              |
| Unsure          | 1              | 7                | 7                 | 7                       |                              |
| <b>TOTAL</b>    | <b>14</b>      | <b>100</b>       | <b>100</b>        | <b>100</b>              |                              |
| <b>GRADE 10</b> | <b>Options</b> | <b>Frequency</b> | <b>Percentage</b> | <b>Valid percentage</b> | <b>Cumulative percentage</b> |
|                 | Yes            | 0                | 0                 | 0                       | 0                            |
| No              | 5              | 83               | 83                | 83                      |                              |
| Unsure          | 1              | 17               | 17                | 17                      |                              |
| <b>TOTAL</b>    | <b>6</b>       | <b>100</b>       | <b>100</b>        | <b>100</b>              |                              |
| <b>GRADE 11</b> | <b>Options</b> | <b>Frequency</b> | <b>Percentage</b> | <b>Valid percentage</b> | <b>Cumulative percentage</b> |
|                 | Yes            | 1                | 5                 | 5                       | 5                            |
| No              | 13             | 65               | 65                | 65                      |                              |
| Unsure          | 6              | 30               | 30                | 30                      |                              |
| <b>TOTAL</b>    | <b>20</b>      | <b>100</b>       | <b>100</b>        | <b>100</b>              |                              |
| <b>GRADE 12</b> | <b>Options</b> | <b>Frequency</b> | <b>Percentage</b> | <b>Valid percentage</b> | <b>Cumulative percentage</b> |
|                 | Yes            | 0                | 0                 | 0                       | 0                            |
| No              | 10             | 100              | 100               | 100                     |                              |
| Unsure          | 0              | 0                | 0                 | 0                       |                              |
| <b>TOTAL</b>    | <b>10</b>      | <b>100</b>       | <b>100</b>        | <b>100</b>              |                              |

Table 4.4 reflects the learners' knowledge on whether you are able to see if someone is HIV +. The options given is yes, no or unsure. The correct option is no. Seventy per cent of the grade 8 learners, 79 % of the grade 9 learners, 83 % of the grade 10 learners, 65 % of the grade 11 learners and 80 % of the grade 12 learners could answer the question correctly. However 14 % of the grade 9 learners and 5 % of the grade 11 learners indicated that you are able to see if someone is HIV +. Thirty per cent of the grade 8 learners, 7 % of grade 9, 17 % of grade 10 and 30 % of grade 12 are unsure which yet again reflects the level of uncertainty amongst learners.

**Table 4.5**

**Average % of different grades' correct responses to questions 1-4**

| <b>Grades</b>                                   | <b>Question 1<br/>responses in<br/>%</b> | <b>Question 2<br/>responses in<br/>%</b> | <b>Question 3<br/>responses in<br/>%</b> | <b>Question 4<br/>responses in<br/>%</b> | <b>Average %<br/>per grade</b> |
|---|--|--|--|--|--------------------------------|
| Grade 8   | 90                                       | 90                                       | 70                                       | 70                                       | <b>80</b>                      |
| Grade 9   | 79                                       | 86                                       | 57                                       | 79                                       | <b>75.25</b>                   |
| Grade 10  | 100                                      | 83                                       | 100                                      | 83                                       | <b>91.5</b>                    |
| Grade 11  | 80                                       | 90                                       | 65                                       | 65                                       | <b>75</b>                      |
| Grade 12  | 60                                       | 80                                       | 80                                       | 100                                      | <b>80</b>                      |
| <b>Overall<br/>average %<br/>for all grades</b> | <b>81.8</b>                              | <b>85.8</b>                              | <b>74.4</b>                              | <b>79.4</b>                              | <b>80.35</b>                   |

Table 4.5 reflects the overall averages for all grades on the individual questions which are 81.8 % for question 1, 85.8 % for question 2, 74.4 % for question 3 and 79.4 % for question 4. The overall average for the learners' knowledge per grade is 80 % for grade 8, 75.25 % for grade 9, 91.5 % for grade 10, 75 % for grade 11 and 80 % for grade 12 on all four questions. The overall average for all the grades is 80.35 % which may be regarded as high. It can thus be assumed that the knowledge levels of the levels on HIV and AIDS are acceptable.

### 4.3.2 LEARNERS' SOURCES OF INFORMATION ON SEX EDUCATION

The following eight questions from question 5 – 12 concentrated on learners' sources of information regarding sexuality education as well as HIV and AIDS prevention. Following is the responses from learners as a whole group on where they obtain their information on sex education (figure 4.1 – 4.8).

**Figure 4.1**

**Learners' responses on where they obtain their knowledge about sex education and HIV and AIDS awareness**

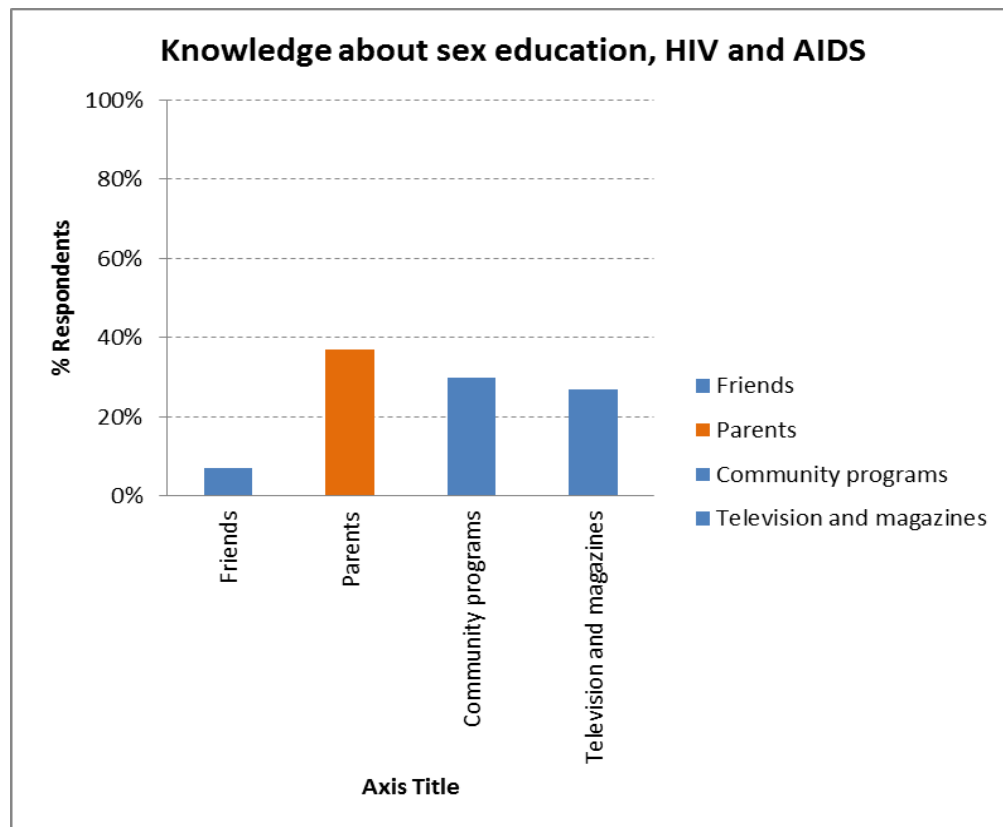


Figure 4.1 indicates that only 7 % of the sixty learners obtain their knowledge from friends and 37 % indicated that they obtain their information from parents which are contradictory with the literature. Thirty per cent indicated that they obtain their information from community programs which indicate that the community is involved in HIV and AIDS awareness to a small degree. Twenty seven per cent indicated that they obtain their information from television and magazines which are relevant sources of information.

**Figure 4.2**

**Learners' responses on how often they speak about sex, HIV and AIDS at home**

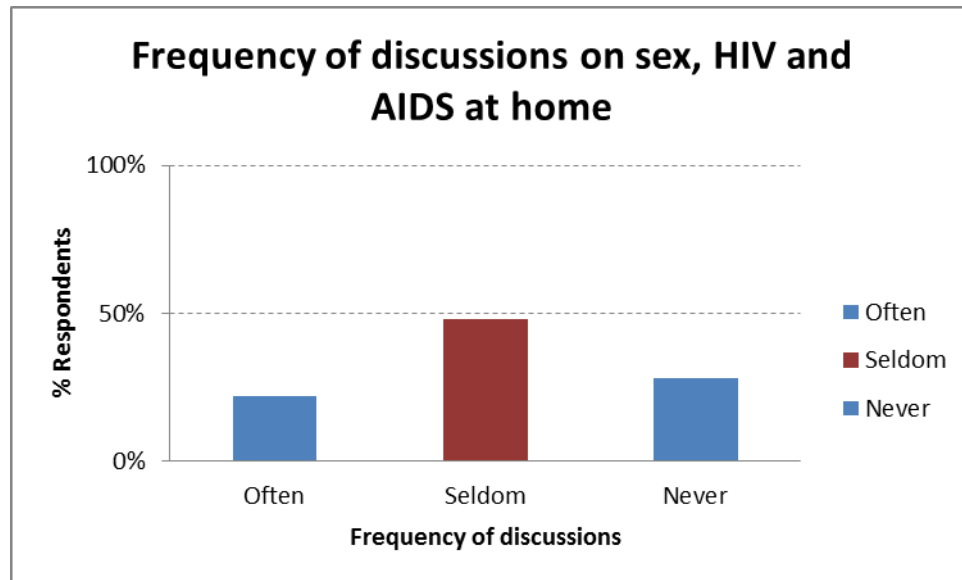


Figure 4.2 reflects how often sex, HIV and AIDS is spoken about at home. Twenty two per cent of learners indicated that they often speak about these issues at home. Forty eight per cent indicated that they seldom speak about these issues at home and 28 % indicated that they never talk about these issues at home.

**Figure 4.3**

**Learners' responses on whether they can speak freely about sex at home**

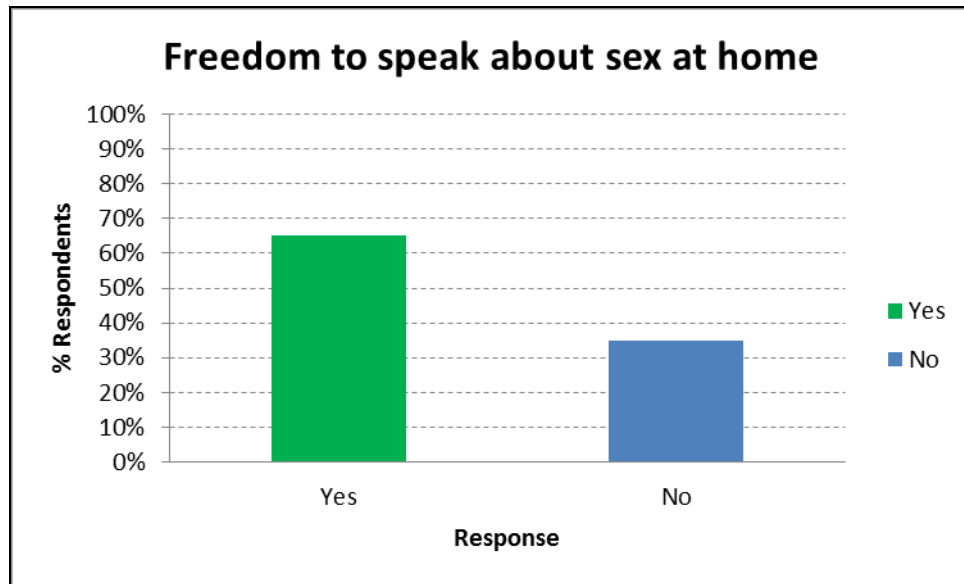


Figure 4.3 reflects whether learners feel comfortable to speak freely about sex at home. Sixty five per cent indicated that they can speak freely about sex at home if the need arises and 35 % indicated that they do not feel comfortable to speak freely about sex at home.

**Figure 4.4**

**Learners' responses on whether they think that their parents know enough to answer their questions about sex, HIV and AIDS**

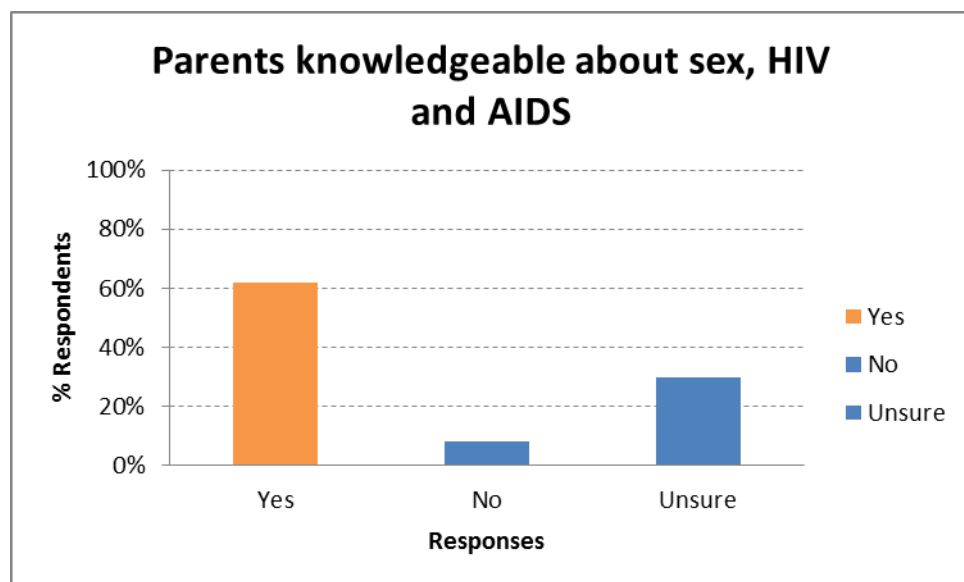




Figure 4.4 reflects learners' opinions whether they think that their parents know enough to answer questions about sex, HIV and AIDS. Sixty two per cent indicated that their parents are knowledgeable on the topics, 8 % indicated their parents are not knowledgeable and 30 % were unsure.

**Figure 4.5**

**Learners' responses on how often they receive sex education at school to prevent unwanted pregnancies, sexually transmitted diseases and HIV infection**

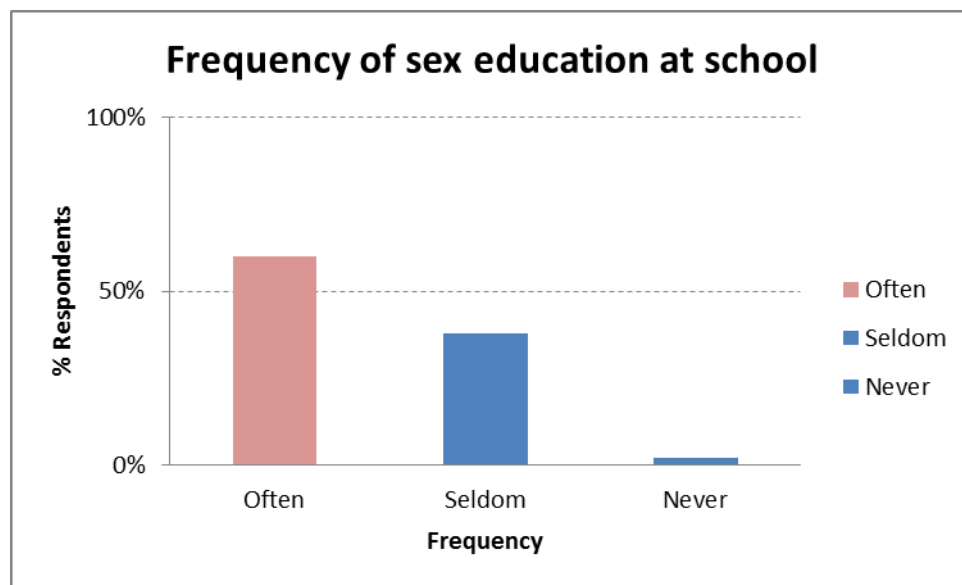


Figure 4.5 indicates the learners' perceptions on how often they receive sex education to prevent unwanted pregnancies, sexually transmitted diseases and HIV infection. Sixty per cent indicated that they receive sex education often at school which proves that the school is succeeding in the relay of relevant information through its Life Orientation curriculum. Thirty eight per cent indicated that they seldom receive sex education and 2 % indicated that they do not receive sex education at all. The discrepancy could be ascribed to different educators' own level of comfort and view about these issues and whether they feel comfortable teaching the content during Life Orientation lessons.

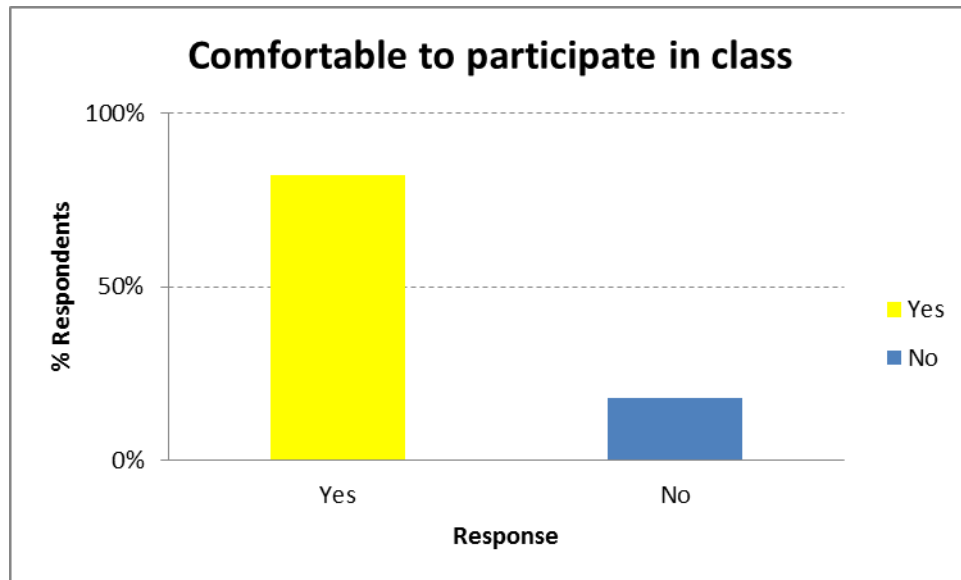
**Figure 4.6****Learners' responses on their level of comfort to answer questions on sex, HIV and AIDS**

Figure 4.6 reflects whether learners feel comfortable to ask questions about sex, HIV and AIDS in the classroom. Eighty two per cent indicated that they are at ease to ask questions whereas 18 % felt that they do not feel comfortable at all. It is pleasing that the majority of learners trust the educators to speak freely and it proves that the school is successful in its task.

**Figure 4.7**

**Learners' responses on whether educators are equipped to answer questions on sex, HIV and AIDS**

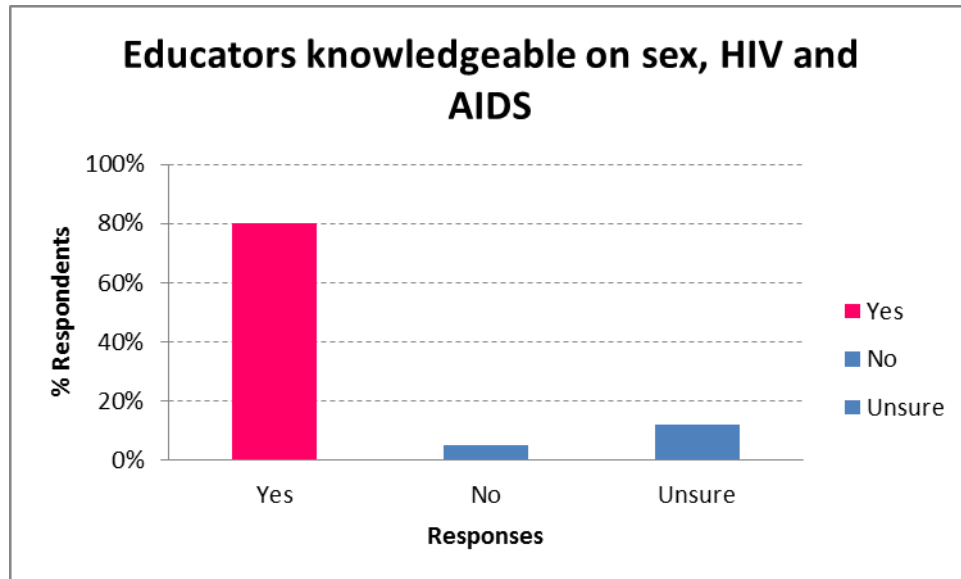


Figure 4.7 indicates the learners' perceptions about whether educators are able to answer their questions related to sex, HIV and AIDS. Eighty three per cent felt that their educators are equipped to answer their questions, 5 % felt that their educators were not equipped and this could relate to educators' own views regarding sexuality and 12 % felt unsure whether their educators were able to answer their questions.

**Figure 4.8**

**Learners' responses about community awareness programs to promote HIV prevention and behaviour change**

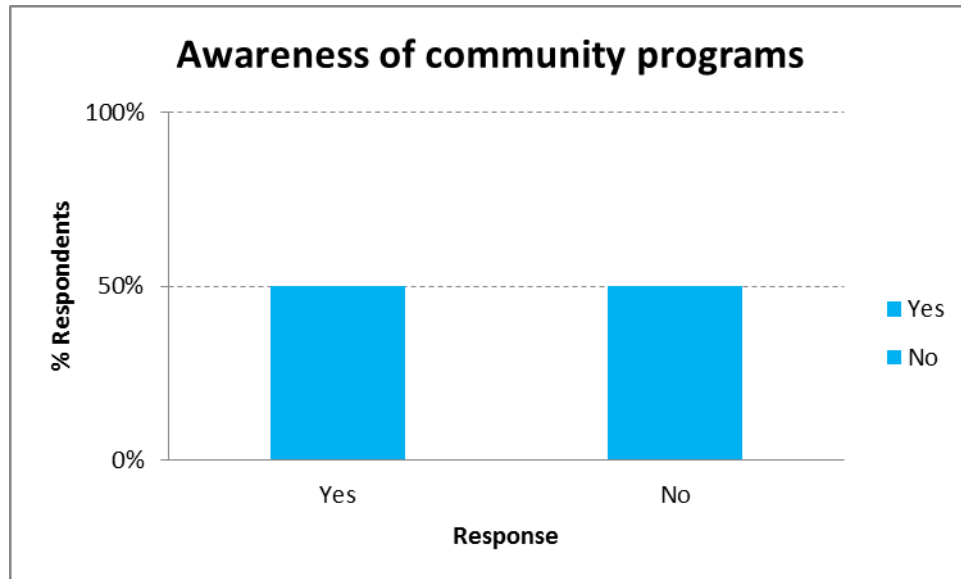


Figure 4.8 indicates whether learners have ever been exposed to awareness programs in the community which promote HIV prevention and behaviour change. Fifty per cent indicated that they have been exposed whereas the other 50 % indicated that they have never been exposed to community programs. Community interaction does take place regarding HIV prevention.

#### **4.3.3 KNOWLEDGE ON CONDOMS AS A PREVENTION STRATEGY**

The following seven questions from question 13 – 19 concentrated on learners' knowledge on condoms as a form of pie charts prevention strategy. Following is the responses from learners as a whole group (figure 4.9 – 4.15).

**Figure 4.9**

**Learners' responses on whether they think that using condoms can prevent HIV infection**

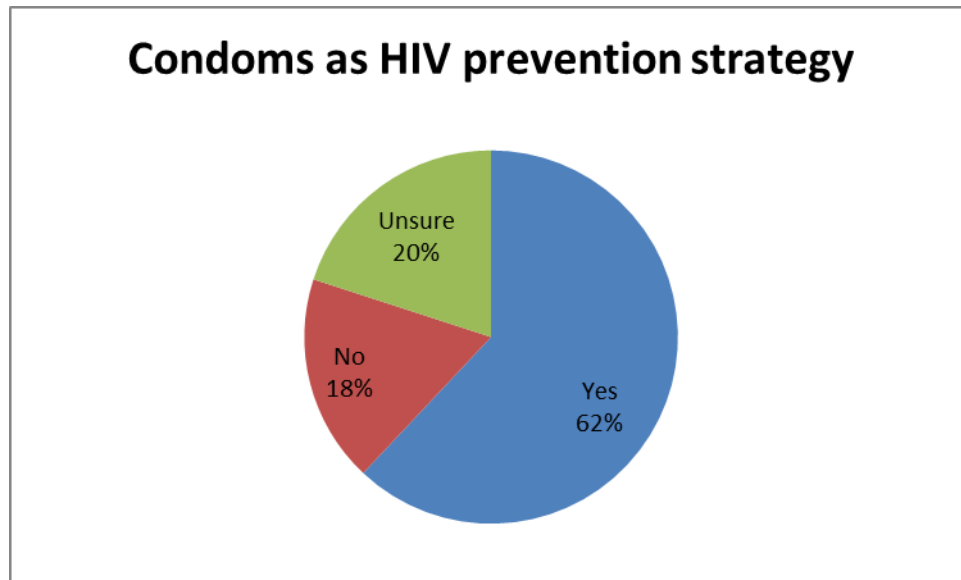


Figure 4.9 indicates whether learners feel that using a condom when you have sex can prevent HIV infection. Sixty two per cent indicated a condom can prevent HIV infection, 18 % indicated using a condom cannot prevent HIV infection and 20 % indicated they were unsure.

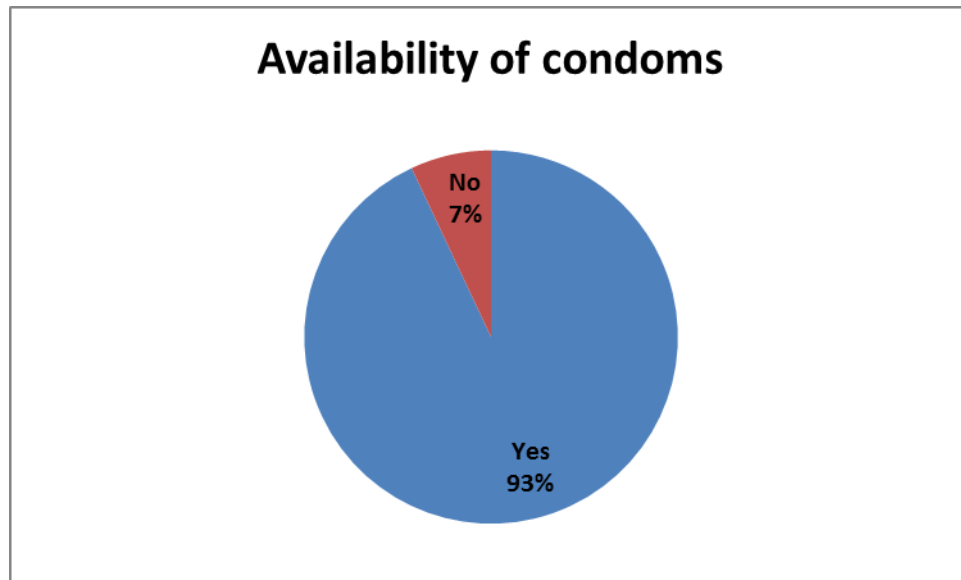
**Figure 4.10****Learners' responses on whether condoms are readily available**

Figure 4.10 indicates whether learners feel condoms are easily available when you choose to have protected sex. Ninety three per cent felt condoms are easily obtainable whereas 7 % felt this was not the case.

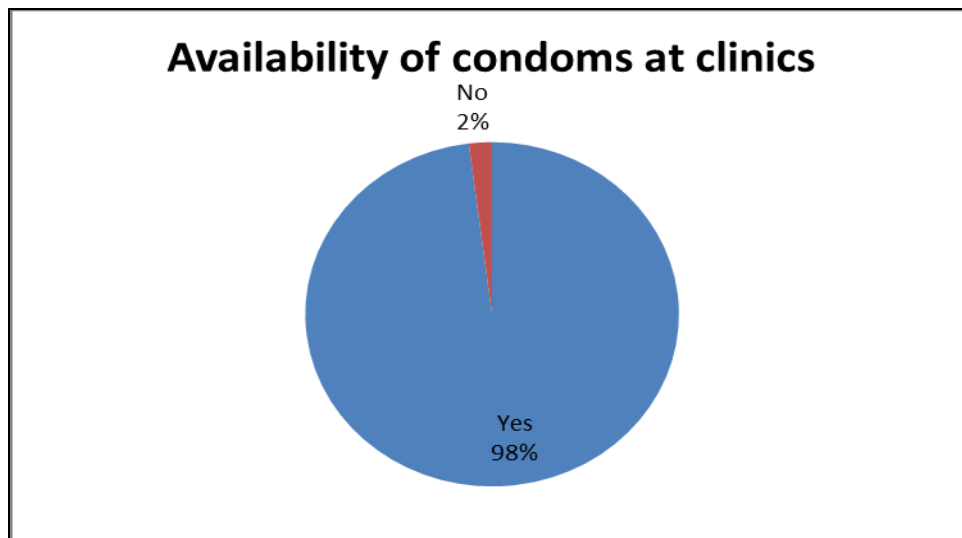
**Figure 4.11****Learners' responses on whether it is easy to collect condoms at clinics**

Figure 4.11 indicated whether learners think it is easy for them to collect condoms at local clinics. Ninety eight per cent felt this was very easy to do whereas 2 % felt it was not easy.

**Figure 4.12**

**Learners' responses on whether it is easy for a girl to negotiate condom use with a boy**

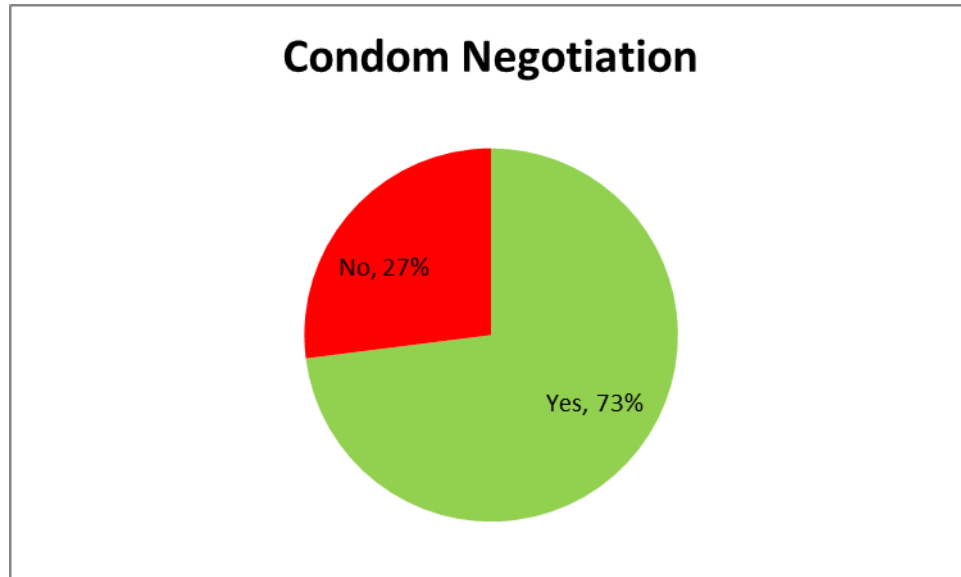


Figure 4.12 reflects whether learners think it is easy for a girl to negotiate condom use with a boy when they plan to have sex. Seventy three per cent felt it was easy to do while 27 % felt it was not easy to do.

**Figure 4.13**

**Learners' responses on whether drugs and alcohol can affect one's judgment and can lead to unprotected sex**

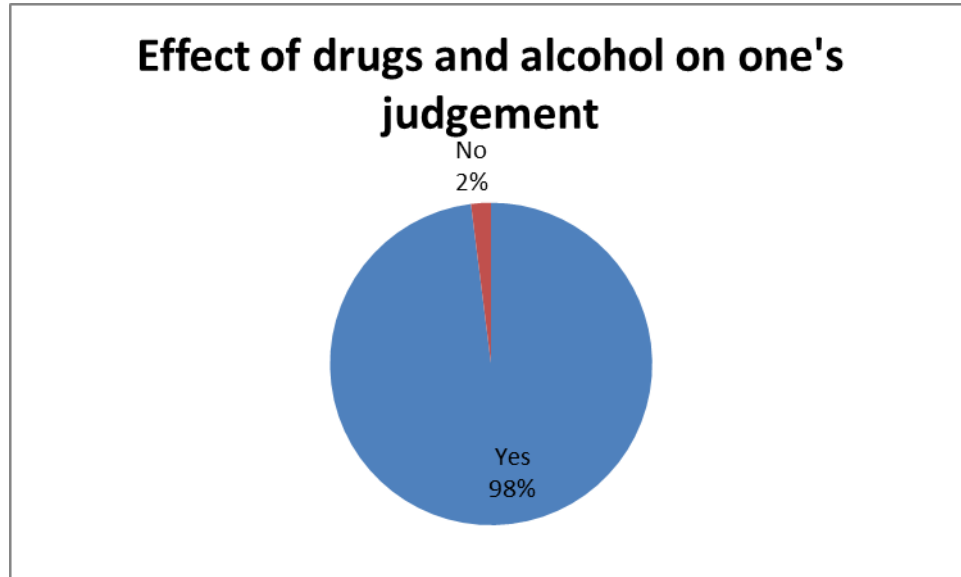


Figure 4.13 indicates whether learners feel drugs and alcohol impairs one's judgment which can lead to unplanned and unprotected sex. Ninety eight per cent felt drugs and alcohol does affect one's judgment whilst 2 % felt this was not the case.



**Figure 4.14**

**Learners' responses on whether the provision of condoms to schools is a good idea**

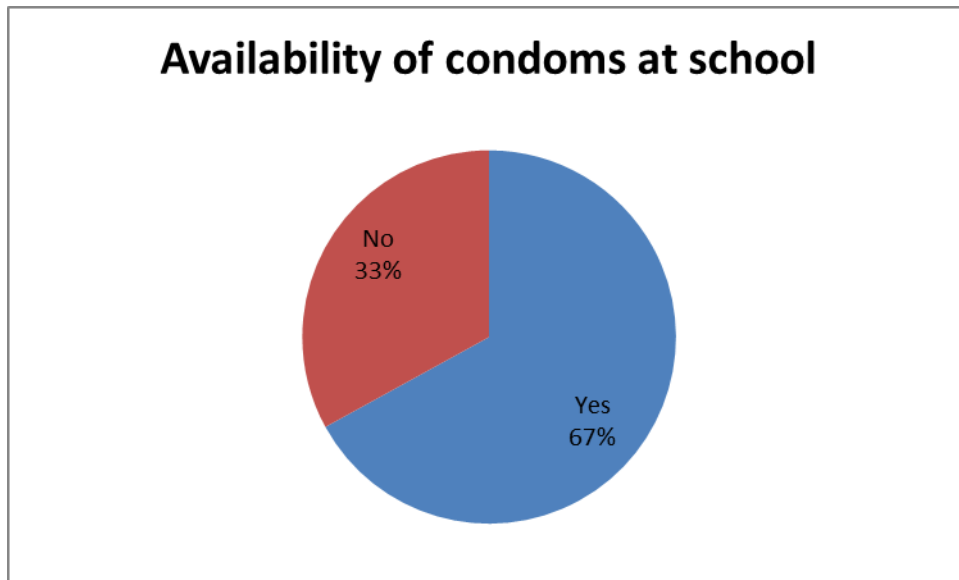


Figure 4.14 indicates whether learners feel it is a good idea that condoms are made available to learners at schools in the future. Sixty seven per cent indicated this is a good idea whereas 33 % felt it was not a good idea at all.

**Figure 4.15**

**Learners' responses on whether the availability of condoms at school will help to prevent unwanted pregnancies, sexually transmitted diseases and HIV infection**

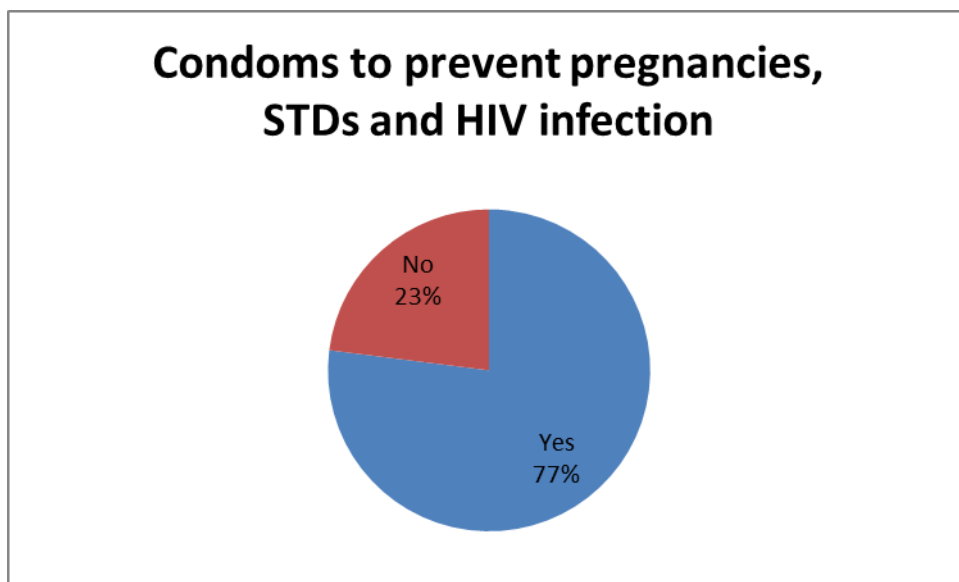


Figure 4.15 indicates whether learners feel the availability of condoms at schools will help to prevent unwanted pregnancies, sexually transmitted diseases and HIV infection. Seventy seven per cent felt the availability of condoms will be a successful prevention strategy whilst 23 % felt the availability of condoms will make no difference at all.

#### 4.3.4 EXPOSURE TO HIV AND AIDS

The following 2 questions from question 20 - 21 concentrated on learners' exposure to HIV and AIDS. Following is the responses from learners as a whole group (figure 4.16 – 4.17).

**Figure 4.16**

**I know of someone who is HIV +.**

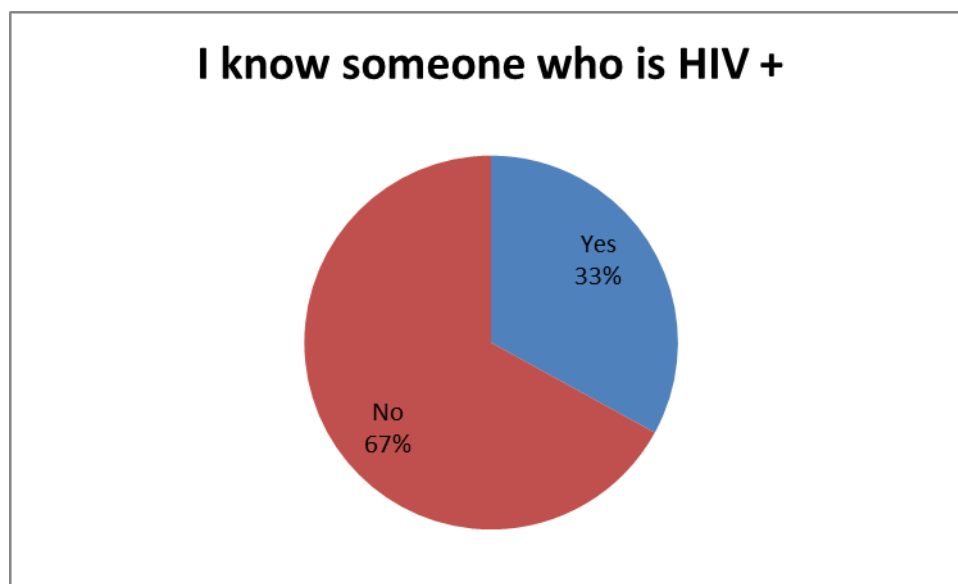


Figure 4.16 reflects 67 % of the learners do not know anyone who is HIV + yet 33 % do know someone who is HIV +. This could be ascribed to stigma, discrimination, ignorance or very little or no exposure to HIV and AIDS yet.

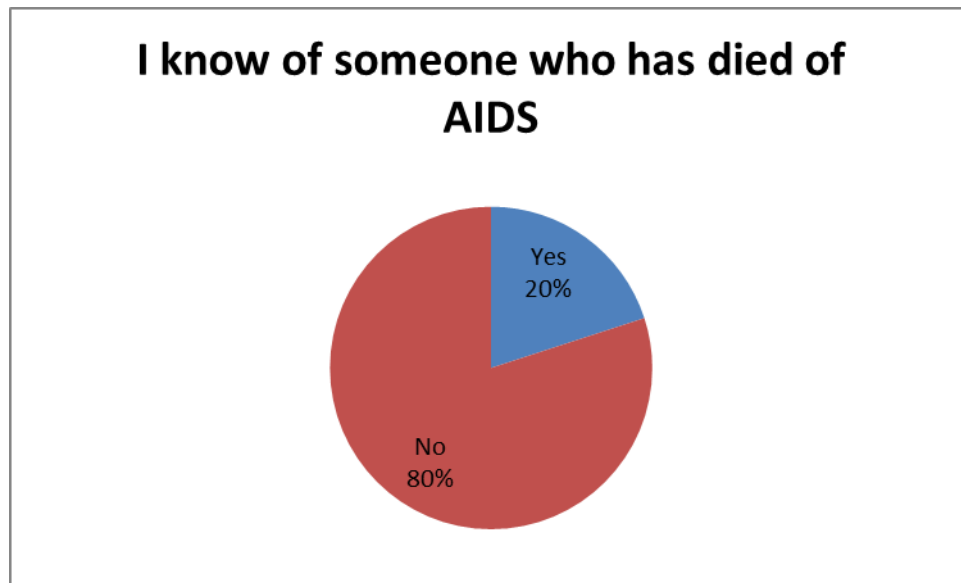
**Figure 4.17****I know of someone who has died of AIDS**

Figure 4.17 reflects 80 % of learners do not know anyone who has died of AIDS whilst 20 % do know of someone who has died of AIDS. It is apparent that a very small number of learners from Malibu High School have been affected by AIDS. The majority seems not to be exposed to AIDS.

It can thus be assumed that the prevention programs are working, that parental and community involvement does exist to a certain degree and that learners possess of healthy knowledge to prevent HIV infection. More still needs to be done to reduce the future impact of HIV and AIDS at Malibu High School.

#### **4.4 EDUCATORS**

Five female Life Orientation educators participated in the study. They teach across all grades. Each educator received a questionnaire with 12 open-ended questions (Table 3.2). The data derived from the responses of educators were analysed and classified according to their responses. Their involvement and role in HIV and AIDS awareness, sex education and perception on the provision of condoms to schools are reflected in a narrative form and where possible charts. Of the nine educators (five female educators and four male educators) selected to participate in the study only the five female educators indicated that they would participate. The four male educators refused to participate in the study.

##### **4.4.1 GENERAL INFORMATION**

Schools are instrumental as an important source of information in HIV and AIDS awareness. It is therefore essential that educators are well-trained, possess of sufficient knowledge and are comfortable to deal with sexuality, HIV and AIDS related issues in the classroom.

Educators were asked the same questions which tested their own views and perceptions of learners' knowledge levels, their own level of training, support required in the classroom, the current curriculum, their view on the distribution of condoms by schools, whether they feel the availability of condoms will have an impact, whether they are aware of any community involvement and what they think learners' main sources of information are.

From the responses received, educators feel the learners' knowledge levels are low. This could be due to no examination testing or due to learners' attitudes towards HIV and AIDS. Many feel learners are unaffected by HIV and AIDS. Many indicated the need for additional training and support from the WCED. They feel the school curriculum needs to be adapted and a stronger focus should be placed on prevention rather than to equip learners with condoms. They feel it would send the wrong message to learners. They also feel learners have misconceptions about condoms i.e. it interferes with the sexual experience therefore the availability of condoms will make no difference should learners plan to have sex. Many educators are not comfortable with the idea of the availability of condoms at school due to their own views regarding sexuality. They therefore feel schools should not promote having sex by making condoms available. Many educators are not aware of community involvement and view it as separate to the role of schools regarding HIV and AIDS awareness (not their job to involve the community organizations).

Educators feel parents are not taking responsibility for their children regarding HIV and AIDS awareness.

Following are the questions posed to educators and the responses received from them.

#### **4.4.2 QUESTIONS AND RESPONSES**

The following questions were posed to the 5 participants (Addendum 2):

**a. How do your learners react when you talk to them about sex education and HIV and AIDS prevention?**

The general theme of the five responses was learners are excited and keen to talk about sex. They are very casual and seem to joke about HIV and AIDS. They do not seem affected by HIV and AIDS. The learners are quite knowledgeable about services offered.

**b. As an educator, how would you describe the learners' level of knowledge about sexuality education and HIV prevention?**

Two themes were highlighted from the responses from the educators. Two of the respondents felt the learners are quite knowledgeable on the topic of HIV and AIDS. Three educators felt the learners' knowledge levels were minimal and they felt this is dangerous because learners believe they will not become infected with HIV. This however is contradictory with the data collected from learners.

**c. How would you as an educator, describe your level of training received on HIV prevention from the WCED?**

Three themes came out from the educators' responses. Three respondents felt insufficient training was received from the WCED. One educator felt she is well-informed on HIV strategies from the WCED. Another educator felt she received no training from the WCED at all.

**d. Do you as an educator require additional support to effectively teach learners about sexuality education and HIV prevention to adequately address their needs?**

Two themes were highlighted. The need for additional support comes from learners' attitude towards HIV and AIDS and the educators' own level of comfort to effectively carry over the information to learners. Two educators felt that there was no need for additional support but require more teaching resources in the classroom.

**e. In your view, do you think the school curriculum on sexuality education and HIV prevention adequately addresses the needs of the learners?**

Three of the five educators felt the school curriculum does not adequately address the needs of the learners. Some felt more demonstrations should be held at school in order to illustrate the effects of HIV and AIDS. Some felt only certain aspects are discussed and the focus on prevention is not stressed as much. Some felt the curriculum actually encourages learners to experiment with sex rather than to deter them. Two of the educators felt the school curriculum does address the needs of the learners.

**f. As an educator, what is your view on the distribution of condoms by schools?**

All the educators do not agree that schools should provide condoms to learners. All of them felt it would appear that schools are giving the learners permission to experiment with sex using condoms. According to them it would thus not be educationally sound even though many learners are already experimenting with sex. They felt it is not the school's responsibility to provide condoms to learners. This is contradictory to the objectives of the planned school – health program.

**g. According to your knowledge and expertise, do you think that the availability of condoms will reduce unwanted pregnancies and risky unprotected sex?**

Four of the five respondents felt the availability of condoms at schools will not reduce unwanted pregnancies and risky unprotected sex. They explained the learners feel the use of condoms interfere with the sexual experience. It takes too much effort and makes sex less enjoyable. They also felt condoms are already available at local clinics yet learners

still find themselves pregnant. One respondent felt the availability of condoms at schools can make a huge difference with regards to teenage pregnancies.

**h. Have you ever demonstrated to learners how to use a condom? If yes, what was their reaction? If no, would you feel comfortable doing this in the future?**

Four educators indicated they have never demonstrated to learners how to use a condom. They also felt they would not feel comfortable to do this in the future. One educator felt this would send out the wrong message to learners. One educator indicated she has demonstrated to learners how to use a condom and she is comfortable doing this. However she feels it should not be the responsibility of the educators alone.

**i. In your opinion, how accessible are condoms to learners currently who want to engage in protected sexual intercourse?**

All the educators felt condoms are readily accessible to learners. They have access to condoms at local clinics and shops. One educator felt they are not informed to follow the instructions on how to use the condoms.

**j. In your experience, how involved is the community in exposing learners to awareness programs which promote HIV prevention and behaviour change?**

From the responses it was clear all the educators were not really aware of any community involvement.

**k. In your opinion, where do learners obtain most of their knowledge on sex, HIV and AIDS?**

Four educators feel learners obtain their knowledge at school and from friends. Educators feel there is limited parental involvement. Learners receive most of their information from peers which is not always correct. They do not believe the adults. One educator indicated learners obtain most of their knowledge at school and from the activities that they do in class. This however, is contradictory to the data obtained from learners which reflected most information is received from their parents.

**1. Is there anything else that you would like to add that could benefit the study?**

From the responses, the following were highlighted: more parental involvement and responsibility regarding sex, HIV and AIDS, a tougher approach is recommended to scare off irresponsible behaviour, more should be done to change the learners' attitude about HIV and AIDS, an emphasis should be placed on their moral values and abstinence should be preached to effectively address the problem of HIV and AIDS. These views are supported by the NSP Plan and the WCED's approach.

#### **4.5 CONCLUSION**

The findings of the study as well as recommendations and limitations are revealed in Chapter 5.



## CHAPTER 5

### CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 INTRODUCTION

Following are the conclusions derived from findings of the study as well as limitations and recommendations.

#### 5.2 CONCLUSIONS

The aim of this study was to provide answers to the objectives:

Objective 1: To determine what the learners' perceptions are on the provision of condoms to schools.

An analysis of the data reveals learners feel it is a good idea for schools to supply condoms to learners as a HIV- and unplanned pregnancy prevention strategy. This is supported by the UNAIDS Global Report (2010) report states there is a shift amongst young people to practice safer sex methods; includes condom use. This view is supported by the roll-out of the combined school-health program (DoH, 2011).

The responses obtained learners feel condoms can prevent HIV infection. This is supported by the UNAIDS (2011) report which states the correct and consistent use of the male latex condom can effectively prevent the risk of HIV infection. The learners also indicated condoms are easily obtainable. This correlates with the literature which states condoms can be obtained free of charge at any public institution or can be purchased at any store (HSRC, 2009). Learners also indicated it is easy to collect condoms from clinics. This contradicts the literature which states there is the lack of access to services (Advocates for Youth, 2001) or that young people feel they are discriminated against for being sexually active when they visit the local clinics (Palitza, 2010). It appears from the study learners do not experience any difficulty to access condoms.

The study also reveals learners feel it is easy for a girl to negotiate condom use with a boy if they plan to have unprotected sex. The literature differs with the learners' responses. According to UNAIDS (2009) young women are unable to negotiate condom use during sexual activity due to

power imbalances. It appears a mind-shift has taken place regarding girls and condom negotiation during sexual intercourse.

Objective 2: To determine the level of knowledge of learners on HIV and AIDS.

The literature suggests learners still lack knowledge on sex, HIV and AIDS and regard schools as important sources of information (UNAIDS, 2010). The study by the Medical Research Council (2007) suggested sex education be incorporated in the school curriculum before the age of 14 (MRC, 2007). Sexual health education and HIV prevention is already part of the Life Orientation curriculum since 2003 (WCED, 2012). In the analysis of the responses from the learners, it is apparent the knowledge levels for grade 8-12 learners are relatively good and is uniform across the different grades. It would appear the learners at Malibu High School are well-informed about HIV and AIDS.

It would appear the learners receive most of their information on sex education, HIV and AIDS from their parents which suggest a degree of parental involvement. Learners also feel they speak about sex at home although they speak about it seldom. They feel their parents are quite knowledgeable on the topic of sex education, HIV and AIDS. The learners' responses differ with the literature which states young people are embarrassed to talk about sex and there is a lack of open discussion and guidance about sexuality at home (Health24, undated).

The learners' responses are also contradictory with the literature which suggests schools are sometimes learners' only source of information (LoveLife, 2007). The literature suggests there is a lack of parental involvement. However, it appears the parents of Malibu High's learners are involved and of a certain intellectual level to be able to teach their children about HIV and AIDS prevention.

The article by AVERT (2011) states the importance of schools in providing HIV and AIDS education because they can reach a large number of young people and because schools are regarded as places of learning. The article also reveals according to a UNESCO study in 2009 it was found learners from schools in Eastern and Southern Africa had low levels of HIV knowledge. This, however, contradicts the findings at Malibu High School where learners displayed a high level of HIV and AIDS knowledge. The learners feel that they receive adequate sex education at school on a regular basis and they feel they are able to ask questions in the

classroom. It would appear as if Malibu High School and the parents are actively involved in sexuality education and HIV and AIDS prevention. Some learners indicated they received their information from community programs.

Objective 3: To establish what the educators' perceptions are on the provision of condoms to schools.

It becomes apparent from the findings educators are of the opinion the learners' knowledge levels are low and they seem unaffected by HIV and AIDS. Low levels of HIV and AIDS knowledge can be attributed to the lack of teacher training, lack of testing learners' HIV knowledge and the unease of educators teaching the subject (AVERT, 2011). Although the HIV and AIDS knowledge levels of the learners do not appear to be low according to the findings of the study, the educators reported a lack of adequate teacher training and some of them are uneasy with the teaching content.

This finding is contradictory to the WCED's commitment that all educators received extensive training on the topic of sexuality education and HIV and AIDS prevention (WCED, 2012). The educators revealed they require additional support from the WCED to change learners' as well as their own attitudes and level of comfort regarding HIV and AIDS which is in contrast to the WCED's commitment that learning support materials were supplied to both the educators and learners of all grades since 2003 (WCED, 2012).

The majority of the educators feel the curriculum does not address the needs of the learners and suggested a stronger focus on prevention. Educators are not comfortable with schools distributing condoms to learners. They feel the availability of condoms at school will not reduce unwanted pregnancies and risky unprotected sex due to the learners' own negative views about condoms. They feel learners already have access to condoms at local clinics and shops. The educators also indicated they are not aware of any community involvement regarding HIV and AIDS nor do they feel it is their responsibility alone to involve the community even though the literature states that schools should involve community organizations (UNAIDS, 2011).

They feel learners obtain most of their information from school and friends and there exist a lack of parental involvement. They stressed parental involvement and a stronger focus on prevention

rather than providing condoms to learners. The educators' views are thus in contrast with the learners' responses.

Objective 4: To provide guidelines to ensure that educators' and learners' challenges regarding HIV and AIDS awareness, sexuality education and condom provision are addressed.

Therefore it can be concluded the knowledge levels of the learners of Malibu High is relatively good at approximately 80 %. Learners feel it is a good idea for condoms to be made available at school as a prevention strategy for HIV, STDs and unwanted pregnancies. Educators are completely against condoms being made available at school because they feel it would not be considered educationally sound to 'promote having sex' at all. It appears as if the educators are not on board or even aware of the roll-out of the intended national school-health program. It also appears as if educators feel they are not sufficiently trained and do not have additional support to tackle sexuality, HIV and AIDS issues in the classroom. There is also no visible evidence of any community involvement via the school regarding HIV and AIDS awareness.

The following guidelines are suggested:

- Clarity on the conflict of interest between the current legislation and policy regarding consent to sex. According to legislation any person who is aware that a 12 year old is having sex should report it. Yet the Children's Act implies a health worker should offer contraceptives to a 12 year old fully aware that the child is sexually active.
- A concerted effort is suggested from the Department of Health and the Department of Education to get buy-in from all stakeholders (governing body, parents, educators, community) at all schools to participate in the intended school-health program in the form of discussions, parent meetings and networking with community programs.
- Adapting the curriculum on sexuality education and HIV and AIDS prevention to address the needs of the learners and a stronger focus on prevention are suggested.
- Retraining of Life Orientation educators and the allocation of relevant resources to assist educators to effectively teach the content on HIV and AIDS.

- Stronger and more visible support to schools regarding HIV prevention as well as support to people living with HIV and AIDS from the WCED and the Department of Health.

### **5.3 RECOMMENDATIONS**

It became apparent educators require more training from the WCED with regards to sexuality, HIV and AIDS issues in the classroom. It is also clear the educators (school) are not aware of the intended school-health program. Buy-in from the respective school and its governing body is imperative in order for this program to be successful or meet its objectives at all. Educators should not be assigned Life Orientation as a teaching subject to fill up their packages but should rather be allocated to dedicated and motivated educators with the right attitude to teach sexuality, HIV and AIDS related issues effectively with the aim on prevention. The school is currently without a Life Orientation Subject Head because the Head has been promoted to the District level as a Curriculum Advisor to schools in the Northern Suburbs. There is thus a need for an experienced and qualified HIV Coordinator at the school. The school lacks community involvement regarding HIV and AIDS prevention and awareness. The school including the educators seem to feel that it is not their responsibility to get the community involved. According to the finding of the study the impact of HIV and AIDS at Malibu High School is still minimal therefore the school should have a stronger focus on prevention and start involving community organizations, non-governmental organizations, churches, institutions and companies. They should aim to get the learners involved in community projects i.e. collecting clothes/ food/ toys for HIV and AIDS orphans, organize speakers to have special talks with learners about the effects of HIV and AIDS, organize discussion evenings with parents in order to share information, commemorate World AIDS Day by organizing fund-raisers or an event like a “Big Walk” in support of the prevention of HIV and AIDS and to expose learners to educational theatre which illustrates the effects of HIV and AIDS to learners effectively through drama such as the Africa AIDS Centre’s Lucky the Hero and Lucky Fish educational theatre road-show based at Stellenbosch University.

## **5.4 LIMITATIONS**

The following limitations were identified:

The researcher could have used a bigger sample. The initial sample size was 100 learners but due to the sensitivity of the topic, only 60 learners' parents gave permission for their children to participate in the study. The parents' views would have been beneficial because it would have highlighted the challenges and misconceptions that parents experience. Due to time-constraints, parents were not included as the learners were preparing for the examinations and the WCED had stipulated clearly when the research should be completed at the school. The learners' responses could have been compared per gender. A comparison could also have been made between the knowledge levels of the grade 8-9 learners and the grade 10-12 learners to establish whether there exists a difference. Sexuality, HIV and AIDS is mostly covered with grades 8 and 9 learners. It would have also been interesting to compare the same study with 3 schools from 3 different socio-economic backgrounds i.e. learners from a poor school, from a middle-class school and from an affluent school. This however could possibly be considered at a doctoral level. Another limitation is of the nine educators selected to participate in the study, only five females agreed to participate. The four male educators indicated their unwillingness to participate which could reflect their unease with the topic of sexuality, HIV and AIDS.

## **5.5 CONCLUSION**

HIV and AIDS will affect Malibu High School in the future even though the impact might seem minimal at the moment. The school therefore has a responsibility to its learners to reach out to all role-players and to make a concerted, continued effort to reduce the impact of HIV and AIDS. It therefore needs to take its role seriously and demand the necessary support from the WCED in order to effectively address the needs of its learners and the surrounding community. So far the WCED need to do a lot more to get schools on board to accept the school-health program at their school which inevitably involves the provision of condoms to learners. The educators at Malibu High School have clearly not bought into this program. Training and support from the WCED seem to be highlighted as needs which should be addressed. The provision of condoms to learners at Malibu High School seems to evoke opposing views from learners and educators.

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Addendum 1: Learners' Questionnaire

**Malibu High School learners' perceptions on condom provision by schools**

**A. Personal information - Please tick off with a cross (X)**

Gender

| Male | Female |
|------|--------|
|      |        |

Grade

| Grade 8 | Grade 9 | Grade 10 | Grade 11 | Grade 12 |
|---------|---------|----------|----------|----------|
|         |         |          |          |          |

Age

| 13 – 14 years | 15 - 16 years | 17 – 18 years | 19 – 20 years | 21 – 24 years |
|---------------|---------------|---------------|---------------|---------------|
|               |               |               |               |               |

**Choose the correct answer. Indicate your response by making an 'X' in the appropriate box:**

**B. Learners' knowledge on HIV and AIDS**

1. A person can get HIV when

- You have sex without a condom with someone with HIV
- You share needles when using drugs with someone with HIV
- A mother who has HIV breastfeeds her baby
- All of the above

2. You can get HIV from

- Kissing an infected person
- Sitting on a toilet seat
- Touching an HIV + person
- None of the above

3. There is a cure for AIDS

- True  
 False  
 Not sure

4. You are able to see if someone is HIV +.

|        |  |
|--------|--|
| Yes    |  |
| No     |  |
| Unsure |  |

### C. Learners' source(s) of information on sex education

5. Where did you obtain your knowledge about sex education and HIV and AIDS awareness?

- From friends  
 From parents  
 From community programs  
 From television and magazines

6. How often do you speak about sex, HIV and AIDS at home?

- Often  
 Seldom  
 Never

7. Can you speak freely about sex at home?

- Yes  
 No

8. Do you think that your parents know enough to answer questions about sex, HIV and AIDS?

- Yes  
 No  
 Not sure

9. At school, how often do you receive sex education to prevent unwanted pregnancies, sexually transmitted diseases and HIV infection?

- Often  
 Seldom

Never

10. Do you feel comfortable to ask questions about sex, HIV and AIDS in the classroom?

Yes

No

11. Are educators able to answer questions on sex, HIV and AIDS?

Yes

No

Unsure

12. Have you ever been exposed to awareness programs in the community which promote HIV prevention and behavior change?

Yes

No

**D. Knowledge on condoms as a prevention strategy**

13. Using a condom when you have sex can prevent HIV infection.

|        |  |
|--------|--|
| Yes    |  |
| No     |  |
| Unsure |  |

14. Condoms are easily available when you want to have protected sex.

|     |  |
|-----|--|
| Yes |  |
| No  |  |

15. It is easy to collect condoms at local clinics.

|     |  |
|-----|--|
| Yes |  |
| No  |  |

16. It is easy for a girl to ask a boy to use a condom when they plan to have sex.

|     |  |
|-----|--|
| Yes |  |
| No  |  |

17. The use of drugs and alcohol affect one's judgment and can lead to unplanned and unprotected sex.

|     |  |
|-----|--|
| Yes |  |
| No  |  |

18. It is a good idea that condoms will be made available at schools in the future.

|     |  |
|-----|--|
| Yes |  |
| No  |  |

19. The availability of condoms at schools will help to prevent unwanted pregnancies, sexually transmitted diseases and HIV infection.

|     |  |
|-----|--|
| Yes |  |
| No  |  |

### **E. Exposure to HIV and AIDS**

20. I know of someone who is HIV+.

|     |  |
|-----|--|
| Yes |  |
| No  |  |

21. I know of someone who has died of AIDS.

|     |  |
|-----|--|
| Yes |  |
| No  |  |

**THANK YOU FOR YOUR TIME TO COMPLETE THIS QUESTIONNAIRE.**



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Addendum 2: Educators' Questionnaire

**Malibu High School educators' perceptions on condom provision by schools**

**A. Personal information-** Please tick off with a cross (X)

Gender

| Male | Female |
|------|--------|
|      |        |

Currently teaching grade/s

| Grade 8 | Grade 9 | Grade 10 | Grade 11 | Grade 12 |
|---------|---------|----------|----------|----------|
|         |         |          |          |          |

Kindly indicate: Number of years teaching Life Orientation: .....

Your field of expertise: .....

**B. Please complete the following questions.**

1. How do your learners react when you talk to them about sex education and HIV and AIDS prevention?

.....  
.....  
.....

2. As an educator, how would you describe the learners' level of knowledge about sexuality education and HIV prevention?

.....  
.....

3. How would you, as an educator, describe your level of training received on HIV prevention from the WCED?

.....  
.....  
.....

4. Do you as an educator require additional support to effectively teach learners about sexuality education and HIV prevention to adequately address their needs? Please motivate.

.....  
.....  
.....

5. In your view, do you think that the school curriculum on sexuality education and HIV prevention adequately address the needs of the learners? Please motivate.

.....  
.....  
.....

6. As an educator, what is your view of the distribution of condoms by schools?

.....  
.....  
.....

7. According to your knowledge and expertise, do you think that the availability of condoms will reduce unwanted pregnancies and risky unprotected sex amongst learners? Please motivate.

.....  
.....

8. Have you ever demonstrated to learners on how to use a condom?  
 If yes, what was their reaction? / If no, would you feel comfortable doing this in the future?

.....

.....

.....

9. In your opinion, how accessible are condoms currently to learners who want to engage in protected sexual intercourse?

.....

.....

.....

10. In your experience, how involved is the community in exposing learners to awareness programs in which promote HIV prevention and behavior change?

.....

.....

.....

11. In your opinion, where do learners obtain most of their knowledge about sex, HIV and AIDS?

|           |  |
|-----------|--|
| School    |  |
| At home   |  |
| Friends   |  |
| Community |  |



Please motivate.

.....  
.....

12. Is there anything that you would like to add which would benefit the study?

.....  
.....  
.....

**THANK YOU FOR YOUR TIME TO COMPLETE THIS QUESTIONNAIRE.**