

**Factors which contribute to learners' perceptions about  
HIV/AIDS education in schools around Malamulele**

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## **Declaration**

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## **ABSTRACT**

There is a growing trend of sexual activity among learners in schools around Malamulele; this is evident from the rise in the number of teenage pregnancies in these schools. This study is aimed at finding factors that contribute to the perceptions these learners have towards HIV/AIDS education. The Department of Education has put in place programmes to educate learners about HIV/AIDS, which form part of the curriculum and is taught in schools as Life Orientation. Despite the intensive attention given to instill knowledge and equip learners with skills to make appropriate and informed decisions on the subject of sex, teenage pregnancies continue to rise in these schools, posing a serious challenge for the productivity of the concerned schools as well as education at large.

The researcher administered a questionnaire to the learners and an interview schedule to the educators. The findings reveal that the content covered in Life Orientation concerning sex and sexuality education is not enough and much should still be done in this regard. The results from the learners' questionnaires indicate that learners do not have enough information or a clear understanding of the subject of HIV/AIDS. They lack the correct information; learners continue to engage in risky behaviours such as unprotected sex. However, there are other contributing factors such as exposure to sex materials and media, which seem to emphasize sex. The learners are also going through a difficult learning curve of discovery and peer pressure which impacts their decision making. The researcher recommends that schools in question to be assisted with skills to deal with peer pressure and media exposure, are offset learners are helped to make appropriate decisions concerning sex.

## **OPSOMMING**

Daar is 'n groeiende tendens van seksuele aktiwiteit onder leerders in die skole rondom Malamulele. Hierdie tendens kan waargeneem word uit die styging in die aantal tienerjariges in die area wat swanger raak.

In hierdie navorsingsprojek is 'n vraelys by 'n steekproef van leerders geadministreer en is onderhoude met opvoeders gevoer deur middel van 'n gestruktureerde vraelys.

Resultate toon aan dat die inhoud van die kursus in Lewensoreïntasie nie voldoende is om die probleem aan te spreek nie. Leerders het nog steeds nie 'n behoorlike begrip van die gevaar van MIV/Vigs nie en stel hulle derhalwe nog steeds bloot aan die gevare wat die pandemie inhou.

Die studie het ook gevind dat daar ander bydraende faktore is wat lei tot onnodige blootstelling aan MIV/Vigs. Leerders word meer en meer blootgestel aan materiaal van 'n seksuele aard en die media speel ook 'n rol in die risiko-gesrag van die leerders.

Die leerders gaan deur 'n moeilike leerkurwe en word dikwels blootgestel aan druk van medeleerders.

In die navorsing word aanbeveel dat skole verder ondersteun word met programme en ingrepe wat sal help om die leerders meer bewus te maak van die gevare van MIV/Vigs en sodoende verhoed dat die leerders hulle nie onnodig blootstel aan die gevare van die pandemie nie.

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## Chapter 1: Introduction

HIV/AIDS is a global concern and a rather daunting challenge because its dire impact is difficult to contain. The challenge is compounded by several facts including that there is no cure for HIV/AIDS. Different countries are affected differently. This emanates from several facts. Throughout the globe, countries are affected differently by this pandemic. Africa is one of the worst-hit continents with the highest HIV prevalence and deaths from HIV/AIDS. Sub-Saharan Africa is the most affected. Globally 35,3 million people were living with HIV/AIDS in 2012, with 2,3 million new infections. A decline in condom use and an increase in the number of sexual partners among Men Sleeping with Men (MSM) were detected in a recent survey commissioned by the Health Protection Agency (2013).

According to the United Nations Agency for AIDS (UNAIDS, 2012) there is an estimated 6.1 million people living with HIV/AIDS in South Africa and new infections dropped from a whopping 540 000 in 2008 to 370 000 in 2012. About 17% of the 6.1 million are aged between 15 to 49 years. In addition, 3,400 000 people aged 15 and above are living with the HI virus and 410 000 are those aged 0 to 14 years. Some of these infections result in death and 240 000 people were estimated to have died from HIV/AIDS and other HIV-related diseases, leaving 2 500 000 children aged 0 to 17 years orphaned. Therefore, from the 2012 UNAIDS estimates, it is clear that the impact of HIV/AIDS is still enormous and leaves a trail of destruction that will take decades or even centuries to correct. The figures also include children of school-going age, fourteen to seventeen year olds. This further shows that schools are directly affected by HIV/AIDS. Besides teenage pregnancies and getting infected with HIV, there are challenges such as constant absenteeism and stress for those learners who find out that they are infected during antenatal visits, those whose parents are sick and dying and the children have to take care of their dying parents and practically run households. These responsibilities are overwhelming for children and they become stressed and also underperform. Some of them eventually leave school.

It is not only learners who constantly stay out of school, but teachers too. There has been high mortality rate among teachers since the outbreak of HIV/AIDS, eradicating skills and competence the Department of Education is trying to invest on for quality education. It is an unending cycle of teacher development. Unimaginable stigma about HIV/AIDS still exists in schools and it is difficult for learners as well as teachers to come out for help. Issues of cultural beliefs and religion make it even more difficult for people to accept their HIV status. In the era of antiretroviral drugs, many people still die unnecessarily.

With all these setbacks, the quality of learners produced in the country leave much to be desired! Although winning the battle against HIV/AIDS seems inevitable, winning the war against HIV/AIDS is a distant dream ... yet achievable. This study seeks to find out the factors which contribute to learners' perceptions about HIV/AIDS education, in schools around Malamulele. These factors motivated this study.

Many school-going adolescents are increasingly becoming sexually active at an early age at secondary schools around Malamulele, despite the extensive attention given to adolescent sex and the sexuality education programmes put in place by the National Department of Education. Sexually active learners are at risk of contracting STDs, including HIV infection. High rates of teenage pregnancies and abortions among teenage girls are evidence that these teenagers engage in unprotected sex, do not use the different methods of contraceptives that are available and other methods of preventing the spread of HIV, such as abstinence.

Most learners attending secondary schools around Malamulele come from different communities, mainly deeply rural and impoverished backgrounds with a smaller percentage from semi-rural areas. The number of child-headed families is high: most children have lost their parents to HIV/AIDS. Most families in these communities depend on child and social grants for survival, meaning that unemployment is rife. This scenario poses an enormous challenge to development in these communities; development in education; future skilled-labour force of South Africa as well as to all the efforts to combat HIV/AIDS.

The National Department of Education has designed school-based HIV/AIDS education programmes for secondary schools in South Africa. Some of these programmes have been incorporated into the school curriculum and are taught as Life Skills under Life Orientation. This was done to facilitate the dissemination of knowledge about HIV/AIDS and to equip learners with skills to make informed and appropriate decisions concerning sex. However, high sexual activity, a risky behaviour, is an indication that either the content of the school based HIV/AIDS education programmes or the approach to enforce behavioural change does not elicit the desired effect or meet the objectives set. There can also be other underlying reasons that need to be unveiled. Other studies indicate that adolescents in Limpopo have inaccurate knowledge about HIV/AIDS.

A National Communication survey conducted in 2009 shows that 61% of women in Limpopo are unemployed. This is important to consider given exposure to HIV messaging in the workplace as well as imbalances in disposable income, which can translate into transactional sex or other risk behaviours. These women come from communities where their children look up to them as their role models.

Children are also bombarded with explicit sex material from both the internet on their cell phones and media. Some learners in secondary schools around Malamulele belong to “sexting” groups. “Sexting” means exchanging explicit sex materials in the form of pictures or words through Social Networks. They call themselves “Friends without Benefits”: This means that within the group, they engage in sexual intercourse without dating or engage in relationships. Everyone is at liberty to sleep with any other member of the group any time and if the member is not supposed to sleep with anyone else at that time. This risky behaviour is a primary source of the spread of HIV and STDs. Therefore, the problem needs attention if risky behaviours such as these are to be addressed. Most parents are reluctant to talk about sex and contraceptives to their children and/or make these available to their teenagers, as they are afraid that their teenagers may interpret this as permission to engage in sexual activity

## **Chapter 2: Literature Review**

### **2.1 Introduction**

Since HIV/AIDS was first identified, the scope of research has been growing steadily day by day, covering a wide range of topics. The topics include the science behind the disease and social demographics of the disease as well as ways to combat the disease. A review of the factors that contribute to learners' perceptions about HIV/AIDS education and the literature associated with HIV/AIDS behaviour among adolescents will follow.

### **2.2 The Impact of HIV/AIDS on Education**

Education has always been seen as an engine to propel knowledge about HIV/AIDS, modes of transmission, prevention and care and support and it is still generally perceived that teachers are the central hope and focus to make this happen, (Kelly, 2000; UNAIDS, 1997; UNESCO, 2000) agree that education is the best tool, considering that it reaches many people in most parts of the world. Every effort to combat HIV/AIDS requires some form of communication to impact on the lives of people. Education is also an essential tool to break the silence, discrimination and stigmatization that comes with HIV/AIDS (UNESCO, 2002). However, education is one of the most affected sectors as the pandemic wreaks havoc by reducing the number of children as well as teachers in their most-productive years, leaving the education system wanting. The disease constrains the ability of the education system to provide educational services as a result of high morbidity and mortality among teachers. In 2002 alone, it has been estimated that 860 000 children in Sub-Saharan Africa lost their teachers to HIV/AIDS (UNAIDS 2003). Learners do not only die of HIV/AIDS but they have to be constantly absent from school in order to care for their sickly parents and some drop-out of school when orphaned by HIV/AIDS. Households are gradually becoming more and more dependent on child labour and the economic contribution they can bring to their homes (UNAIDS, 2003). This situation compromises the quality of education and hope to contain the pandemic. Furthermore, the situation is magnified by facts such as the following: general levels of poverty, scarcity of resources, uncertainty about the relationship between education and the reality outside the classroom, and a sense of despair that creates doubt about the need for education, as it is evident that many will die young because of AIDS (UNAIDS, 2003)

### 2.3 The Impact of HIV/AIDS on Adolescents

Adolescence involves a transition of physical and psychological human development from childhood to fully- fledged adulthood (0-19 year olds). This age-group is regarded as a healthy age group, yet about 20% of adolescents experience mental health problems resulting from anxiety and depression each year (WHO, 2000-2010). It is believed that a state of mental well-being translates to happy confident adults who lead good quality lives at a later stage. Mental well-being forms the basis of emotional well-being which has implications for self-esteem, good behaviour and attendance at school. This group of teenagers are said to have problem-solving skills, competence and a sense of purpose in their lives. These qualities help them strive in the face of adversity and poverty and make them rebound from challenges that might occur, and they generally continue a productive life.

Teenagers' lives are impacted by mental ability to achieve and make something out of their lives; as individuals, in schools, neighbourhoods and/or broader social level; by risk factors such as poverty, violence, social exclusion, peer rejection and lack of family support and protective factors. If teenagers are exposed to and experience risks, there is a greater probability that they will experience psychological distress and mental health disorders. According to UNICEF and WHO, (2010) report, if young people are given opportunities in childhood and adolescence to acquire the positive effects of protective factors that far outweigh negative risk factors, they are more likely to sustain mental health and well-being in later life.

This background understanding of teenagers forms the basis of understanding what they go through and informs interventions to assist them make appropriate decisions concerning sex and sexuality. In order to combat the impact of HIV/AIDS, international organizations have undertaken initiatives to improve adolescence and emotional well-being, promoting actions at policy level, streaming mental health within primary health care, community and school-based programmes. Throughout South Africa, large numbers of adolescents are affected by the HIV/AIDS pandemic, creating serious psychological, social and educational problems (Department of Education, 2001; Coombe, 2002). In support, Whiteside and Sunter, (2000) reiterate that HIV/AIDS have profound educational, economic and political stability implications for South Africa in its entirety. Therefore, it becomes imperative to understand reasons why adolescents are the most affected population group- by HIV/AIDS. This study hopes to explore the factors that contribute towards these perceptions making learners in Malamulele area susceptible to HIV/AIDS.

## **2.4 Adolescents' Perspectives about HIV/AIDS**

### **2.4.1 Introduction**

Despite extensive interventions at international and national as well as local school programmes to mitigate the impact of HIV/AIDS, learners continue to be sexually active at 12 to 14 years of age. This is evident by teenage pregnancies and high incidents of abortion. The implications thereof are that teenagers practice unsafe sex and do not use any form of contraception. A UNESCO study in 2001 discovered that Eastern and South African children have low levels of knowledge regarding HIV/AIDS which can be attributed but not limited to; lack of teacher training, lack of examination for learners on the topic, and unease in teaching the subject, finding it embarrassing to talk about sex given the fact that teachers have their own perceptions about sex and HIV/AIDS.

### **2.4.2 Relationship between risky behaviours, peer pressure and parenting**

Adolescents' perceptions about HIV & AIDS do not just emanate from nowhere, but as indicated earlier, they are environmentally, psychologically and socially orientated. According to Whitaker and Miller, (2000), factors such as peer- group interactions, parent- adolescent communication, and school environment are closely related and impact more directly on the lives of the youth than facilitating positive safe-sex communication between parent and adolescent. In support, Small and Luster (1994), reiterate that sex risk behaviours among adolescents do not operate individually, but are interconnected and interact with one another to maximize one another's effects. The argument raised here is that, exposure to peers who are sexually active is risk behaviour on its own, if combined with lack of parental monitoring of adolescent activities- the total risk of engaging in unsafe sexual behaviour may be compounded (Ary, Duncan, Duncan and Hops, 1999). Adolescents' behaviour is mostly influenced by what their friends think or say and if parents take a backseat and for one reason or the other, and do not monitor the activities their teens involve themselves in, can further expose adolescents to risk behaviour and HIV/AIDS. The same incident happened in the bible- Jonathan lusted after his sister Tamar, when he confided in his friend who advised him to pretend to be sick and request only to be served food by his sister. Out of advice, he raped his sister. This happened because the boy was developing physically, and his parents should have taught him what he was going through and given him tips on how to handle this stage of development. Unfortunately the parents only felt the shame of dealing with incest and rape in the family. In an African context, parents are reluctant to talk about sex and sexuality, as discussion about these subjects goes against the predominant view in which sex is seen as taboo and the interpretation of the disease also goes against values, attitudes and beliefs emphasized at home.

### 2.4.3 General Poverty

General poverty in Africa also aggravates HIV/AIDS because there is a close link between poverty and HIV/AIDS. Tolan and Gorman Smith (1997) report that families from economically disadvantaged neighbourhoods are highly susceptible to most social and psychological challenges which expose them to several risks than their counterparts- youth and families that are from both socially and economically advantaged communities. Apparently, parents from socio-economically disadvantaged families and low levels of education, tend to display less frequent nurturing, more frequent discipline and low levels of participation in school activities contributing towards compulsory natural growth, growth that is devoid of parental guidance when it comes to serious matters of life such as sex and sexuality. McLoyd (1998), found that the negative influence of poverty and economic challenges on adolescents' emotional well-being, may result from its immediate relationship with dire and more inconsistent parenting behaviours. Chavkin and Williams (1989), concluded that parents who possess lower levels of education and are greatly economically disadvantaged, may lack adequate skills and social support imperative for effective parental involvement in the lives of their children. In a society devastated by HIV/AIDS, a large number of children are orphaned. There is a loss of hope for these children to make something of their own lives when their parents, who represent a source of income and shade from harsh conditions of life, are no more. Positive parent-child relationships, parental disapproval of unbecoming behaviours, and constant parental monitoring have been found to be among the most important factors preventing youth from engaging in unhealthy behaviours, delinquency and substance abuse. A study conducted in India revealed that when parents are better educated and well-informed, adolescents are less likely to become sexually active (Selvan, Ross and Kapadia, 2001). Poverty created by lack of education, deaths of parents from HIV/AIDS and/ or any other socio-economic problems, is an enormous challenge facing Africa that demands the attention of schools, both government and private sectors, and the community in order to address the crisis of HIV/AIDS.

### 2.4.4 Adolescence

Adolescence is also a cognitive developmental stage in which adolescents struggle to forge and find their identity amidst contradicting expectations between the complexities of adolescence; and parents, schools and the society at large. Social cognition develops from social interactions and social domains within which adolescents exist and function. Adolescents become confused by the physical development and puberty that emphasize the impending adulthood stage. The confusion comes because adolescents still cannot figure out who they are and what roles, as adults to-be, they are and will be expected to play. Others are in denial of adulthood and are therefore not prepared to move forward. These ones report signs of immaturity and childishness. On the other hand, another group manages to define who they are by responding to all changes that come with adolescence, with maturity and manage to resolve these changes.



According to Piaget (1954), adolescents develop a special type of egocentrism that involves an imaginary audience and a personal ideology of being unique and indestructible. They feel they are invincible regardless of what they do. Erickson (1965) regards the prime danger of this stage of development as identity confusion. This leads to impulsive behavioural patterns consisting of poorly- thought- out decisions.

#### **2.4.5 HIV/AIDS education and reality, and gender inequality issues**

Besides the many benefits education brings, there are also enormous challenges associated with it. Sexuality education is one of the highlights in the components of HIV/AIDS education programme to mitigate the HIV/AIDS pandemic. Skills to be acquired from such programmes are, but not limited to, communication; for instance, to enable learners to negotiate safe-sex; critical thinking- in order to discern a dangerous situation and/or manipulation and find a way out of it before it gets out of hand; and self-efficacy. However, most programmes are knowledge-orientated and fall short of eliciting the required outcomes such as behaviour change. HIV/AIDS education programmes were introduced as part of the curriculum in secondary schools by the Department of Education in 1995 and a Life Skills programme in 2000 (Department of Education, 2000), these programmes are geared towards imparting knowledge about HIV/AIDS and its transmission. Although it is assumed that these programmes will in turn influence behaviour patterns, thereby reduce the impact of HIV/AIDS, there still exist gaps between what learners hear at school and life realities outside the classroom.

A study conducted in the Caribbean- which has the second highest prevalence rates after sub-Saharan Africa- revealed that although girls do better than boys throughout the education system, including university where many women successfully graduate, the rate of new infections among girls aged 15-19, is five times higher than that of boys of the same age group (UNAIDS, UNFPA & UNIFEM, 2010). The only logical explanation for this paradox between higher education levels and higher rates of HIV prevalence is that the skills and knowledge acquired throughout formal education are not sufficient and effective enough to assist them to take control of other spheres of their lives. In fact, a study conducted by PAHO (2010), shows that 50% of all young women in the Caribbean admit that their first sexual encounter was forced or unwillingly persuaded. Instead of schools being places of education and safety, it was reported that it is in schools where girls experience acts of discrimination, sexual harassment and abuse either from other students or teachers, for the first time. It was reported that approximately one-third of school girls in Johannesburg have been subjected to sexual violence at school. In addition, teachers in different countries, including the Democratic Republic of Congo, Ghana, Nigeria, Somalia, South Africa and other countries were reported to demand sexual favours in return for good grades (African Rights Report 2010). Finally, this also indicates that people neither own the disease nor feel they can also be infected, but rather perceive it as a disease of some people somewhere (Greene, 2000). This viewpoint is in line with a report by Greene, Kremar, and Walter, Rubin & Halle (2000), which indicates that although more than a third South African



adolescents are sexually active and engaging in sex at an early age. Few of them see themselves as being vulnerable to HIV/AIDS infection or see AIDS as a threat to them.

#### **2.4.6 Influence of Mass Media on Adolescents**

The youth are also bombarded with mass media and the availability of internet. The impact of mass media has been found to be more serious and potentially harmful in negatively influencing the health-related behaviour of children and adolescents. The majority of the youth still cannot differentiate fantasy from reality, particularly if such is displayed as 'reality'. All that is needed is a cell phone and internet connection and all information is readily available, be it educational, entertainment, sports and even sexually explicit material. Although some of them take time to access the internet for other purposes, it is also developmentally normal for adolescents to be sexually curious. Löf gren- Mårtenson & Mansson (2010), posit that internet –enabled gadgets have indiscriminately permitted people of all ages to view, consume, innovate and disseminate sexually explicit content. The distribution of sexually explicit data is fast-growing and clearly indicates that this growing trend commonly affects adolescents all over the world. According to the Federal Bureau of Investigation (2011), Adolescents are at risk of cyber bullying, sexual harassment and victimization from others. Adolescents often lack the attenuation required to predict and manage online dangers and content in a healthy and safer way (Delmonico and Griffin, 2008).

Available literature has reviewed the impact of pornography on sexual attitudes, beliefs and sexual aggression as well as its influence on self-concept, body image, social and physical development of adolescents. Tsitsika et al. (2009) discovered that adolescents exposed to pornography, may develop delusional attitudes about sex and misleading attitudes towards relationships. In addition, the investigation found that adolescents perceive sex as a physical and casual activity than being affectionate and relational. The study concluded that, the more sexually explicit materials are consumed, the greater the urge to engage in more stimulating sex life. It was also found that incredible consumption of sexually explicit materials can also lead to a belief that women are sex objects, encouraging pre-marital and extramarital sexual relations (Tsitsika, 2009). Another study by Nordin, Hanson & Tyden (2005), found that Swedish adolescents, who were exposed to large content of sexually explicit materials reported positive attitudes about having casual sex with a friend and uncommitted sexual exploration. Therefore sexually explicit materials act as an accelerant for engaging in oral and sexual intercourse at an earlier age and getting involved in a variety of sexual behaviours that are considered as risky as well as problematic, including; anal sex, drugs and alcohol during sex, contributing to sexually aggressive behaviour ( Kraus and Russel, 2008). Lenherts (2009), conducted a survey regarding 'sexting' (distributing sexually explicit material) among adolescents aged 12-18, and noted that there are three reasons why adolescents get involved in 'sexting': firstly, for partners who are not physically engaged as a romantic gesture; for partners who are physically engaged and those

outside relationships for casual uncommitted sexual exploration; lastly, to encourage sexual aggression inside a relationship or outside. These findings clearly contribute to high HIV prevalence among adolescents and require an immediate integrated intervention by all stakeholders.

#### **2.4.7 Teacher Perspectives on HIV/AIDS Education**

The role of disseminating information about HIV/AIDS is largely placed on the shoulders of teachers. According to UNESCO, (2000), policy documents and programmes emphasise the role of teachers in combating HIV/AIDS, and the key areas of focus being: creating preventive awareness of the disease by generating knowledge and understanding of the disease; promoting attitude development and awareness; and making sure that children develop skills that will allow them to be competent and assertive in managing relationships and sexual issues. However, it was discovered that HIV/AIDS education in schools still focuses on imparting knowledge of HIV/AIDS rather than imparting skills to make learners able to negotiate condom-use, how to deal with peer pressure and make informed decisions concerning sex (Action Aid, 2003). Other reasons why HIV/AIDS education programmes seem ineffective, are lack of adequate teacher training. A study in Tanzania revealed that teachers are selective when it comes to topics they teach under HIV/AIDS. Teachers also have their own perspectives when it comes to HIV/AIDS and they live in communities ruled by denial of the existence of HIV/AIDS. There are cultural beliefs embedded in their consciousness, stigma surrounding the transmission of the disease and many other factors. All these impact negatively on the transfer of knowledge and skills to handle the pandemic. In an internet article entitled: Sex Education, Sexuality, Society and Learning by Meason (2009), it was concluded that instead of assuming that teachers assume a neutral role when it comes to HIV/AIDS education, teacher attitudes, beliefs and often superstitions about HIV/AIDS and adolescent sexuality should be taken into consideration when developing HIV/AIDS programmes.

The brief review on the factors that contribute to the perceptions learners have about HIV/AIDS education, has familiarized us with the world of teenagers and what influences them. The present researcher looked at peer pressure, mass media, adolescence, issues of gender inequality, poverty and the HIV/AIDS Life Skills programmes. She hopes to probe further and find answers for these factors through this study.

## **Chapter 3: Research Method**

### **3. Research problem**

#### **To find out Factors which Contribute to Learner's Perceptions about HIV/AIDS Education, in Schools around Malamulele**

According to Eaton, Flisher & Aar (2003), a growing body of evidence about high HIV prevalence among adolescents points towards the complexity of sexual behaviour, which is influenced by factors at individual, proximal and distal levels. In their study about 'Unsafe sexual behaviour in South African youth' it was revealed that 50% of the youth in South Africa are sexually active by the age of sixteen, and between 50% and 60% of sexually active youth report never using a condom (Eaton et al., 2003). This, on its own is risk behaviour and makes the youth susceptible to HIV infection. It was also found that despite research that has been done so far, there has been no significant change in HIV infection among South African adolescents, prompting a new generation of behavioural interventions (Hartel and Cyal, 2005). The reasons why the youth including those of school going age continue to report risk behaviours despite all that is done to raise awareness about HIV/AIDS and its impact on their lives are not known. It is also not known whether learners at Malamulele have received any information on HIV/AIDS and skills to assist them to face their day to day challenges concerning sex. Further, if they are indeed informed about HIV/AIDS and acquired skills to negotiate safer sex, whether they do understand the information, and that they do use the information and skills to positively impact their personal lives. This study hopes to find out answers to the issues raised above, as well as give recommendations to assist both the schools and learners concerned.

### **3.2 Research question:**

**The research question investigated in this study has been the following: “What factors contribute to the perceptions learners have about HIV/AIDS education in schools around Malamulele”**

### **3.3 Significance of study**

It is intended that the study would contribute, firstly, in the reduction of teenage pregnancies, abortions and HIV infections among school- going adolescents aged 13-17 years in secondary schools around Malamulele. If teenagers know more about sex and sexuality, it will influence behavioural change and help them to make informed decisions concerning sex. Secondly, schools are faced with challenges of being an environment in which pregnant learners spend most of their time learning. The Education Department permits these learners to attend school and learn actively until they are highly expectant.

These learners sometimes fall ill and are hospitalised for high blood pressure and other complications; some test positive for HIV and some cannot concentrate during hot weather. All these problems impact negatively on the final results the school produces each year. This study seeks to raise awareness so that these problems are addressed. Research from a variety of sources indicates a strong correlation between sexual activity among adolescents and teens and the likelihood of engaging in other high risk behaviours; such as tobacco, alcohol and illicit drug use. A Social Science and Medicine study reported on Paediatrics’ magazine, describes sexual activity as a “significant associate of other health-endangering behaviours”.

In addition, the study may also influence societal change. Conservative attitudes strengthened by cultural and traditional beliefs may shift towards a realization that when children have children of their own, it places a burden on individuals, families, communities and society at large. Finally, knowledge about barriers that might prevent school-based HIV/AIDS education programmes on sex and sexuality education to meet the desired outcomes, will be used to make recommendations to intensify these programmes or change them if need be.

### **3.4 Aims and objectives**

The aim of the study is to establish factors which contribute to the perceptions of learners about HIV/AIDS education in schools around Malamulele.

objectives

1. To find out what information teenagers get from school based HIV/AIDS education programmes in secondary schools around Malamulele.
2. To establish teenagers' understanding of the information offered by school based HIV/AIDS education programmes.
3. To establish which of the information acquired, they apply in their personal lives.
4. To use the findings to make recommendations on the existing strategies or programmes to improve and to increase efficacy.

### **3.5 Research methods and design**

A quantitative design was used this study. Questionnaires were completed by learners and interview schedules were conducted among teachers. The Life Orientation curriculum content was also assessed using document analysis.

The dependent variable was learner perceptions about HIV/AIDS education and the factors which inform these perceptions. The study sought to determine or find out if independent variables such as HIV/AIDS education and the Life Orientation curriculum content (independent variable) contribute or inform the dependent variable. The target population was grades 8 to 12 learners from three different secondary schools: Malamulele Secondary School, Shingwedzi Secondary School and EPP Mhinga Secondary School, and one Life Orientation teacher from each of the three schools, in Malamulele area. Questionnaires were distributed among teachers (besides Life Orientation teachers) in the different grades to determine the information learners

have on HIV/AIDS; and test the learners' understanding of the information they have as well as whether they apply the information in their personal lives.

A random sample of 45 learners was done using stratified random sampling method. Stratified random sampling is defined as a sampling method in which the target population is divided into mutually exclusive groups called strata, from which a random sample is drawn (Christensen, Johnson & Turner 2011). In two of the schools with larger enrolments, getting strata was challenging. However, class lists which are available at the schools were used, and these lists indicate learners' gender and learners are arranged alphabetically, with a number allocated to the learner. It was from these lists that the learner population was randomly selected but ensuring a balance between male and female learners. The total sample consisted of 22 male learners and 23 female learners. The extra female learner was randomly selected from the school with the highest enrolment, EPP MHINGA Secondary School, which had over 500 learners in grade 10.

Through the assistance of the principal and staff, questionnaires were self-administered simultaneously in the same venue determined by the school. Questionnaires were completed under the supervision of the researcher. They consisted of questions that required a 'YES' or 'NO' response, indicated by a 'tick' or 'cross' in the relevant box. Learners were advised to fold and place their completed questionnaires on a ballot box to ensure anonymity. The Life Orientation teachers were interviewed by the researcher and a small recording tape was used to collect data. From the Life Orientation teachers in each school, one volunteer was randomly selected by the researcher. The questions on the interview schedule ranged from those that checked experience on teaching the subject, to the scope and impact of the programme as well as getting recommendations for better intervention. The collected data was then analysed by the researcher. Out of the data collected from the questionnaires, the interview schedules as well as the document analysis, recommendation were made and conclusions drawn.

### **3.6 Ethical Considerations**

The topic of HIV/AIDS is a highly sensitive one with medium risk. Learners were expected to experience a degree of discomfort when responding to some of the questions, particularly questions on their sexual practices. Parental consent was sought for the learners to participate in the research as well as learner consent. Learners were also informed that they could choose to continue with participation or withdraw their participation any time and that this would be inconsequential. A professional nurse, currently in charge with the HIV/AIDS clinic and a non-profit organization that deals with HIV/AIDS at Malamulele Hospital, Mrs Sono, kindly offered her services in case learners felt uncomfortable and require counselling. Consent was also sought from participating Life Orientation teachers, principals of concerned schools as well as the Department of Education in Limpopo Province.

## Chapter 4: Results and Discussion

The results of this research are presented below. The questionnaire consisted of three sections: Section A: Information related to HIV/AIDS. It consists of five questions relating to learners' knowledge about topics related to HIV/AIDS. Section B: Consists of eight questions and evaluates learners' understanding of HIV/AIDS education, and Section C: Evaluates whether learners apply the skills and knowledge gained at school on HIV/AIDS in their daily lives. A brief review of the Life Orientation curriculum will also be presented, as well as results from interviews for teachers.

### 4.1 Section A: General Information

A sample of 45 learners was drawn from consent forms that were initially sent to parents. All parents consented to their children taking part in this study. The questionnaire had the same questions for learners in grades 8 to 12 at all three schools and all participants responded to the same set of questions. Out of a 45 learner sample, 98% of the learners indicated that they knew about HIV/AIDS and 70% indicated that they heard it from their Life Orientation teacher. About 25% said they heard about HIV/AIDS from parents and nurses. Very few heard it from the media and their friends (the remaining 5%). It is not known why the school seems to be the most reliable source of information at this stage, but as mentioned earlier, most learners come from impoverished communities with low levels of education and with cultural and traditional beliefs, which limit discussions around HIV/AIDS. Discussions around HIV/AIDS and other matters concerning sex are regarded as taboo in their culture. Parents are also reluctant to discuss HIV/AIDS and safe sex with their teenagers for fear that teenagers may interpret this as license to engage in sex. However, the topic of HIV/AIDS seems to be common knowledge among the learners in the three schools, and the main source of information are the schools.

A considerable percentage, about 67% of the learners, feel that they have enough information to make informed decisions concerning sex and 29 % of the learners felt they still had a lot to learn when it comes to matters concerning sex. Most learners out of the 67% were grade 11 and 12 learners, followed by grade 10 and few from grades 8 and 9. This further means that the 29% of those who said 'No' do not feel fully informed, were mainly the grades 8 and 9, with a decrease in number as level increased. The present researcher cannot claim that the learners become



confident about sex matters and decisions as they grow up and progress through the grades. However, such a relationship may exist.

**Table 4.1.1 Educational information about HIV/AIDS and related topics**

Topic	NO. of learners	% YES	NO. of learners	% NO
	YES		NO	
Sex organs and how they function	18	40	27	60
Sexually transmitted diseases	45	100	0	0
Teenage pregnancy	40	89	5	11
Abortion	35	78	15	33
HIV/AIDS	45	100	0	0
Sexual abuse	37	82	13	29
Homosexuality	15	33	35	78
How to say 'No' to sex	25	56	20	45
Contraceptive pill, injections and condoms	45	100	0	0

**Table 4.1.2 Why learners cannot make informed decisions about sex?**

	NO. of learners	% Yes	NO. of learners	%NO
	YES		NO	
Peer pressure	39	87	6	13
Not sure about some issues	22	49	23	51
Lot of sex materials on the media	42	93	3	7
Unable to say NO to sex	40	89	5	11
Need to explore	45	100	0	0
Knowing too little about sex	20	45	25	56

## Discussion

Most of the learners have information on two or several topics. Learners' responses were spread over the nine topics, with all learners who said 'Yes' they had heard about HIV/AIDS (100%), knowledge about sexually transmitted diseases was at 100%, and contraceptive pill, injections and condoms at 100%- most learners selected condoms and the understanding here is that most of them know about condoms but not the other two forms of birth control. Responses to items on: homosexuality, abortion and saying 'No' to sex ranged between 56% and 78%. In addition, learners have information about teenage pregnancy; sex organs and their function, and sexual abuse. One of the main aims of the Department of Education is to teach learners about Sexual and Reproductive Health using an integrated approach- that is across the curriculum and not only Life Orientation.

Generally, knowledge on all topics above is fair. However, there seems to be gaps when it comes to information on homosexuality, abortion and skills to negotiate sex. Therefore, if learners cannot say 'No' to sex, it might not be easy to negotiate safer sex or condom use. Topics such as homosexuality and abortion are within the scope of their learning and it is good that learners are well informed about them to equip them for the future. However, only about 40% of the learners agreed that they feel they have enough information about sex and sexuality to be able to make informed decisions, hence they might find it hard to say 'No' to sex (56%). This might mean that there are other factors that compel learners to engage in unprotected sex, although they know about condom use. It is worth noting that in Table 4.1.2, the main reasons why teenagers or learners feel they cannot make informed or appropriate decisions about sex are: peer pressure (87%); influence from mass media (93%); and their need to explore (100%). These seem to be the driving factors and they seem to override all other sources of information. It can therefore be concluded that amidst all other interventions to influence behaviour change among learners, the three factors need more attention. If learners acquire skills to process information from media and deal correctly with peer pressure, they might be in better positions to negotiate safe sex. It can be concluded that peer pressure and being unable to synthesise information from media and the internet are some of the factors that contribute to how learners view sexuality education.

## 4.2 Section B: General Information

Section B of the questionnaire consists of eight questions that test the understanding of the learners on HIV/AIDS- related issues. At this point, it is clear that although different topics were covered at school, there is a sense of lack of confidence in other topics. When asked if the learners have ever had sex with their boyfriend/girlfriend, 47% said, yes and 49% said, no. There is technically nothing wrong with boyfriends and girlfriends having sex. However, a 47% affirmative response shows that a large number of learners are sexually active. As established from preceding data, many learners who are sexually active do not use condoms (50% to 60%). Unprotected sex is risk behaviour and learners may become pregnant, or even contract STIs, including HIV/AIDS. In one of the schools there is a committee that deals with HIV/AIDS awareness campaigns, teenage pregnancy and other related issues, which also keep statistics of vulnerable children, orphans, and pregnant learners, in order to find assistance for the learners where possible.

The statistics for teenage pregnancy in the school, are on the rise since 2010 as one grade 12 learner and 2 grade 11 learners were pregnant in 2010. By 2013, the total number of pregnancies in the school had increased to nine learners. This time it was three grade twelve learners, five grade ten learners and one grade nine and one learner in grade eight. The rise in the number of pregnancies further proves that learners have sex without condoms. The information was made available by a Life Orientation teacher at the school who happens to head the committee, although it was not part of the interview schedule. The teacher provided the information relevant for the purposes of the research in question. Follow up questions were asked on whether the learners had or had not had sex with boyfriend/ girlfriend; whether there were discussions on the reasons to engage or not to engage in sex. The results indicate that 51% discussed before they had sex, and 47% did not. Learners still maintain that their decisions to have sex and/ or not to have sex were informed (69%); 27% said they feel their decisions were not informed and the remaining 2% did not respond. The 47% of learners who had sex without talking about it, and the 27% who agreed that their decisions were not informed, may be interpreted as lacking understanding of issues of sex, and having poor communication skills and negotiation skills.

However, there might be other factors that influence learners to behave the way they do. Culture and shyness (40 % and 60% respectively) prevented discussions around sex and condom use between parents and their teenagers. Factors at proximal context level include interpersonal relationships, physical and organizational structures. These are relationships with friends and family, and the school and home environment. If learners feel shy to discuss with parents (or vice versa) issues of sex and sexuality, it implies they will turn to other sources of information which might not be reliable. The literature above showed that friends' views are seen as paramount by adolescents.

Table 4. 2.1 Sexual partners

	%	
None	15	
One	30	
More than one	52	
Total	97	

Table 4.2.2 Sex without protection may cause STIs, and even HIV?

	% Yes	% No
	89	11

## Discussion

The main mode of transmission of HIV is through sex, and the use of shared injections in drug consumption. When asked about the number of sexual partners learners have, 15% of the learners said they do not have any; 30% have one partner and 52% have more than one partner while 2% did not respond. On the other hand 99% of the learners indicated that they were aware that sex without protection makes them vulnerable to HIV infection as well as other STIs. This shows a gap between what is taught at school and reality.

It is inconceivable that these learners know about the consequences of their actions yet go ahead as if they are somehow guaranteed that the tragedy of getting infected can never happen to them. These learners come from communities ravaged by HIV/AIDS and poverty. In fact, some have witnessed the deaths of loved ones, relations, friends and community members because of the pandemic, yet all these experiences do not make them change their risk behaviours. In the discussion in 4.1, it came out that learners have access to a considerable amount of explicit sex materials through the media and that they feel an urge to explore. In addition, such behaviours can also be attributed to the missing link that seems to exist between the classroom and the world outside the classroom. A look back at the literature review, it was raised that though adolescents have the information about HIV/AIDS, yet they still do not see it as a threat to them, but rather a disease of some people somewhere.

### **4.3 Application of knowledge and skills about HIV/AIDS**

The last section of the questionnaire consists of 17 questions. Most of them are follow-up questions to probe if learners use the information they learned about HIV/AIDS to address sex challenges in their day to day lives. The general overview of this section is that most learners, although informed about condoms and condom use, still engage in sex without condoms or protection although they are not interested in making babies. Despite these risky behaviours, learners feel parents have a role to play when it comes to sex and sexuality matters, about 82% agree and 18% of the learners feel they would not be comfortable to discuss issues of sex and sexuality with their parents. Although, most learners would love to talk with their parents about these issues, they were reluctant to say their parents would also want to talk to them. About 67% said yes, their parents can freely discuss the topic, but 33% were not positive. The latter seems comfortable discussing sex with their boyfriends and girlfriends, rather than with teachers and parents. About 93% agrees that it would be better to abstain from sex until they are mature and informed enough to make better decisions because getting pregnant or making a girl pregnant interferes with their studies. Although learners have this understanding, they seem to act differently as 47% agreed to being sexually active. Distal factors such as culture, religion and customs and belief systems play a role when it comes to issues of sex and sexuality in an African context. However, strategic targeted interventions that encourage the need for openness about HIV/AIDS can make a difference.

**Table 4.3.1. Age at first sexual encounter**

	%
13 years old	15
14-15 years old	19
16-17 years old	28
Younger	11
Never had sex	23
Total	96

**Table 4.3.2. First sexual encounter was;**

	N0. of leaners YES	% Yes
Forced	9	21
Felt like doing it	6	14
You and your boyfriend/girlfriend planned it	5	12
Just happened	11	25
Never had sex	9	19
Total	40	89

## Discussion

From the 96 % distributed as per Table 4.3.1, only about 4% of the learners did not respond. The table gives an indication of ages at which learners become sexually active. A higher percentage is shared between 14 and 17 years. In this age group, many learners become sexually active or had their first sexual encounter. A reflection to the literature review indicates that by the time they turn 16; most young people are sexually active. About 15% learners became sexually active

or engaged in sex at 13 years old, and 11% at an unstated younger age. This is a cause for concern because these learners are still young and at this age it might be difficult to negotiate safer sex. The outcome of the Table 4.3.1 may be summarized by saying that learners at these three schools become sexually active at an early age- a risk behaviour that exposes the learners to HIV infection.

Table 4.3.2 highlights the first sexual encounter of learners in the three schools. According to the table, the first sexual encounter of most learners just happened (25%). It was neither communicated nor planned; and chances are there was no protection used. This situation calls for a focused research and skills to help teenagers deal with such challenges correctly. The literature review shows that most teenagers cannot discern an impending danger and escape from it. The issues of gender equity also come in as 21 % of the learners indicated that they were forced. Most learners in this category were female learners. This proves that the issue of gender sensitivity needs to be emphasized, as it does not only come from fellow male learners but also from teachers. It is therefore, important to equip female learners with skills to deal with these challenges.

#### **4.4 Results for the interview with Life Orientation teachers.**

The present researcher approached Life Orientation teachers through principals' consent in each school, and indicated the researcher's intention and research topic. The present researcher also requested one volunteer per school. The volunteers were given consent forms to participate in the study. The consent forms were signed and given back to the researcher and dates for interviews were agreed upon. The interview session was recorded with a small tape recorder. The interview schedule was sent to the Life Orientation teacher two days before the interview to allow the teachers to go through the questions and indicate their responses on the spaces provided and later use as reference during the interview session.

A variety of questions from open-ended section to specific were posed to understand the contribution of teachers to HIV/AIDS education. Teachers were confident that they had enough information and there was no way learners could be found lacking when it comes to HIV/AIDS. The perceptions of teachers were evaluated in chapter 2 and the literature associated with it. The

results of the interviews are analysed below. The questions are conceptualized into three categories and each category was discussed in depth.

4.4.1. With regard to the question on how long these teachers have been teaching Life Orientation, all three teachers have some experience on teaching the subject. They however indicated that they were not qualified to teach Life Orientation and that the subject is shifted from one teacher to the other each year depending on the workload per teacher. The lack of expertise and the fact that schools allocate generalist teachers to teach the subject show that little value is attached to the subject. Rooth (2005) and Christiaans (2006) argue that the epistemology and skills of the teachers who teach a learning area, determines the status thereof. How then can learners add value to it in their personal lives?



#### 4.4.2 Topics covered concerning sexuality education and HIV/AIDS

The results are summarized in Table 4.4 below figure.1.

Table 4.4: Reported teacher coverage of programme topics and skills		Yes	No
<b>A. TOPICS</b>			
Understanding of my body		2	1
My relationships with family, friends and relatives.		3	
Causes of HIV/AIDS		3	
Spread of HIV/AIDS		3	
Living and caring for people with HIV/AIDS		2	1
<b>B. SKILLS</b>			
Coping skill-decision making		1	2
Coping skill-assertiveness			3
Coping skill- communication		1	2
Coping skill-self-esteem		1	2

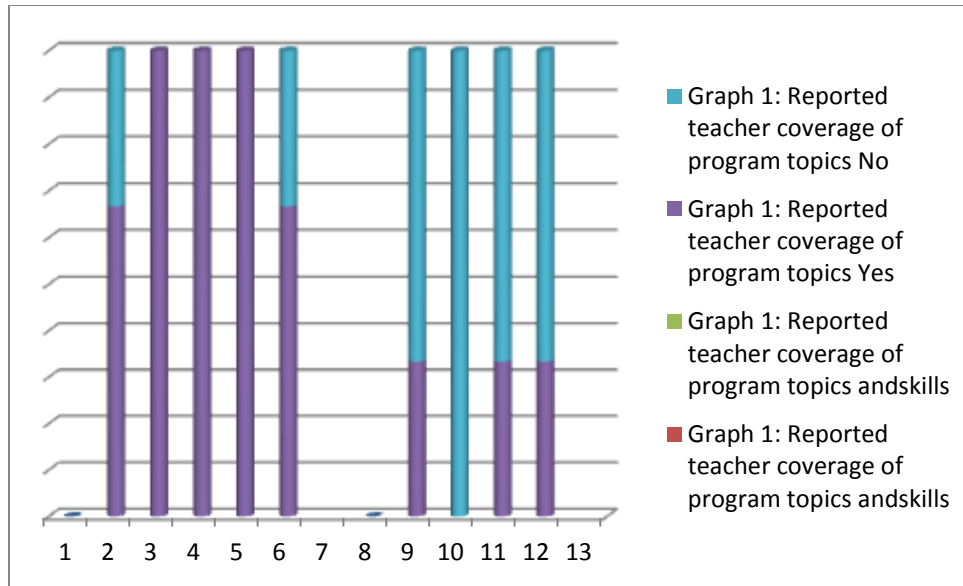


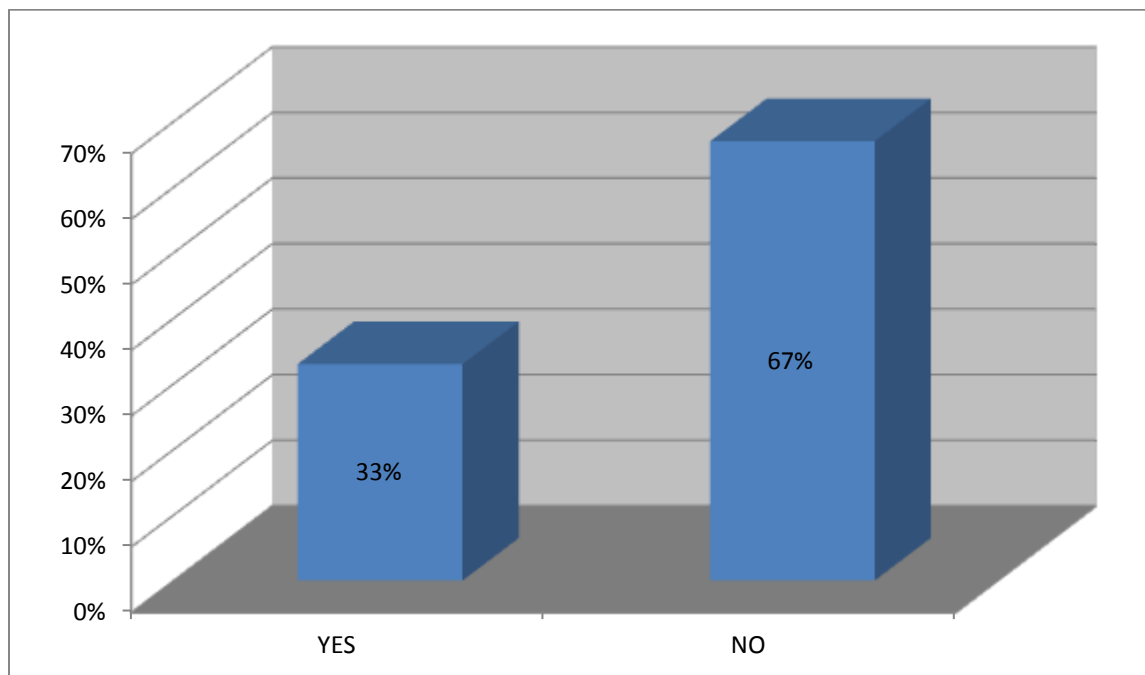
Figure 4.1: **Reported teacher coverage of topics and skills**

## Discussion

From Figure 4.1, it is evident that teachers cover information aspects of the curriculum and neglect the skills necessary to help learners reconcile the theory and application of knowledge in everyday challenges. According to Visser (2005), the Life Orientation curriculum being implemented, emphasise information about HIV/AIDS and disregard the advancement of life skills that would allow students to develop ‘healthy life styles’. In support of this, Abel and Fitzgerald (2006) argue that increasing the youth’s knowledge about HIV/AIDS and sexual interactions does not necessarily lead to the prevention of ‘negative health outcomes’. In addition, the Life Orientation curriculum comprises of a number of diverse themes such as health promotion; physical development and movement: guidance; life skills education; environmental education; citizenship and human rights, and religion. Sexuality education is not a topic on its own, but it is integrated into some of the components above. This gives school teachers a considerable amount of autonomy in respect of the implementation of sex education. Many teachers teach on the basis of their own values and beliefs, Harley et al (2000). So, despite the Department of Education’s policy ideals, sexuality education within classrooms is often an adult or teacher’s own construct of knowledge rather than a reflection of the youth’s sexual experiences.

Skills transfer should be measured to ensure proper transfer from educators to learners. Figure 4.1 also helps to explain why learners do not seem to apply what they learn to address challenges about sex and sexuality in their own lives.

4.4.3 On the question whether teachers are confident that their learners have enough information to make informed decisions, the results are shown in Fig 4.2 below. The DoE policy was designed to respond to the HIV/AIDS epidemic across South Africa by creating and implementing life skills curriculum in schools (DoE, 1999)



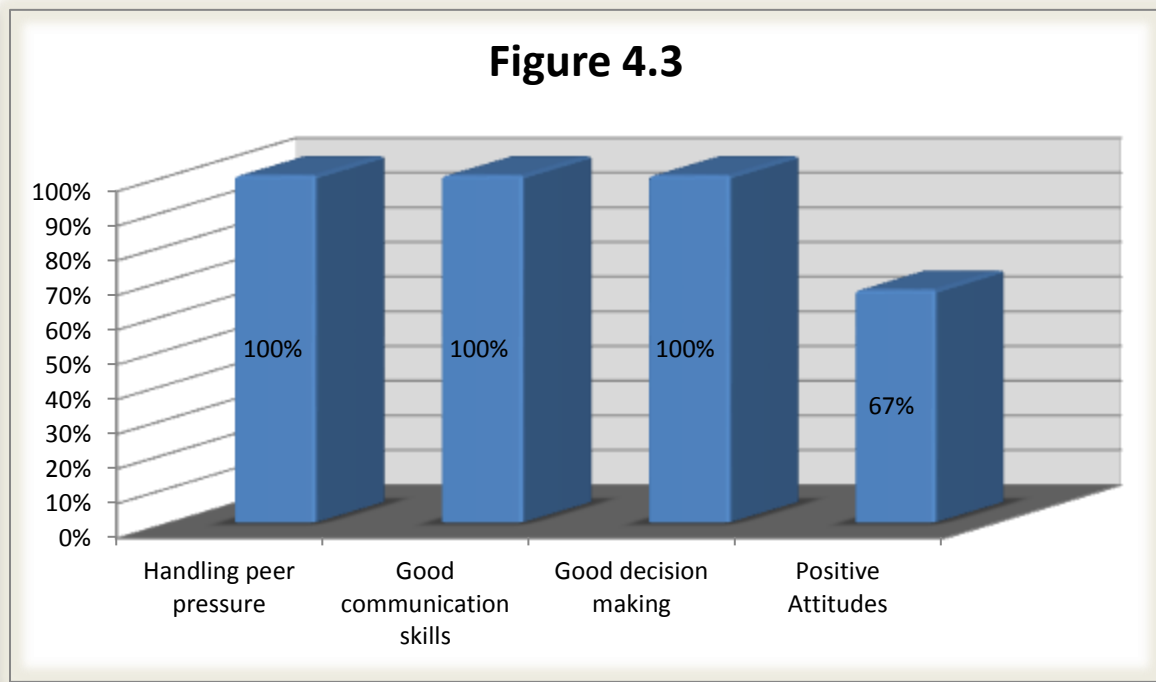
**Figure 4.2 if knowledge and skills acquired help learners to make informed decisions concerning sex.**

## **Discussion**

The graph shows that 67% of the teachers interviewed, felt that they do not feel confident that what they have taught their learners is enough to help them make responsible decisions concerning sex. They cited increasing number of teenage pregnancies in their respective schools as evidence that they are not winning this battle. 'We are cultural people and issues of culture are always paramount'; and 'We are not sure of the content, we were not adequately trained'. This information came out during the interviews with teachers. This shows that teachers feel trapped

between policy values and their cultural beliefs and values, and those of their communities (Harley, Barasa, Betram, Matteson & Pillay, 2000). Teachers do not want to be seen as the ones responsible for breaking the cultural beliefs and values. As a result, they deny learners an opportunity to learn by teaching what they feel is 'appropriate' and being comfortable with 'youth innocence'. This is seen as safe than telling learners that sex is risky but pleasurable. Issues of inadequate teacher training also came out. This is worsened by the fact that the subject is frequently shifted from one teacher to another. So new teachers in the subject constantly have to be trained and the DoE cannot live up to the challenge. Once learners detect some lack of confidence and competence in content, they are unlikely to learn anything . However, 33%, one of the three educators felt that he is confident that his learners are able to make informed decisions. This sounded as if the teacher wanted only to impress the researcher by saying something positive, because the teacher could not give a clear answer on how he managed to do that. There was no evidence pointing in the direction of the claimed achievement. Issues of cultural beliefs and values, as well as inadequate teacher training, make curriculum delivery ineffective and cause learners to disregard whatever information taught.

#### 4.4.4 Knowledge gaps that teachers think might exist.



**Figure 4.3 Knowledge gaps**

Figure 4.3 shows what educators felt are reasons for their lack of confidence in qualifying that their learners are fully equipped to make informed decisions concerning sex. High-risk sexual behaviour is strongly influenced by peer pressure trends which are observed within a community. All teachers (100%) felt that learners still lack skills to handle peer pressure. What their friends do or advice is taken as correct. Zambuko (2005) argues that due to diminishing roles of parents in controlling their teenagers, peers play an integral role in influencing the sexual behaviour of others. Sexual experience is seen as a status symbol especially among males (Visser, 2004). This impacts negatively on skills transfer and sexuality education.

Teachers also feel that their learners do not possess good communication skills (100%) and therefore cannot make good and informed decisions (100%) when it comes to sex. It was discussed above that being knowledgeable about HIV/AIDS does not necessarily lead to healthy lifestyles. Finally, teachers feel that negative learner-attitudes towards Life Orientation and sexuality education further perpetuate learner perspectives towards the programme. It can then

be safely said that peer pressure; poor negotiation skill; bad decision- making and negative attitudes are some of the factors that contribute to the way learners perceive HIV/AIDS education.

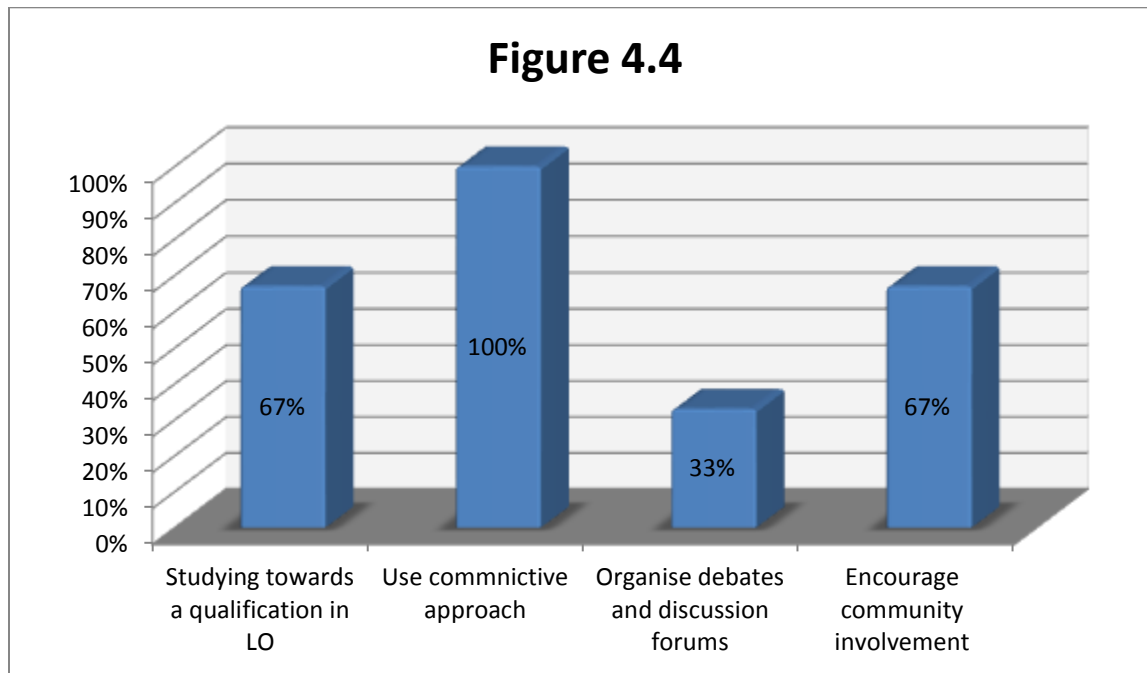
4.4.5 On the question of whether the curriculum limits teachers on what to teach and what not to teach, and whether teachers see their learners apply skills acquired through learning. All three (100%) of the teachers said ‘NO’ to the first part of the question and also agreed that there are learners who focus a lot on learning until they pass their matric. It is not clear though, whether it is because of what was taught at school or whether their parents prepared them for it. However, it is acknowledged that a considerable number of learners, fall pregnant once or even twice before they complete their matric. The Life Orientation curriculum is broad and therefore allows flexibility, as will be discussed under document analysis. Some of the reasons why learners do not seem to apply the knowledge about HIV/AIDS and skills thereof, were discussed above. However, teachers also feel that socio-economic problems such as; poverty, crowded homes, lack of privacy, lack of positive role models, alcohol abuse, and child-headed homes, to mention but a few, fall within the same category. One teacher indicated that, “despite the Department of Education policy which indicates that going-out and/or impregnating a learner is a dismissible offense, teachers do these things and get away with their actions because most of the learners are poor”. Kelly (2002), purports to the same idea, socio-economic problems have a detrimental impact on the ability of schools to be healthy-affirming environments necessary for effective sexuality education.

#### 4.4.6 General Issues

On the question of redesigning the programme or curriculum, teachers mentioned a number of general issues as well as different methodologies to deliver the content. Teachers feel that a good curriculum should be designed with the best interest of the learner. Learner values and experiences should be taken into consideration. It should address issues of children being individuals. Encourage decision making through collaboration, communication, creativity, and critical thinking. Allen’s (2005) study on school sexual health in New Zealand reveals that, the youth need to be positioned positively and legitimately as sexual subjects within sexuality education programmes, in order to equip them to make responsible choices about their sexual health. According to UNESCO (2008), all sex education and relationship programmes are value

based. This means that instead of teachers hiding behind cultural values and beliefs, they must understand that teaching sexuality education is about values too. Children and healthy development is vital and precious.

4.4.7 Lastly, teachers affirm that an impact is made no matter how small. Figure 4.4 summarises the responses.



**Figure 4.4 the impact made by Life Orientation teachers.**

Despite all the challenges discussed, teachers try to make a difference in their respective schools. About 67% of the interviewed teachers are developing themselves professionally by studying Life Orientation on part-time basis. This is an indication of self –motivation because teachers finance their own studies. All teachers (100%) use the communicative approach to ensure that all learners get involved during learning. One teacher also organises debates and discussion forums in which learners talk openly and critically about sexuality education. In order to bring the community, including parents to the picture, 67% of the teachers organise community meetings. This shows that something can always be done with the right attitude.

#### **4.4.8 Recommendations by Life Orientation Teachers**

Teachers recommend that the subject, Life Orientation, should be given a better weighting and an extra hour per week be allocated for visits and role modelling (visiting hospitals, HIV clinics, orphanages and such places where a class is brought to life).

They also recommended that Life Orientation should have a final examination paper like other subjects. Finally, teachers appealed for support from all stakeholders.

#### **4.5 Brief Analysis of the Life Orientation Curriculum**

The National Curriculum Statement has divided the Life Orientation Curriculum into different phases. However, two phases which concern grades 8 to 12 will be discussed. Grades 8 and 9 belong to the senior phase and grades 10-12 belong to the same phase. The curriculum for grades 8 and 9 has been divided into five main topics. The curriculum is allocated two hours per week and it is specifically stipulated that an hour should be dedicated to Physical Education and the other hour be shared among the remaining four main topics. Part of the main topics that address life skills and HIV/AIDS sub-topics are: Development of the self in society; and Health, Social and Environmental responsibilities. The remaining two main topics deal with constitutional rights and responsibilities, and the world of work.

The main topics are sub-divided into the following: Development of self and society; and Health, Social and Environmental responsibility. There are six topics for grade 8 learners which, include among others; Self-formation and motivation, sexuality, relationships and friendships, and decision-making about health and safety under which HIV/AIDS is discussed. In grade 9, there is a progression to goal setting skills; personal life styles and choices, sexual behaviour and sexual health, and of challenging situations such as depression, grief, loss, trauma and crisis.

This leaves the educator with the latitude to decide what information, concerning HIV/AIDS, sex and sexuality and coping skills to teach these learners. Another reason is that the Department of Education policy allows flexibility to accommodate diverse learners and their diverse environments throughout South Africa. The Department of Education assumes that every teacher will play a neutral role in the dissemination of knowledge and skills about HIV/AIDS, which might not necessarily be true. Teachers have their own perspectives about some of the topics in the curriculum. This oversight causes the dissemination of knowledge and skills sceptical and even ineffective. Hence learners seem not to benefit much as they should from the programme.



The grades 10 to 12 curriculum consists of six main topics namely: development of self in society; social and environmental responsibility, democracy and human rights, study skills and physical education. Again, from the main topics, sub-topics which are not so specific are given and the teacher has to fit in the topics because even the teaching plan does not specifically indicate what to be taught and which skills to emphasize. Possibly, the Department of Education allowed this flexibility to address different social, environmental as well as physical settings in South Africa as a whole. Nevertheless, the flexibility limits the effectiveness of the curriculum. Learners throughout South Africa and the world, face similar challenges although not the same. Interventions should be more focused and be able to measure levels of knowledge and coping skills accurately. The initial introduction of HIV/AIDS education in Outcomes Based Education was health orientated. It focused mainly on issues transmission and prevention. A communicative Curriculum 2005 was later introduced. It focuses on learner involvement and skills acquisition. But the DoE does not specify what should be taught. Rooth (2005), points out that LO teachers in most South African schools lack uniformity of training which limits them to deliver sexuality education effectively and confidently.

#### **4.6 Limitations of study**

Considering Life Orientation teachers' concerns, the study could have been broadened to include the whole school community or stakeholders. Understanding the perceptions of all stakeholders would address the concern of lack of support for Life Orientation teachers by all stakeholders. The data gathered from all stakeholders could also give an overall view of the lives of teenagers who come from homes belonging to communities and they attend schools. Their challenges come from proximal as well as distal factors.

## Chapter 5: Recommendations

In spite of the limitations, it can be concluded that learners become sexually active at an early age of thirteen. In Table 4.3.1, 14, 9% of the learners agreed that their first sexual encounter was at thirteen years old. Table 4.3.2, shows that out of the 91% of learners who agreed that they are/or became sexual active at some age, did not plan or discuss about engaging in sexual intercourse with partners beforehand. They do not apply the knowledge gained through HIV/AIDS education because they somehow feel HIV/AIDS does not affect and will not infect them. They see it as a disease of some people somewhere. In order to address the issues affecting adolescents, school performance, communities and government, the following recommendations are given. In 4.2, Section B, it was mentioned that through the learners' pregnancy statistics records in the school, teenage pregnancy is increasing. This shows that the learners are not practicing safe sex and they risk being infected by HIV and AIDS.

Based on the findings of this study, the following recommendations were made to facilitate the imparting of knowledge, together with skills which the learners and others can use in other areas of their lives.

### 5.1 Adequate training for teachers

From the interview schedule, challenges faced by Life Orientation teachers were discussed and teachers felt they needed more resources and teacher in –service training in order to deliver the curriculum objectives optimally. Teachers also feel that more time should be dedicated to fun-filled practical activities which bring life to the knowledge packed curriculum. Learners will begin to make a connection between classroom and reality. Factors such as peer pressure and gender inequalities counter curriculum objectives and teachers do not know how to deal with these situations. More in service training would assist in this regard.

## **5.2 Life Orientation should be examinable**

Learners see Life Orientation or HIV/AIDS education as only an inconvenience that wastes their precious time to practice mathematics, sciences and other key subjects which are important for their life careers. This is because there is no examination credit for this subject, even if learners end-up with outstanding grades for it. It amounts to nothing when it comes to university entrance. Teachers indicated that the weighting given for Life Orientation is demotivating to both teachers and learners. They recommended that the subject be given more attention by the Department of Education.

## **5.3 Overall Support**

The factors that are responsible for risky sexual behaviours reported by the learners in this study, such as being sexually active at an early age, and practicing unsafe sex was influenced by consuming explicit sex materials. These make learners susceptible to HIV infection. A skills- packed approach to counter risk behaviours is required to mitigate HIV/AIDS infections and teenage pregnancies. This approach could entail exposing the learners to real life situations of the impact of HIV and AIDS by visiting hospitals, orphanages, and listening to these peoples' stories. The schools could also organize camps and create a free learning environment where learners can speak freely of their challenges. The teachers could then put more emphasis on the skills that they feel their learners need.

## **5.4 Role modelling**

The Department of Education, through schools, should have its human resources to motivate learners to do what is right. There are people who live with the virus, and they voluntarily disclose their status to assist others. Teenagers who have experienced teenage pregnancy and are young mothers- can assist our learners understand reasons why it is bad to be a teenage mother and reduce HIV/AIDS infection among peers.

### **5.5 The content should be skills –orientated**

Instead of just imparting knowledge about what HIV/AIDS is, transmission modes, prevention and/ or testing, learners should be equipped with skills to say ‘ No’ to unsafe sex, to negotiate condom use in relationships, to communicate about it and how to understand each situation and respond accordingly, and be self-assured ( principled). The learners cannot acquire these skills at once. The teachers could use different methods and emphasise each skill repeatedly. The use of teenage forum discussions, camps, and role modelling could help the learners to acquire different skills. The curriculum emphasizes the development of self-concept from grade 8 through to 12, to assist learners to have a strong sense of self so that they are able to respond to challenges appropriately.

## Chapter 6: Conclusion

From the research conducted in this study, the following conclusions are made:

Firstly, despite interventions by the Department of Education and other sectors, learners in schools around Malamulele continue to report risky behaviours such as teenage pregnancy, being sexually active at an early age and practice unprotected sex. Some learners have multiple sex partners. These behaviours are influenced by a number of factors, including peer pressure. It was established through questionnaire data analysis and literature review that learners take their friends' opinion and advice seriously than any other persons.

Secondly, the internet (which makes explicit sex materials available to teenagers), influence the teenagers' attitudes towards sex negatively and the drive to engage in unprotected sex is sharpened. They are exposed to explicit sex materials before they learn or acquire skills to process and respond to the information correctly. They are still young and lack skills to negotiate safe sex, communicate effectively and evade impending dangers.

In addition, the curriculum design creates loopholes in HIV/AIDS education delivery, by being too flexible to allow teachers room to select and exclude some of the topics. Most teachers concentrate on the knowledge part of the curriculum and neglect the skills that make the application of knowledge easier. This creates a gap between what is taught and the reality of day to day challenges faced by adolescents. Teachers are not confident with the content because they do not receive adequate training. Once learners detect this lack of confidence, learning does not take place because they lose interest. Issues of cultural beliefs and values also interfere with learning and impacts on what is taught in class.

Moreover, female learners are subjected to sexual abuse by both fellow learners and teachers because of gender inequalities. Female learners admitted that their first sexual encounter was forced. Teachers also mentioned lack of support by school community and cited colleagues who abuse learners by promising them money and favours in exchange for sex. This injustice is aggravated by issues such as general poverty. It was indicated earlier that most learners come from impoverished communities which mainly survive on child grants.

Finally, adolescence is a stage of development characterized by physical development, and introduces teenagers to a world of adulthood. Therefore, learners are easily swayed by almost anything around them. It is the responsibility of all stakeholders including parents to ensure that their children do not just go through compulsory natural growth but development that is nurtured and guided.

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ADDENDA

Addendum A

Male		Female	
SECTION A: INFORMATION ABOUT HIV/AIDS			

OFFICE  
USE

1	Do you know about HIV/AIDS?	<table border="1"> <tr><td>YES</td></tr> <tr><td>NO</td></tr> </table>	YES	NO	<input style="width: 50px; height: 20px;" type="text"/>	1
YES						
NO						

2	From whom did you learn about HIV/AIDS?	<table border="0"> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td style="text-align: center;"><input style="width: 40px; height: 15px;" type="text"/></td> <td style="text-align: center;"><input style="width: 40px; height: 15px;" type="text"/></td> </tr> </table>	YES	NO	<input style="width: 40px; height: 15px;" type="text"/>	<input style="width: 40px; height: 15px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	2
YES	NO							
<input style="width: 40px; height: 15px;" type="text"/>	<input style="width: 40px; height: 15px;" type="text"/>							
	Parents	<input style="width: 40px; height: 15px;" type="text"/> <input style="width: 40px; height: 15px;" type="text"/>						
	Nurses/doctors	<input style="width: 40px; height: 15px;" type="text"/> <input style="width: 40px; height: 15px;" type="text"/>						
	Teachers	<input style="width: 40px; height: 15px;" type="text"/> <input style="width: 40px; height: 15px;" type="text"/>						
	Public campaign/Advertisement	<input style="width: 40px; height: 15px;" type="text"/> <input style="width: 40px; height: 15px;" type="text"/>						

3	Have you ever received education information on the following topics?	<table border="0"> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td style="text-align: center;"><input style="width: 40px; height: 15px;" type="text"/></td> <td style="text-align: center;"><input style="width: 40px; height: 15px;" type="text"/></td> </tr> </table>	YES	NO	<input style="width: 40px; height: 15px;" type="text"/>	<input style="width: 40px; height: 15px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	3
YES	NO							
<input style="width: 40px; height: 15px;" type="text"/>	<input style="width: 40px; height: 15px;" type="text"/>							
	Sex organs and how they function	<input style="width: 40px; height: 15px;" type="text"/> <input style="width: 40px; height: 15px;" type="text"/>						
	Sexually transmitted diseases	<input style="width: 40px; height: 15px;" type="text"/> <input style="width: 40px; height: 15px;" type="text"/>						
	Teenage pregnancy	<input style="width: 40px; height: 15px;" type="text"/> <input style="width: 40px; height: 15px;" type="text"/>						
	Abortion	<input style="width: 40px; height: 15px;" type="text"/> <input style="width: 40px; height: 15px;" type="text"/>						
	HIV/AIDS	<input style="width: 40px; height: 15px;" type="text"/> <input style="width: 40px; height: 15px;" type="text"/>						
	Sexual abuse	<input style="width: 40px; height: 15px;" type="text"/> <input style="width: 40px; height: 15px;" type="text"/>						
	Homosexuality	<input style="width: 40px; height: 15px;" type="text"/> <input style="width: 40px; height: 15px;" type="text"/>						
	How to say NO to sex	<input style="width: 40px; height: 15px;" type="text"/> <input style="width: 40px; height: 15px;" type="text"/>						
	Contraceptives pill, injections, condoms	<input style="width: 40px; height: 15px;" type="text"/> <input style="width: 40px; height: 15px;" type="text"/>						

4. Do you think you have enough information on sex and sexuality to be able to make informed decisions concerning sexual intercourse?

YES	NO
-----	----

4

5. If the answer is no to question 4, what could be the problem?

YES NO

- Peer pressure
- Not sure about some of the issues
- Lot of sex materials in the media
- Need to explore
- Unable to say NO to sex
- Knowing too little about sex


5

Addendum B

SECTION B: UNDERSTANDING ABOUT HIV/AIDS
--

- 1 Have you ever had sexual intercourse with your girlfriend/boyfriend?
- |     |  |     |    |   |   |
|-----|--|-----|----|---|---|
|     | <table border="1" style="margin: auto;"> <tr><td>YES</td></tr> <tr><td>NO</td></tr> </table> | YES | NO | <input style="width: 40px; height: 20px;" type="checkbox"/> | 6 |
| YES |  |     |    |   |   |
| NO  |  |     |    |   |   |
- 
- 2 If the answer is yes to question 6, did you discuss about why you should or should not have sex?
- |     |  |     |    |   |   |
|-----|--|-----|----|---|---|
|     | <table border="1" style="margin: auto;"> <tr><td>YES</td></tr> <tr><td>NO</td></tr> </table> | YES | NO | <input style="width: 40px; height: 20px;" type="checkbox"/> | 7 |
| YES |  |     |    |   |   |
| NO  |  |     |    |   |   |
- 
- 3 If you did, do you think your decision of engaging/not engaging in sex was informed?
- |     |  |     |    |   |   |
|-----|--|-----|----|---|---|
|     | <table border="1" style="margin: auto;"> <tr><td>YES</td></tr> <tr><td>NO</td></tr> </table> | YES | NO | <input style="width: 40px; height: 20px;" type="checkbox"/> | 8 |
| YES |  |     |    |   |   |
| NO  |  |     |    |   |   |
- 
- 4 If you said NO to sex, was it because you remembered what you were taught by:
- |                                | YES | NO |   |
|--------------------------------|-----|----|---|
| Your Life Orientation educator |     |    | <input style="width: 40px; height: 20px;" type="checkbox"/> |
| Parents                        |     |    |   |
| The media                      |     |    |   |
| A friend                       |     |    |   |
| School in life sciences        |     |    |   |
- 
- 5 How many sexual partners do you have?
- |               | YES | NO |   |
|---------------|-----|----|---|
| None          |     |    | <input style="width: 40px; height: 20px;" type="checkbox"/> |
| One           |     |    |   |
| More than one |     |    |   |

6 Do you discuss issues about sex and contraception with your parents?

YES
NO

11

7 If the answer is no to question 11, is the reason

YES NO

Cultural  
Shyness  
Not  
sure

YES	NO

12

8 Do you know that if you are sexual active and have sex with your partner without protection, you may get STIs, and even HIV?

YES
NO

13

Addendum C

<b>SECTION C: APPLICATION OF INFORMATION ABOUT HIV/AIDS</b>
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1 How often do you have sexual intercourse?

- Once per week
- At least once per month
- Once per year
- Never

YES	NO

2 How old were you when you had sexual intercourse for the first time?

- 13 years old
- 14-15 years old
- 16-17 years old
- Younger
- Never had sex

YES

3 The first time you had sex, were you,

- Forced
- Felt like doing it
- You and your girlfriend/boyfriend planned it
- Just happened
- Never had sex

YES	NO

4 When last did you have sex?

- A week ago
- A month ago
- Six months ago
- About a year ago
- Never had sex
- Not sure

YES

5. When you last had sex, did you use protection?

YES	NO
-----	----

6. If you did not use protection, was it because you,

	YES	NO
Did not want to		
Forgot		
Wants a baby		
Caught off guard		
Never had sex		

7 Do you always discuss what you were taught about HIV/AIDS with your girlfriend/boyfriend before engaging in sex?

YES	NO
-----	----

8 Do you think the information is important and enough to inform your decisions about sex and sexuality?

YES	NO
-----	----

9 Sexually active teenagers should discuss sex and contraception with their parents

YES	NO
-----	----

10 Would your parents discuss these issues with you?

YES	NO
-----	----

11 Sex education should be offered by both parents and the school

YES	NO
-----	----

12 Sexuality education should be more formalized with more content.

YES	NO
-----	----

13 Are you willing to discuss sex matters with

Your parents  
Teachers  
Girlfriend/boyfriend

YES	NO

14 Is it a good thing to abstain from sexual intercourse until you are matured and ready to make better decisions?

YES	NO
-----	----

15 Getting pregnant/making a girl pregnant, interferes with your studies

YES	NO
-----	----

16 HIV/AIDS is a major problem in homes, communities, the country and the world

YES	NO
-----	----

17 Are you willing to take decisions and actions that would not contribute to the further spread of HIV/AIDS and teenage pregnancy?

YES	NO
-----	----



Addendum D

**INTERVIEW SCHEDULE FOR EDUCATORS**

1. For how long have you been teaching Life Orientation?

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2. Which topics do you cover concerning sexuality education and HIV/AIDS?

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3. Do you feel it is enough information to make learners to take informed decisions concerning sex, and HIV and AIDS?

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4. If not enough, what knowledge gaps do you think exist?

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8. If you were asked to redesign the program or improve on it, what would you add/ leave out?

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9. What do you think is the best approach to motivate learners to take the subject of sex and HIV/AIDS seriously?

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10. As an individual, do you think you are making an impact on these issues?

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