

**PERCEPTIONS OF HIV/AIDS AND HIV-RELATED ACTIVITIES  
AMONG SCHOOL-GOING LEARNERS: WHERE DO WE CURRENTLY STAND?**

by

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## **DECLARATION**

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## **ABSTRACT**

This study explored the HIV-related perceptions of school going learners' (aged between 15 and 18) at a high school in the Western Cape with the objective of identifying possible factors that could improve current HIV-related programs and activities at the school. An explorative cross-sectional design using a structured questionnaire was used to obtain the responses from participants.

The findings revealed that most participants had relatively high HIV-related knowledge levels. However, when asked about the 'window period', many of the respondents were unsure what was meant by this term. Participants had overall optimistic beliefs around condom use. Yet, many believed their peers do not make use of condoms when engaging in sexual activities. This warrants further investigation. Based on the general positive findings on their beliefs around condom availability in school, it is suggested that condoms should be made available at the school. Participants also had positive intentions toward encouraging their friends to use condoms as well using condoms themselves should they have sex. Respondents' perceived effectiveness of the sex education and HIV awareness programme at the school were generally encouraging. It is recommended that the current school programme to be expanded to include younger learners.

## OPSOMMING

Hierdie studie het die MIV-verwante persepsies van skoolgaande leerders (tussen die ouderdom van 15 en 18) aan 'n hoër skool in die Wes-Kaap ondersoek met die doel om moontlike faktore te identifiseer wat huidige MIV-verwante programmeme en aktiwiteite by die skool sou kon verbeter. 'n Ondersoekende kwantitatiewe deursnee-ontwerp, waar van 'n gestruktureerde vraelys gebruik gemaak is, is ingespan om die reaksies van deelnemers te verkry.

Die bevindinge het getoon dat die meerderheid deelnemers oor relatief hoë MIV-verwante kennisvlakke beskik het. Maar, toe hulle oor die 'vensterperiode' uitgevra is, het talle van die respondente laat blyk dat hulle onseker was oor wat met dié term bedoel word. Oor die algemeen het hulle optimistiese opvattinge rondom kondoomgebruik gehad. Tog was talle van hulle die mening toegedaan dat hulle maats (portiergroep) nie van kondome gebruik maak wanneer hulle seksueel verkeer nie. Dié feit regverdig nadere ondersoek. Gerig op die algemeen positiewe bevindinge oor hulle opvattinge rondom kondoom-beskikbaarheid in skole, word aan die hand gedoen dat kondome by skole beskikbaar gestel behoort te word. Deelnemers het ook 'n positiewe ingesteldheid getoon dat hulle hul vriende sou aanmoedig om kondome te gebruik en dat hulle dieselfde optrede sou volg indien hulle seks beoefen. Die persepsie van respondente oor die doeltreffendheid van seksopvoeding- en MIV-bewusmakingsprogrammeme by die skool was oor die algemeen heel bemoedigend. Daar word aanbeveel dat die huidige skoolprogramme uitgebrei word om ook jonger leerders in te sluit.

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Glory be to the lord.

## ACRONYMS

ABC:	Abstinence, Be Faithful, Condomise
AIDS:	Acquired Immune Deficiency Syndrome
ARRM:	AIDS Risk Reduction model
BCC:	Behaviour Communication change
BCM:	Business, Commercial and management
DOH:	Department of Health
GCHS:	Gardens Commercial High School
HIV:	Human Immunodeficiency Virus
KAP:	Knowledge, Attitude and Practices
KZ:	Kwazulu-Natal
MRC:	Medical Research Council
NGOS:	Non-Governmental Organisations
SA:	South Africa
SPSS:	Statistical Package for Social Science
STIs:	Sexual Transmitted Infections
UCT:	University of Cape Town
TRA:	Theory of Reasoned Action
UNAIDS:	Joint of United Nations Programmeme on HIV/AIDS
UNESCO:	United Nations Educational, Scientific and Cultural Organization
UNFPA:	The United Nations Population Fund is one of UNAIDS
UNICEF:	United Nations International Children's Emergency Fund
WC:	Western Cape
WHO:	World Health Organization

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## **CHAPTER ONE**

### **Focus of the Study**

#### **1.1 Introduction**

An estimated 23.5 million people in Sub-Saharan Africa are infected with the HIV/AIDS pandemic pitching the region as the most infected area in the world, representing about 70% of the global population infected by the disease (UNAIDS 2012). In 2011, it was estimated that the youth (15-24) accounted for about 40% of all new global HIV infections among people aged 15 years and older (United Nation Youth, 2012). While an estimated 1 in every 20 adults, are infected by the disease, the United Nations estimates that about five million young people (15-24) are living with HIV. Based on available data, it is also suggested that about 2400 young people become infected with HIV (United Nation Youth, 2012).

#### **1.2 HIV and the Youth**

The rates of HIV among youths has caused the international community to identify the importance to scale up HIV preventive measures among young people. This message took central stage in various conferences, including the International Conference on Population and Development held by Member States at the 1994, the World Conference on Women in 1995 and the United Nations General Assembly Special Session on HIV/AIDS held in 2001. In spite of the efforts mustered to curb the affection among this population, it is estimated that about 2.1 million adolescents (10–19) live with HIV globally. Many sources have shown that more females within this age group are affected by the infection than their male counterparts with an estimated 60% of girls affected (Wallace, 2014). Findings from surveys conducted by Statistics South Africa (2012) estimates that 16.6% of South Africans adult population (aged 15-49) years were living with HIV in 2011. According to the UNAIDS global report (2012), lack of correct health information leading to indulgence in risky behaviours, and lack of access to

adequate reproductive health services have substantially contributed to the high prevalence found among young people.

It is recommended by the global community that programmes must be designed and resources deployed to also focus on the adolescents and youth as they have been identified to easily engage in risky behaviours, such as unprotected sex, being promiscuous including selling sex, injecting drugs and men having sex with men. Experience from nations with concentrated epidemics, has demonstrated over the past decade, how to address HIV among young people. Sex education has been demonstrated by various studies to reduce the risk of HIV. This is achieved providing information to the youth on delaying the onset of sexual activity as well as encouraging safer sexual behaviour (United Nation Youth, 2012).

### **1.3 Background**

HIV/AIDS among adolescents and youths has received significant attention from various organisations dealing with the pandemic. For instance, in a study conducted by Fako (2006) to investigate the effects of socio-demographic background on willingness of students from secondary schools and tertiary institutions to take an HIV test in Botswana, it was found that low levels of HIV testing were identified among young males (Fako, 2006). Various studies have explored the lack of knowledge on HIV/AIDS related issues among young people especially in developing countries. For example, studies conducted by Aomreore, Alikor and Nkanginieme (2004) in Nigeria and Ghana to investigate KAP levels among learners, found that knowledge about the transmission of HIV was poor in senior high school learners in Nigeria. Results show that 31% of the learners studied correctly identified sexual intercourse as a cause for HIV transmission; 14.4% identified blood transfusion; 9.1% correctly identified mother to child (vertical) transmission as a route for HIV transmission while 8% identified intravenous drug use. Only 7.1% identified all of the listed four modes of transmission of HIV whilst 0.7% of the learners identified all of the listed preventive methods.

The pregnancy rate is often used by researchers as a tracer for preventing sexual behaviour, especially condom use. A study conducted by the Human Sciences Research Council on teenage pregnancy on behalf of the South African Department of Education, reviewing the literature supported by secondary data analysis to provide an overview of research on the prevalence, determinants and interventions for teenage pregnancy, the findings showed that there was an upsurge in teenage pregnancy nationally between 2004 and 2008 (Panday, Makiwane, Ranchod, & Letsoalo, 2009). A probable deduction from these findings is that teenagers are engaging in unprotected sexual intercourse which predisposes them to contracting HIV and other STIs. It is, therefore, not surprising that a high incidence of HIV was found among young females aged 15–24 years in national HIV survey by Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu Labadarios, Onoya, et al. (2014). This study showed that almost a quarter (24.1%) of all new HIV infections in South Africa occurs among this group. This high incidence among young women is troubling and is seemingly becoming a public health concern. Furthermore, a general decline in accurate HIV-prevention knowledge has been identified in a recent study by Simbayi et al. (2014) in South Africa. This might also have serious implications for efforts to reduce new HIV infections among youths and in South Africa in general. .

#### **1.4 Research problem**

To combat that exponential growth of the HIV infection in South Africa, HIV and AIDS Life Skills Education Programmes were implemented by the national government in all public primary and secondary schools in 2002 (AVERT, 2014). The focus of these programmes are to integrate HIV and AIDS education into the school curriculum with the aim of mitigating further spread of the HIV infections and to provide care and support for young people already infected and living with the infection . Through Life Orientation lessons, these programmes were implemented to enrich the young people with the knowledge on how HIV/AIDS is transmitted, how it could be prevented, and how to live and accept people who are living with HIV and AIDS.

Despite these efforts, a survey conducted by the Western Cape Government Provincial Treasury (2012), among learners in grades 8-10 in the province, found the following. One third (31.6%) of these learners had engaged in sex in their lifetime, 59.5% of those who had ever had sex reported having sex without a condom at least once, a quarter (25.3%) who had engaged in sexual activities reported that they had at one time been high on drugs or alcohol when they had had sex with someone and 20% of the participants who were sexually active reported having had sex with two or more people (multiple partners) in the previous 3 months. Based on these alarming findings, as well as the mentioned high HIV incidence rate among young women currently experienced in SA in general, this study seeks to explore the perceptions related to HIV and the programmes implemented to address HIV issues of young high school learners, specifically in the Western Cape.

### **1.5 Research question**

What are the perceptions of HIV/AIDS and HIV-related activities among learners aged between 15 -18 at a high school in Cape Town?

### **1.6 Objectives of study**

This study had two objectives

1. To explore the perceptions of HIV and HIV-related activities of school going learners' (aged between 15 -18) at a high school in the Western Cape.
2. To make possible suggestions based on the findings of this study pertaining to appropriate HIV-related activities or programmes for the school that could help in enhancing the knowledge, and instilling positive perceptions towards HIV/AIDS for this age group.

## 1.7 Research context

The Garden Commercial High School was built in 1882 and was established in 1968. It was first existed as part of the University of Cape Town residences during the 1920's. The Gardens Commercial High School is located at Paddock Avenue, Gardens. Cape Town, South Africa. In 2006, the school was designated a Business, Commerce and Management (BCM) Focus School, and the school is a leading institution that supports learners with exceptional interest, talent, interest or aptitude in the field of business, commerce and management. The learners' enrollment in grades 8-12 averages 650 learners per annum. The Gardens Commercial High School is a coeducational inner city Secondary School in Cape Town with learners aged 12-18 years. The Gardens Commercial offers the following focus field subjects: Accounting, Business Studies, Economics and Computer Applications Technology. The introduction of the seven core values at the Gardens; friendliness, respect, honesty, hard work, teamwork, spirituality and sense of caring, is meant to be a guide that can grow the learners into becoming holistic individuals. The educators and learners are committed to living and embracing these values every day at school as well as the neighborhood and community where they find themselves. All learners, educators and parents should strive to uphold these values on a daily basis encouraging a quality school family.

The Garden Commercial High School has a diverse learner population. The table below shows the population distribution by ethnicity of the learners enrolled in the academic year 2014.

LEARNER TYPE	BLACK AFRICAN	COLOURED	INDIAN ASIAN	WHITE	OTHERS	TOTAL
ORDINARY	211	316	4	4	2	537

According to the table, the bulk of the learner population lies between the coloured and African populations in descending order. The Indian and white population share the minority of the population. This school was selected because it has a high population

density of the two population groups that are mostly affected by the HIV pandemic. By targeting both population groups, the investigator intended to capture the dynamics around having various ethnic populations, so that a diverse view could be captured. While this was not the only school that multi-racial, it was the only school that readily gave permission to the investigator to conduct the studies. This convenience gave that extra notch for the selection of this site for the research.

### **1.8 Significance of study**

The results of the study could furnish policy-makers with information on the current perceptions about HIV and HIV-related activities among learners in the 15-18 years age group in order to institute an appropriate remedial action in the event of an undesirable social trend. It could also highlight possible positive outcomes that the Social Development, Department of Health and the Department of Basic Education could profit because HIV prevention and behaviour change programmes can be tailored and adapted to the requirements of adolescent groups. Insight may also be attained on the perceptions of these groups with regards to the provision of services such as whether to provide condoms to school or not. The Garden Commercial High School could benefit from the findings because the results of the investigation might reveal information which could lead to the development of more effective educational programmes.

### **1.9 Operational definitions of terms**

**Intention:** Likelihood or subjective probability to engage in a given behaviour

**Knowledge:** Awareness or acquaintance with the information, facts and skills acquired through education or experience.

**Belief:** Opinion or a conviction on an issue

**Perception:** Intuitive recognition or appreciation of an issue

## **1.10 Structure of the assignment**

The dissertation comprises of five chapters with the information discussed as follows.

### **Chapter One**

In this chapter, the introduction and background of the study have been highlighted. In addition the problem statement, objectives and significance of the study have also been provided.

### **Chapter Two**

Chapter two provides an in-depth presentation of the current HIV statistics of the teenagers, as well as research on their HIV-related perceptions. It also looks at possible conceptual frameworks associated with explaining HIV-related behaviours.

### **Chapter Three**

Chapter three presents the methodology that was used to assess the knowledge, perceptions and beliefs of the youths. The methodology incorporates the research design, sampling strategy, data collection procedures, measuring instruments and the methods employed in the statistical analyses.

### **Chapter Four**

The results of the data analysis process are presented using descriptive statistical methods in chapter four.

### **Chapter Five**

In this chapter a discussion of the findings presented in chapter four is offered. The chapter is devoted to the discussion of the implications of the results/findings for practice, theory and future research.

## **1.11 Conclusion**

Chapter one provides the description of the research and the focus of the research. It unveils the aim of the research and the research objectives. It also spelled out the main research problem, including the question of the research. The significance of the study is also explored with the chapter ending with a description of the various chapters.



## CHAPTER TWO

### LITERATURE REVIEW AND CONCEPTUAL FRAMEWORKS

#### 2.1 Introduction

In the previous section, the research problem and background of the study were introduced and discussed. In this section the literature relating to the knowledge to, perceptions and beliefs towards HIV is reviewed. The roles of the schools and educators in educating the young people on HIV are also discussed. Finally, various frameworks relating to the acquisition of knowledge and the formation of perception and beliefs are also explored. This section is therefore discussed under the following headings.

- HIV among young people and predisposing factors
- The school's role in combating HIV/AIDS
- HIV-related perceptions of young people
- Conceptual frameworks for explaining HIV-related behaviour

#### 2.2 HIV among young people and predisposing factors

Young people have been identified to be at the centre of the global AIDS epidemic (UNFPA, 2014). It is estimated that of the 1.8 billion young people (15-24) worldwide, an estimated 5.4 million are living with HIV with an estimated incidence of 780,000 youths in 2012. In 2010, this group accounted for approximately 42% of new HIV infections in people aged 15 and older (UNAIDS 2012). Of the total number of young people living with HIV, an estimated 80% (4 million) live in sub-Saharan Africa. Patterns of HIV infection among young people are more similar across countries in the region of sub-Saharan Africa, with the prevalence of HIV increases after the age of 15 more rapidly among women than among men, reaching a peak among women in their twenties and men in their thirties (Gouws et al., 2008)

Epidemiological studies show that the rate of HIV infection among young South Africans aged 15–24 has been increasing faster than in any other age group, with 10% of young people within this age group already infected (Dawood, Bhagwanjee, Govender & Chohan, 2006). The same survey showed that by age 16, 2% of boys and 4% of girls in South Africa are already infected, with disproportionately high HIV prevalence among black African youths and young women. This shows a ratio of 1:2 for males to female infection ratio. In 2013, this ratio of infection had changed to 1:3 for males to females among 15-19 year-olds, with 5.6% of girls within the age range 15-19 year-olds being HIV positive and 0.7% boys within the same age range being HIV positive (Shisana et al., 2014).

According to the Department of Health (2010), the prevalence of HIV in South Africa, differs from one province to another with KwaZulu-Natal (KZN) having the highest HIV prevalence (39.5%) and the Western Cape (WC) having the lowest prevalence (16.9%). Irrespective of the provincial incidence rates, the incidence of the young people is higher across the provinces. Several reasons have been associated with the high incidence and prevalence of HIV among youths and these reasons have been categories as social, cultural, political, biological, and economic reasons.

Furthermore, due to power dynamics in relationships, vulnerability may be aggravated for young girls who do not have the skills and the power to negotiate condom use (Parker, Makhubhele, Ntlabathi & Connolly, 2007).

### **2.3 The School's role in combating HIV/AIDS**

Programmemes such as the Millennium Development Goals, ICPD+5, and the General Assembly Political Declaration on HIV/AIDS in 2011 have spelled out the importance of preventing HIV infections among young people. In the UNAIDS Policy Position Paper on Intensifying HIV prevention, it was highlighted that HIV prevention among young people

is also one of the 'Essential Programmatic Actions for HIV Prevention.' Sex education is identified as one of the major components of HIV prevention, targeting young people, what form it takes and whether or not it works, impacts directly on the HIV risk to which they are exposed (DOH, 2002).

Schools are expected to play a central role to communicate knowledge, instill and enforce values and promote behaviors that could enable learners to protect themselves against the HIV pandemic (Kelly, 2000). The reason for this is that schools do not only have the capacity to reach a large number of young people, but also because learners are particularly receptive to learning new information. Therefore, schools are a well-established point of contact through which young people can receive AIDS education (The World Bank, 2002). According to UNFPA (2013), if young people are well informed of HIV risks and prevention strategies, they are capable of changing their behaviours in ways that could reduce their vulnerability. To explore the differences in HIV prevalence in relation to sexual behaviour, Hargreaves et al. (2006) compared two groups of young people; school going and those not attending school or college. They discovered that the prevalence of HIV was higher among the young people not going to school and they had more risky behaviours than the young people who attend schools. There is also evidence that school going young adults have delayed sexual initiation behaviours compared to those who are going to school (Kelly, 2000; UNFPA, 2013).

Low levels of knowledge on HIV/AIDS, was identified among young people in Eastern and Southern Africa, in a UNESCO study conducted in 2009. The main reason for their inadequate knowledge was related to the fact their teachers lacked the appropriate teacher training to deliver such information to the learners. It is suggested that information on HIV/AIDS should have no age restrictions, thus, HIV/AIDS education should be started at a younger age. A common misconception is that will not relate to such information appropriately, so they are deprived of life-saving education on HIV/AIDS because the information is usually considered too 'adult' for the younger learners to understand (UNESCO, 2008). This poses as a hindrance to the fight against HIV especially among the youths, owing to the crucial nature of the information on how

it is transmitted before they are exposed to situations that carry a risk of HIV transmission and subsequent infection.

According to UNESCO (2013), information can be adapted so that awareness of AIDS can begin from an early age whilst still ensuring that the topics are age-appropriate. For example, UNESCO guidelines advise that basic education on human reproduction should begin as early as age five. This information provides the foundation on which children can build AIDS specific knowledge and skills as they develop; education about condoms and how they can protect themselves from HIV infection can be introduced from around the age nine (UNESCO, 2008). It is emphasised by UNICEF (2011) that AIDS education is very important young people as they go through early adolescence (10-14 years). This is because higher risks of contracting HIV are associated with people in their late adolescence 15-19 years (UNICEF, 2011).

To respond to the call of UNICEF and other international cry-outs, many countries have included HIV education in their school curriculum, especially in countries that are heavily hit by the pandemic. In 2000, the South African national government implemented the HIV and AIDS Life Skills Education Programme in all public primary and secondary schools (Selesho & Modise, 2012). The focus of the programme was to integrate HIV and AIDS education into the school curriculum with the intention to alleviate the HIV infections while providing much needed care and support for young people already living with the infection (AVERT, 2014). Nevertheless, a number of schools are yet to come to terms with the importance of issues regarding sexuality and AIDS (Kelly, 2000). This poses some challenges with regards to providing the much needed help which the learners would need to improve their understanding of issues around their sexuality and the transmission of HIV and AIDS.

Kelly (2000) identified some challenges that schools in SA face when it comes to incorporating messages of HIV/AIDS and sexuality to the school curriculum. He pointed that conspicuous multi-sectoral approach that is crucial to the comprehensive HIV/AIDS response is usually absent in these programmes and that these programmes have not successfully contextualize HIV/AIDS messages taking into consideration cultural and

traditional ideas. Secondly, there are many problems at the level of implementation. For example, when it comes to offering lessons on bio-medical topics and barrier methods of HIV prevention, it appears not to be presented at a level that learners can understand. Thirdly, the author highlighted that even among teachers, there seems to be a problem relating to teacher knowledge, understanding and commitment about HIV/AIDS. This leads to legitimate concerns about the possible dilution and even misrepresentation of content. This leads to the fourth problem which relates to the role of the teacher in this form of education. Often the teacher has been found to have "anxiety" and "resistance" concerns. Kelly elucidates that anxiety concerns relates to e.g. offending the parents of the learners, violating taboos, fear of being accused of encouraging promiscuity and the possibility of encouraging sexual behaviours among the learners. These resistant concerns often relate to the fact that teachers do not feel that doing sex education and HIV prevention methods is not their responsibility.

In order to contain the HIV problem among school learners, HIV/AIDS awareness programmes should address the factual reality of the matter without ignoring the importance of the learners' values, beliefs, perception and attitudes towards their emerging sexuality (Kok, 2000). It is also important for teachers to have more open attitudes towards HIV/AIDS issue at school level, placing an emphasis on the important role that they hold as role models to the learners (Govender, 2001). Combined life skills and HIV/AIDS education could help to distribute knowledge and build on the understanding beliefs of those who seek to influence others in their attitudes and beliefs. In a study conducted by Selesho and Modise (2013) to evaluate the impact of life skills as a strategy to combat HIV/AIDS among school-going young people in the Motheo District of the Free State, Province, the authors conclude that the life skills implemented in the schools changed the behaviour of the learners and their attitude towards HIV/AIDS. The recommendation that stemmed from this study is that learners, through the life skill programme, should be educated about HIV/AIDS and pregnancy and how to prevent them, as a strategy to reduce HIV/AIDS in schools. Although the before-mentioned study found that education and providing information on HIV and AIDS lead to positive behaviour change, Reddy and Frantz (2011) report conflicting

findings. They found that information sharing on HIV/AIDS among learners did not necessarily translate into a change in behaviour.

High dropout rates in schools in SA are often identified as a challenge to effective HIV and AIDS and sex education. Therefore, it suggested that educational programmes should commence before learners reach puberty (AVERT, 2014).

## **2.4 HIV-related perceptions of young people**

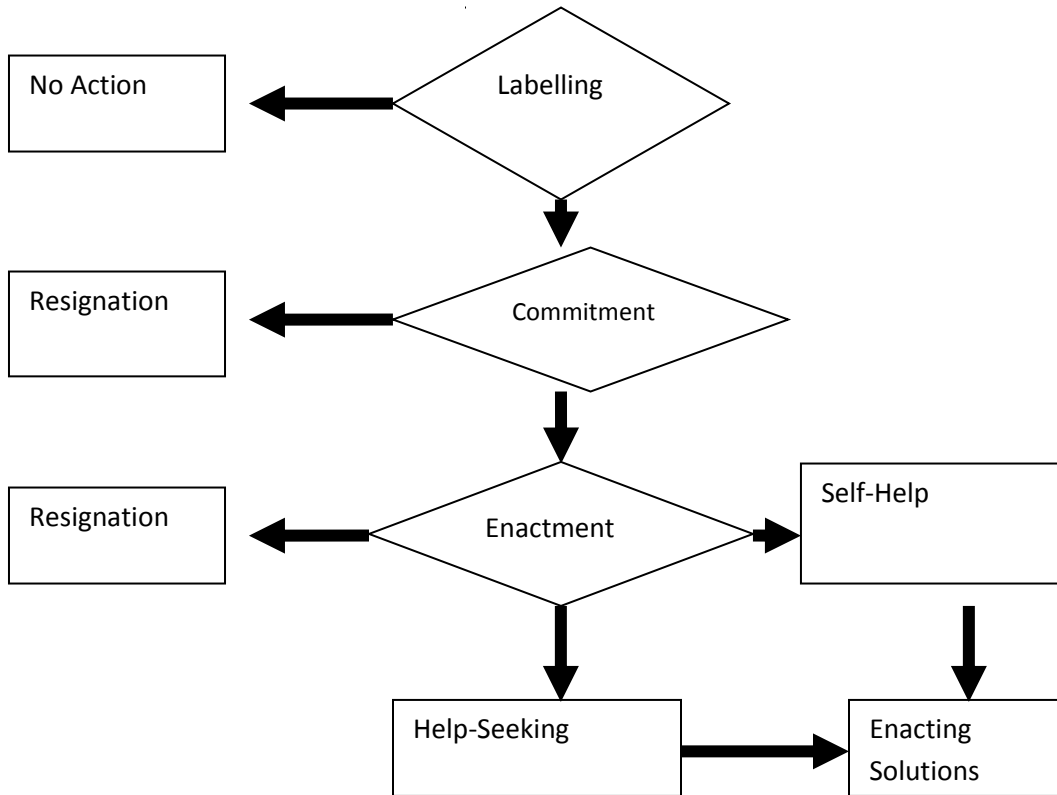
It was estimated after recent population based surveys in low- and middle-income countries, that only about a quarter (24%) of young women and a third (36%) of young men correctly responded when they were asked five questions on HIV prevention and HIV transmission (UNAIDS, 2012). This confirmed a lack of knowledge, appropriate perceptions and holding of irrational beliefs with regards to HIV and AIDS. These shortcomings have created barriers to prevent the spread of AIDS (Becker, 2012).

The knowledge that youths have on HIV/AIDS is expected to determine their attitude and beliefs towards the disease. The attitude and beliefs in turn are expected to determine their sexual behaviour (Koopman, 2001). In some cases, the youths may have some knowledge, appropriate perceptions and beliefs towards HIV/AIDS but fail to practice the correct behaviour. This was shown in a study by Reddy, Taylor and Jinabhai (2004). These researchers explored data to determine the baseline information of learners with regards to their knowledge of sexually transmitted infections (STIs) including HIV and AIDS of secondary school learners in the Midlands district of Kwa-Zulu Natal, South Africa. They also investigated the knowledge base of the learners with respect to the spread, prevention methods, their general awareness and sources of information, their perceptions of their vulnerability and their sexual beliefs. The results indicated that the learners possessed a good baseline of information with respects to HIV awareness and spread of STIs and the participants were well informed about issues relating to protection against STIs and seeking treatment, but there were significant deviations in reported behaviours.

A study by UNAIDS (2008), emphasised that sex education that focuses on abstinence based on the belief that encouraging young people not to have sex until marriage is the best way to be adopted by the youth and can protect them against HIV infection. This approach limits AIDS education by not providing information about how young people can protect themselves from HIV infection if and when they do choose to have sex (UNAIDS, 2008). As long as the cure is not yet found, changing behaviour and beliefs should be the best thing which must be adopted by the youth (Hancock, 1986). Hancock further suggested that education is a vaccine right now for HIV. It is vital for HIV schools to provide prevention programmes aimed at imparting comprehensive sex education, which educates on the importance of condom use as well as promoting the delayed initiation of sex. In this regard, various models have been proposed to help change people's beliefs, perceptions and attitude towards HIV.

## **2.5 Conceptual frameworks for explaining HIV-related behaviour**

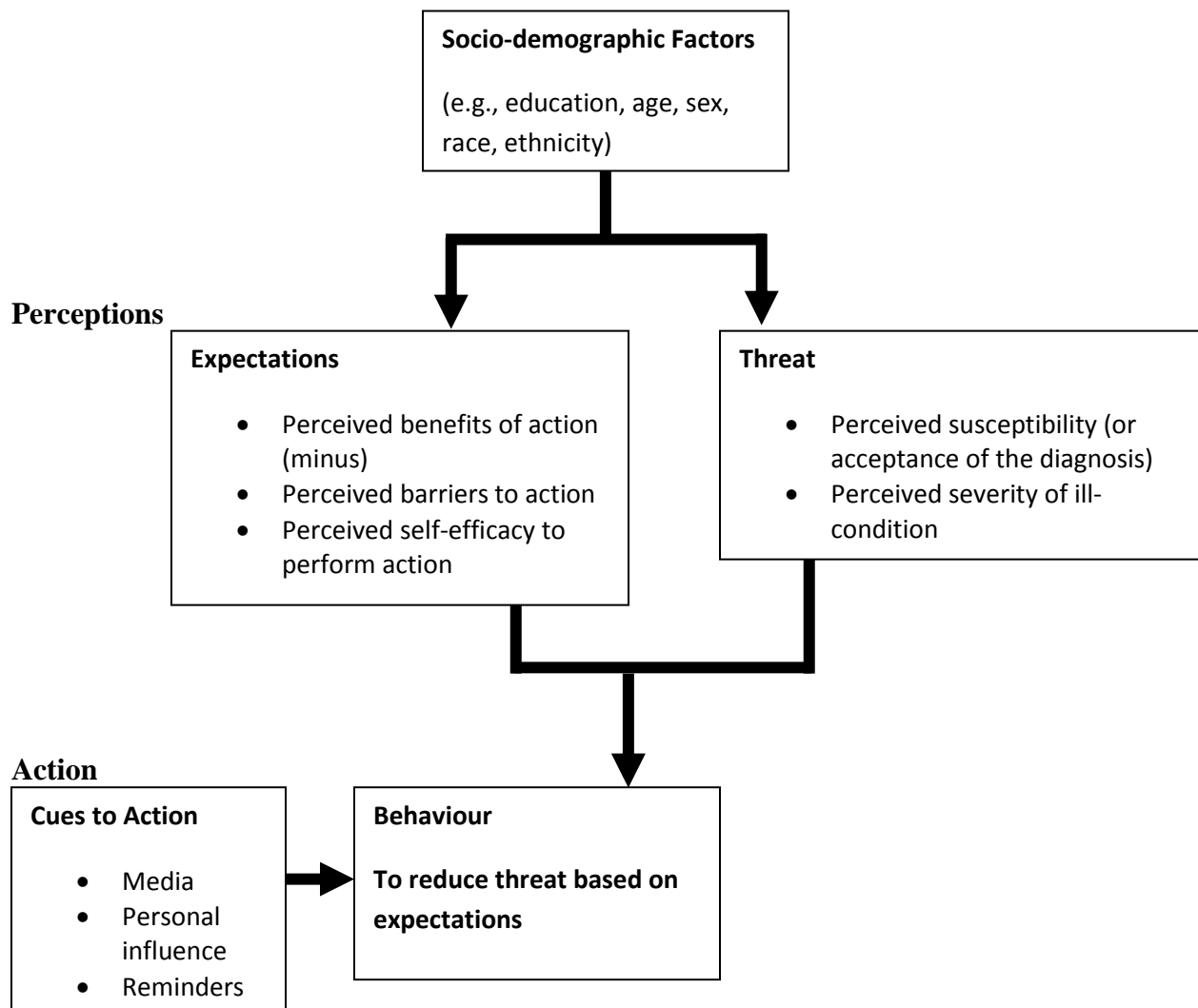
Despite the increased emphasis on the ABC approach to HIV/AIDS prevention, the ideal response, individuals continue to engage in high risk behaviours. This can be explained through the AIDS Risk Reduction Model (ARRM) postulated by Catania & Coates, 1990). The general framework of ARRM integrates elements of the health belief model, efficacy theory, emotional influences and interpersonal processes. The ARRM is based on the assumption that to avoid HIV infection, people exhibiting high risk activities must typically perceive that their sexual practices place them at risk for HIV infection (Catania & Coates, 1990). Individuals might fail to label a behaviour as high risk due to peer pressure or comparison with similar others. Festinger (1950) hypothesized that people evaluate their opinions and abilities by comparing them with the opinions and abilities of others. The 'similar others' normally incorporate friends and peers. The individual must be able to label behaviour as high risk, make a commitment to change the risky behaviour and subsequently act to avoid the risky behaviour as depicted below:



Source: Catania, Kegeles, & Coates (1990).

Another theory that can be used to explain HIV-related behaviour is the Health Belief Model. According to this theory, perceived threat, perceived susceptibility, benefits, barriers and cues to action all play a role to determine health or health-related behaviour. In a literature review of all the Health Belief Model studies published from 1974 – 1984, across study designs and populations, perceived barriers were found to be the most influential variable in predicting and explaining health-related behaviours (Janz & Becker, 1984). Perceived benefits, perceived susceptibility and perceived severity were the least significant variables. The Health-Belief model can be summarised as follows:

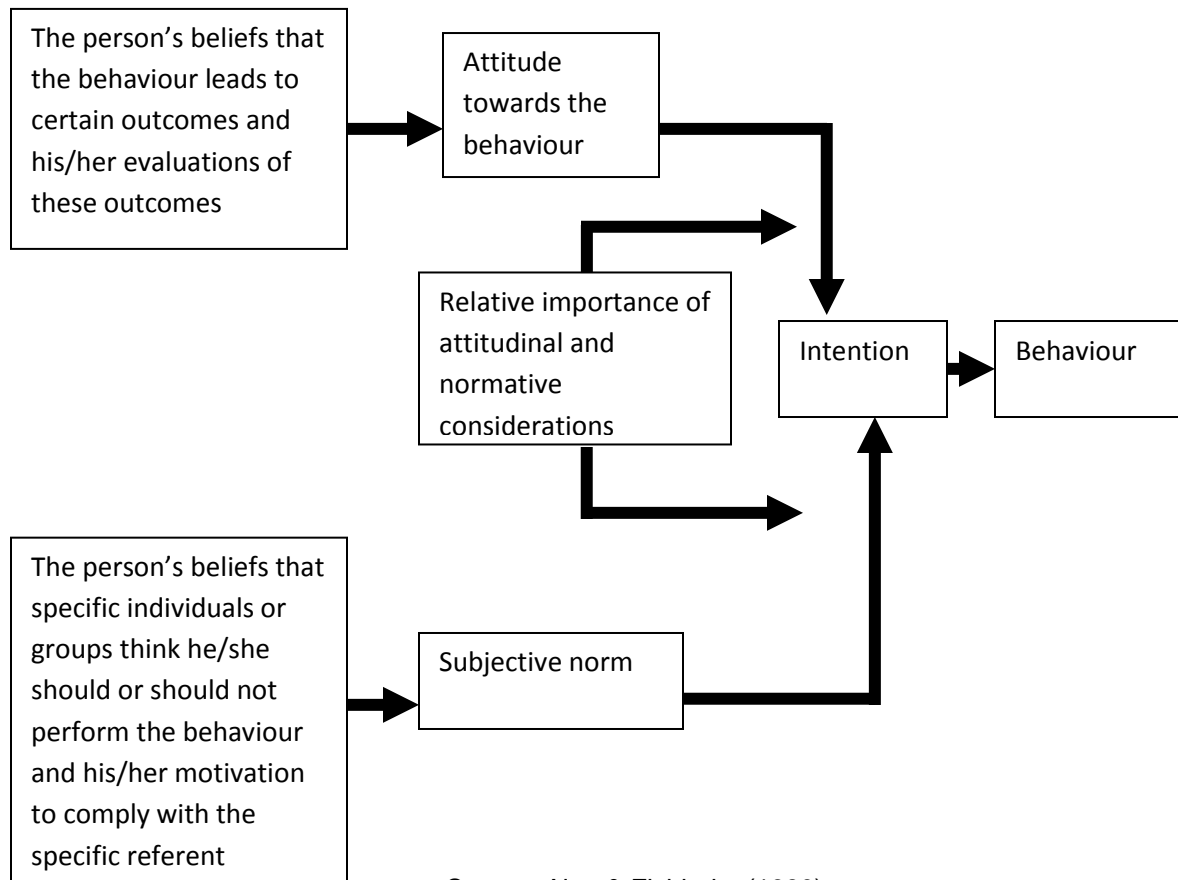




Source: Rosenstock I., Strecher, V., and Becker, M. (1994). The Health Belief Model and HIV risk behaviour change. In R.J. DiClemente and J.L. Peterson (Eds.), Preventing AIDS: Theories and methods of behavioural interventions (pp. 5-24). New York: Plenum Press.

Another theory that can help to explain HIV-related behaviour is the Theory of Reasoned Action (TRA). This theory is underpinned in the assumption that human beings have the ability to control certain behaviours (Fishbein, Middlestadt, and Hitchcock, 1994). This theory postulates that the behavioural and normative beliefs of an individual are related to the individual's actual beliefs. Consequently, the decision to display certain HIV preventive behaviours such as continuous and correct condom use during sexual encounters will affect their beliefs about condoms. One's cognition,

attitude and also determine the intention of the individual and thus, their behaviour. The TRA was supported in a study conducted by Van Landingham, Suprasert, Grandjean and Sittitrai, (1995), which confirmed that male perceptions of their peer norms was a strong predictor of condom use. Another study that found support for this theory by Middlestadt and Fishbein (1990) among females in the United States, revealed that respondents' attitudinal beliefs greatly influenced their intent of sexually active females to use condoms (). The Theory of Reason Action is summarised below:



Source: Ajen & Fishbein, (1980)

## 2.6 Conclusion:

Evidence presented in this chapter highlighted that adolescents are one of the population groups in South Africa and beyond that are not experiencing a decrease in unwanted pregnancies, new HIV infections or HIV related mortality. Therefore, because the largest component of this population are in schools, school programme meant to

address these issues are pivotal. These programmes, however, often face many difficulties that hamper successful implementation. It is therefore not surprising that many young people – also in South Africa – are still ignorant about HIV-related matters, despite such programmes and activities being in place. Such programmes and activities, therefore, need to be investigated.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

The literature available on the knowledge, attitude and behavioural practices of the youths with respect to HIV/AIDS has been reviewed and discussed in the previous chapter. This chapter outlines the methodology employed in answering the research question under investigation.

#### **3.2 Research design**

A research design is a strategy for gathering evidence about the knowledge desired (De Vos, Strydom, Fouche & Delport, 2005). According to Babbie and Mouton (2004), a research design is a blueprint of how the researcher proposes to conduct the research. This study employed a quantitative research approach using questionnaires. A quantitative study requires the collection of numerical data to answer a given research question as cited by (Christensen, Johnson & Turner, 2011). The principal advantage of a quantitative research design using questionnaires is that, it is easy for learners to complete and give responses from the given alternatives since the responses are close-ended. The main advantage of the self-administered type of questionnaires is that they are easily distributed to a large number of participants.

#### **3.3 Research participants**

The study was conducted using 100 learners' grades 8-12 in the 15–18 age groups which were divided in terms of 20 learners in grades (10 boys and 10 girls) from Gardens Commercial High School in Cape Town, South Africa. Sampling was an important issue in selecting the participants. Sampling refers to taking a subset or

segment of the population and using it as representative of that population (Bryman and Bell, 2003). The aim of sampling is to obtain a set of individuals representative of the target population in the research study (Gravetter and Forzano, 2003). Then the sample population will be the test population operationalised as the target population. To obtain the sample for this study, the investigator used the convenient sampling method. The reason for this method of choice is related to the complex nature of applying a random sampling method and the practical challenges that providing the questionnaires without contamination will share. For these reasons, the convenient sampling method was selected by the participants from the institution during normal school hours.

### **3.4 Data collection procedure**

The head of the school introduced the study investigator to the students. After securing the school hall as a venue for the study, the head of the school asked the students who are willing to take part in the study to wait behind for a few minutes after the break period began. By grade, they were called to the school hall to come and take part in answering the questionnaire. When they got to the hall, they were first asked to sign the consent form to take part of the study. One of the teachers assisted us with the distribution of the questionnaires to the learners. The participants received a questionnaire which included a covering letter which spelt out the ethical considerations of the study, including the participant's rights and the contact information of the researcher as well as the procedure for reporting any irregularities. The covering letter gave the reason for the study and instructions on completing the questionnaires. The questionnaire also had a biographical section, and sections on knowledge, beliefs and intentions.

A researcher designed questionnaire was developed for this study for learners and educators to complete. The first section (Section A) consisted of demographic information; looking at the race, sex, age and the grade of the learner. The next three sections (Section B, C and D) comprised of items to measure HIV-related knowledge and knowledge sources, beliefs on condom use and condom availability in school,

intentions toward HIV-related activities and perceived effectiveness of the school's HIV programme. A five point scale of 'Strongly Agree', 'Agree', 'Unsure', 'Disagree' and 'Strongly Disagree' was used to extract this information. These were explored from items 21 to item 32.

### **3.5 Ethical considerations**

Ethical principles are meant to protect the participants from any form of harm and psychological trauma. Therefore, the researcher has the moral obligation to respect the participants and their rights. This meant obtaining an informed consent from the participants and ensuring their safety at all levels of the study. This study involved the collection of information with the use of a questionnaire from learners. In this regard, ethical clearance permission to conduct the research at Gardens Commercial High School was obtained from the Stellenbosch University research ethics committee and the Western Cape Department of Education. The ethical clearance letters were delivered to the head of school who also gave further permission to conduct the study at the school. The Informed consent and other participant rights formed part of the first section of the questionnaire that was given to participants before questionnaire completion.

As the learners were under age, the parental consent forms for the children to participate in the research were addressed to the parents for permission request. The purpose of the research was clearly explained, and the participants assured that the data/information obtained from them will be maintained under strict confidentiality and privacy. The anonymity of the participants was also assured as participants were identified by a code number. This means no names were written on the questionnaires. The participants had the right to withdraw any time without penalty. The information obtained by means of questionnaires will be stored for five years, after which it will be destroyed. In this study the following ethical considerations were observed.

The investigator ensured that the rights and dignity of the participants were respected by ensuring that they agreed to take part in the study by signing the consent forms without being coerced, promised anything or threatened. The investigator also adopted a non-judgmental and tolerant attitude towards the research participants. This also meant refraining from imposing one's personal values of the participants.

Before the students were allowed to answer the questionnaire, the investigator took out time to explain the purpose of the study to the learners. He also allowed enough time for the participants to ask any questions related to the study. After this, the investigator asked the learners to sign the consent forms if they were still willing to participate in the study.

To ascertain that the concepts of confidentiality and anonymity are respected in this study, the investigator first ensured that the names of the participants are not required on the questionnaire or anywhere else. By doing this, the identities of the participants were protected. Any information obtained from the participants in relation to the study was kept secret by the investigator. This was achieved by ensuring that the questionnaires were locked up in a cabinet with only the investigator having access to the key. The data analyst who worked on the raw data was also made to sign a non-disclosure document to ensure the confidentiality of the information obtained from the participants.

### **3.6 Data analysis**

Data analysis was performed using the Statistical Package for Social Sciences (SPSS) Version 21. The measures used in the study were subjected to an initial reliability analysis. The data analysis process was in the form of descriptive analysis. Tables, bar charts and pie charts were used to represent the findings and they were discussed based on the display of the finding

## CHAPTER FOUR

### RESULTS

#### 4.1 Introduction

The purpose of this chapter is to report the results of the statistical analyses performed. The data from the responses of learners obtained by means of questionnaires were analysed and the results are presented using tables and pie charts. It was also decided to perform some correlational tests on the learners' knowledge, attitude and practices as well as established whether significant differences exist along gender lines.

#### 4.2 Demographic profiles of the sample

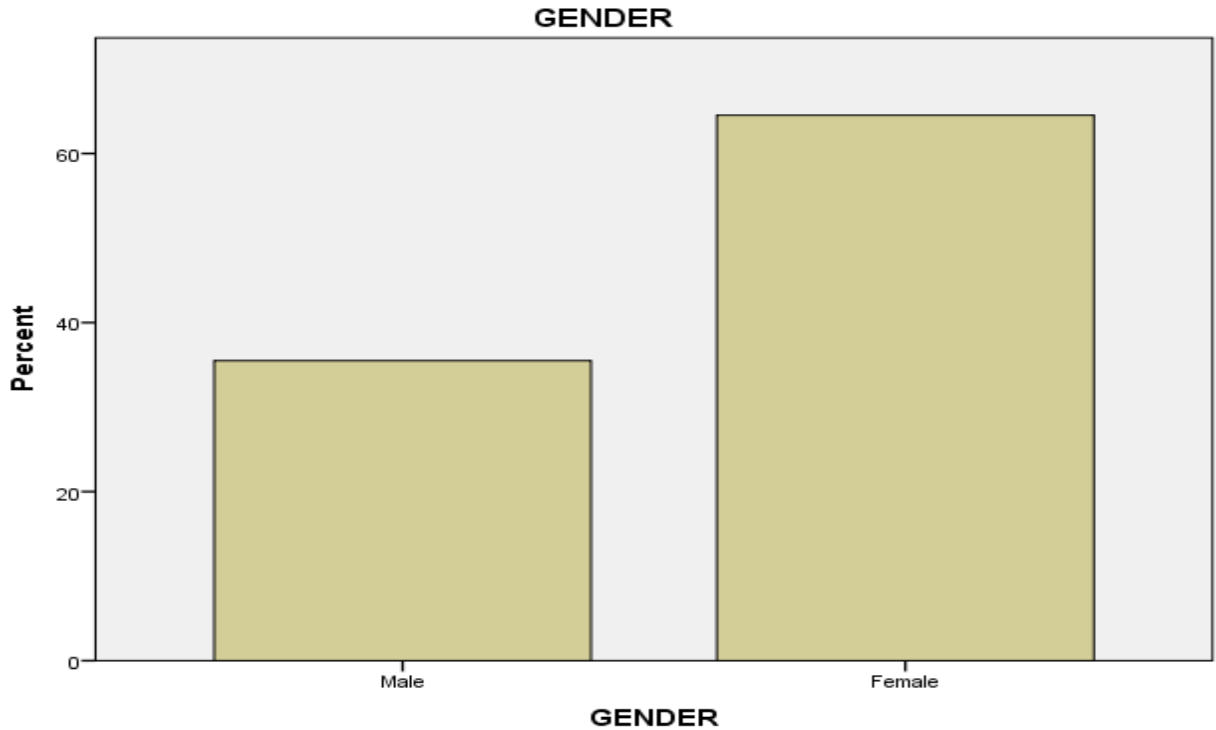
##### 4.2.1 Gender

A total of 100 questionnaires were distributed to the learners and 93 questionnaires were completed indicating a 93% response rate. 35.5% of the participants were boys while girls constituted 64.5% were boys. This information is represented in Table 4.2.1 and Figure 4.2.1 correspondingly.

**Table 4.2.1: Gender**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Male	33	35.5	35.5	35.5
Female	60	64.5	64.5	100.0
Total	93	100.0	100.0	



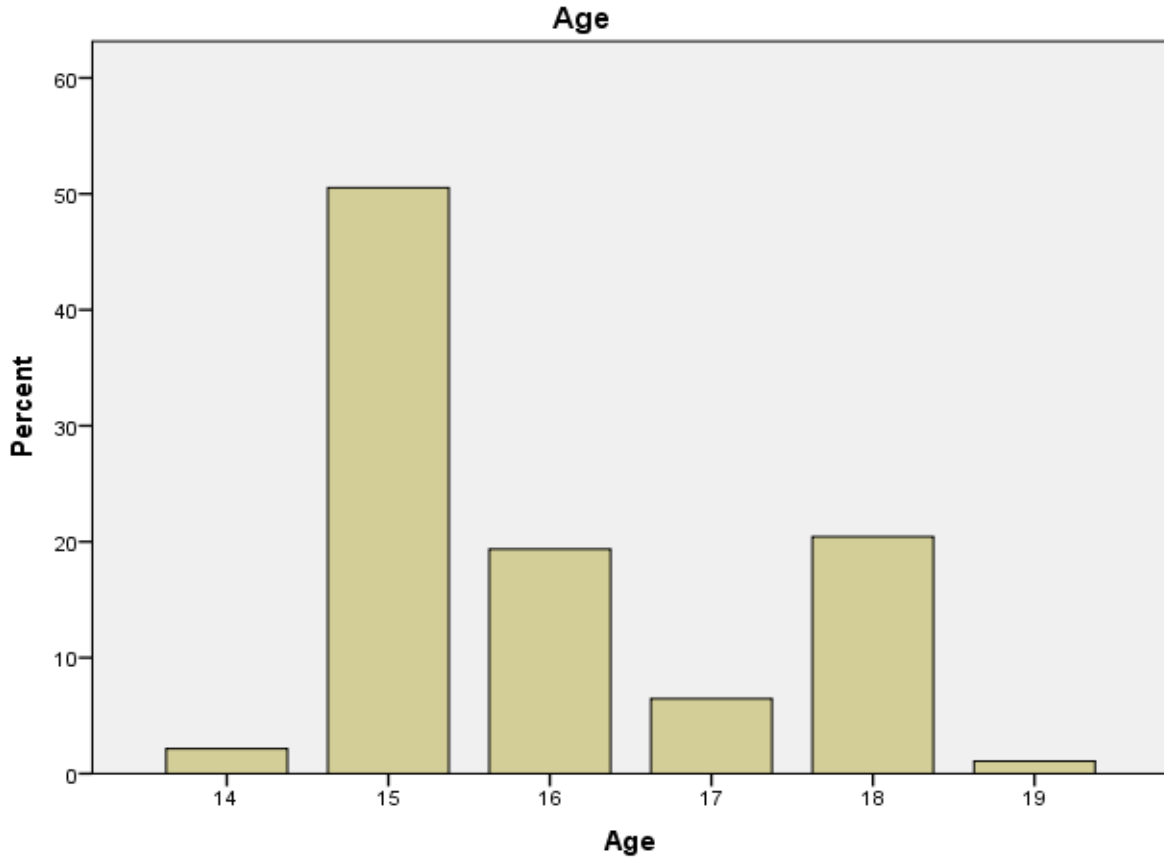


**Figure 4.2.1: Gender distribution of participants**

#### 4.2.2 Age

With respect to age distribution, 50.5% of the participants were aged 15, A total of 2.2% were aged 14; 19.4% were 16 years old; 6.5% were 17 years old; 20.4% were aged 18 and 1.1% were aged 19. This statistic is represented in Table 4.2.2 and the Figure 4.2.2.

Age				
	Frequency	Percent	Valid Percent	Cumulative Percent
14	2	2.2	2.2	2.2
15	47	50.5	50.5	52.7
16	18	19.4	19.4	72.0
Valid 17	6	6.5	6.5	78.5
18	19	20.4	20.4	98.9
19	1	1.1	1.1	100.0
Total	93	100.0	100.0	



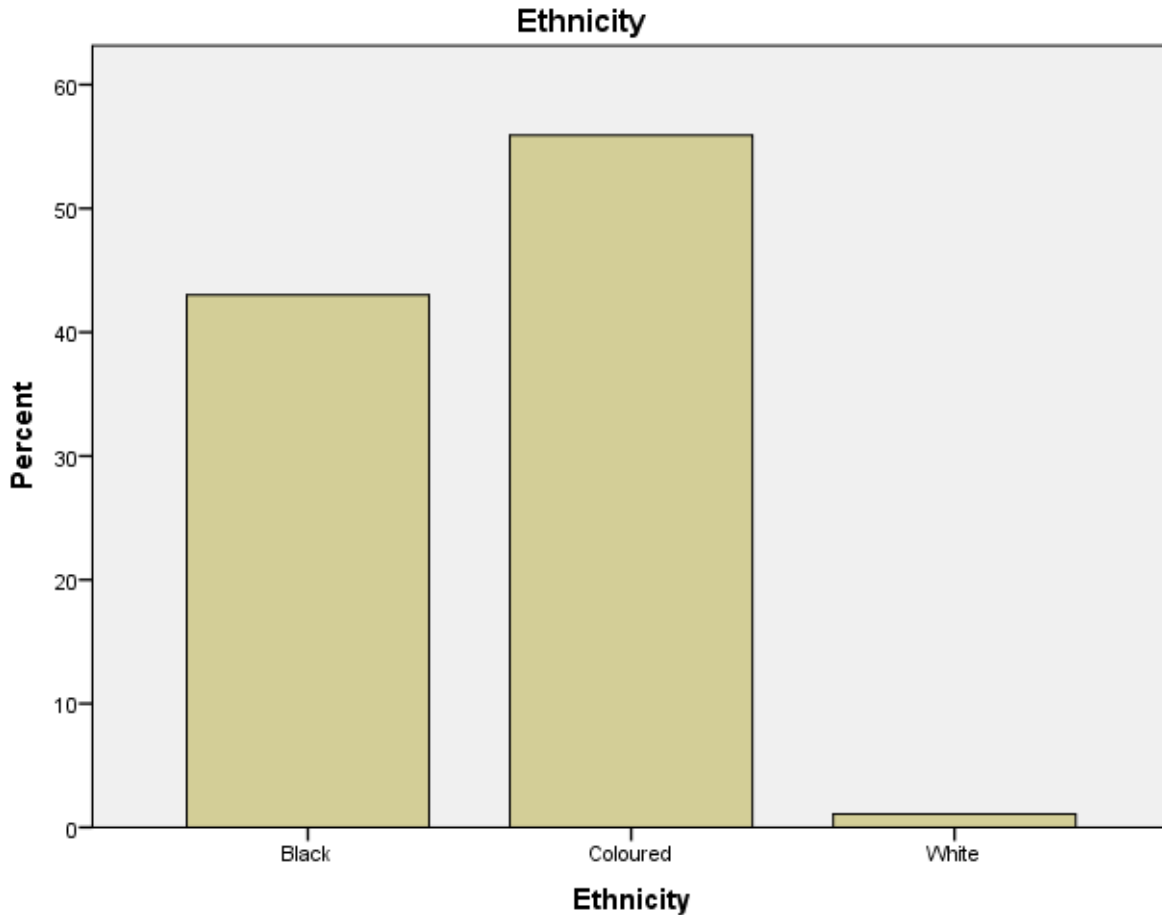
**Figure 4.2.2: Age distribution of research participants**

### 4.2.3 Ethnic Distribution

In terms of ethnicity, 71% were black; 55.9% were coloured and 1.1% white. With regards to religion, 71% were Christians; 26.9% Islam; 1.1% were non-religious and 1.1% were from other religions. These are represented in Table 4.2.3 and Figure 4.2.3 below.

**Table 4.2.3: Ethnicity of the Research participants**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Black	40	43.0	43.0	43.0
Valid Coloured	52	55.9	55.9	98.9
Valid White	1	1.1	1.1	100.0
Total	93	100.0	100.0	



**Figure 4.2.3: Ethnic Distribution of Research Participant**

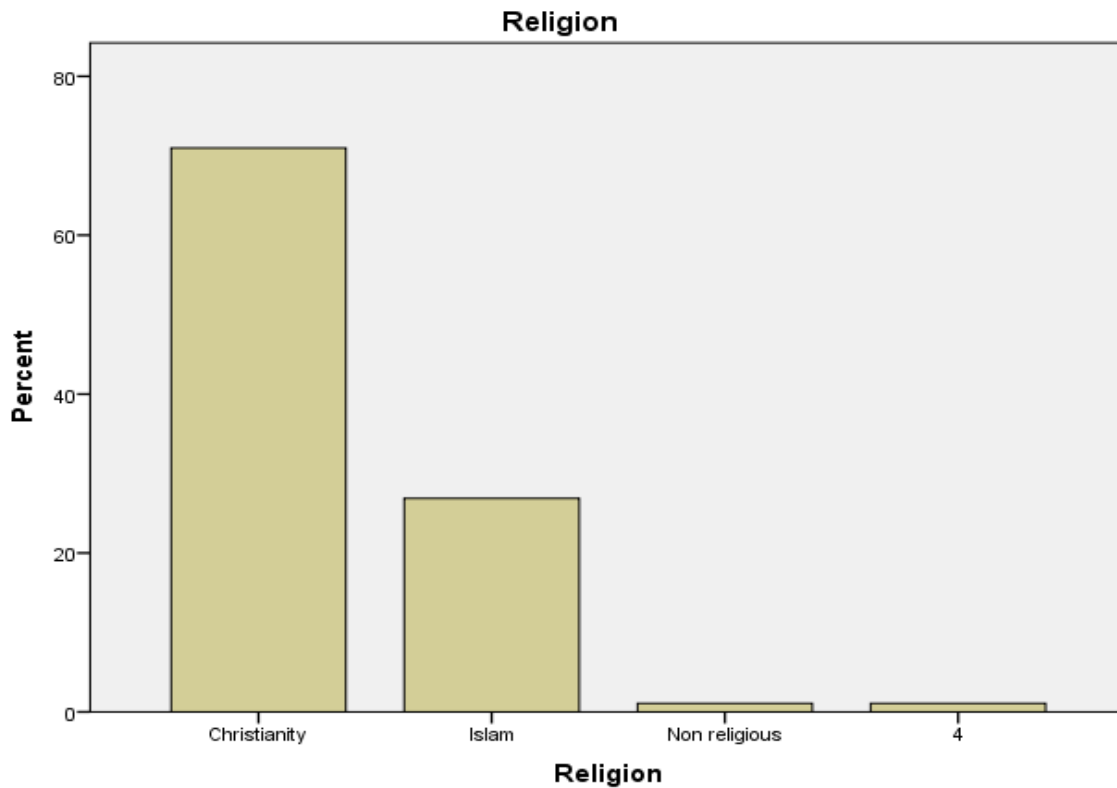
#### **4.2.4 Religious Affiliation**

In terms of the religious affiliations of the research participants Christianity was found to be the most prominent religious affiliation among the research participants. They formed 70% of the total participants. This is followed by the Islamic region represented by 26.9% of the study participants. A total 1.1% of the participants indicated that they had no religious affiliations while another 1.1% of the participants had other religious affiliations such as Hinduism, Buddhism, etc. The religious affiliations of the research participants are represented in Table 4.2.4 and Figure 4.2.4 represented below.

**Table 4.2.4 Religious Affiliations of the research participants**

	Frequency	Percent	Valid Percent	Cumulative Percent
Christianity	66	71.0	71.0	71.0
Islam	25	26.9	26.9	97.8
Valid Non-religious	1	1.1	1.1	98.9
Other religions	1	1.1	1.1	100.0
Total	93	100.0	100.0	

The diagrammatic representation of the religious affiliation of the participation is shown below.



**Figure 4.2.4: Religious Affiliations of the research participants**

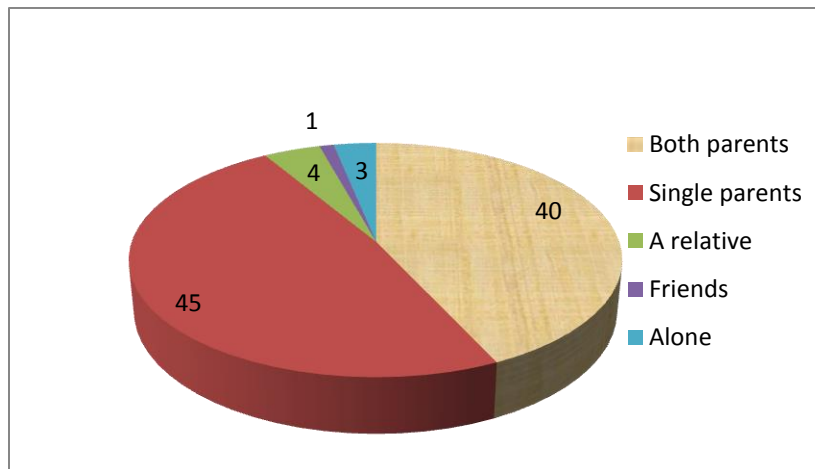
### 4.2.5 Who participants live with

Because the study deals with minors, one of the demographics that the investigator thought would be relevant is to know the persons with whom the participants live. Almost half (48.4%) of the participants revealed that they live with single parents. This was followed by (43%) of the participants revealing that they live with both parents. Another 4.3% stay with relatives, while 3.2% stay alone and 1.1% with friends. This distribution on Table 4.2.5 and shown in Figure 4.2.5

**Figure 4.2.5 People participants live with**

	Frequency	Percent	Valid Percent	Cumulative Percent
Both parents	40	43.0	43.0	43.0
Single parent	45	48.4	48.4	91.4
Living with a relative	4	4.3	4.3	95.7
Living with friends	1	1.1	1.1	96.8
Alone renting a room	3	3.2	3.2	100.0
Total	93	100.0	100.0	

The pie chart below represents the distribution of the participants according to the people they live with.



**Figure 4.2.5: Representation of persons the participants live with**

### 4.3 Sources of HIV information

Section B of the questionnaire explored the knowledge of the school-going learners with regards to the sources from which they get information on HIV. In response to the statement “I get most of my knowledge about HIV and AIDS from my school’s programme on sex education, and HIV prevention”, the majority of the respondents agreed with this the statement (92.5%). Also, 45.2% of the participants agreed that they “get most of my knowledge about HIV and AIDS from my friends and family.” When also asked if they get most of their knowledge about HIV and AIDS from the media such as the radio, TV or the internet, 78.5% of respondents agreed. Table 4.3 displays the full responses of the respondents.

**Table 4.3 Source of HIV information**

Statement	Agree	Unsure	Disagree
1. I get most of my knowledge about HIV and AIDS from my school’s programme on sex education and HIV prevention.	92.5	3.2	4.3
2. I get most of my knowledge about HIV and AIDS from my friends and family.	45.2	24.7	30.1
3. I get most of my knowledge about HIV and AIDS from the media, e.g. radio, TV or social media.	78.5	16.1	5.4

### 4.4 Knowledge about HIV-related issues

This section covered questions that explored the knowledge of the research participants on HIV/AIDS. This involved questions that tested their knowledge of the window period, when the HIV could be detected in the blood and if one could be affected by taking other substances when HIV positive. The results are displayed in Table 4.4.

**Table 4.4** Knowledge about HIV-related issues

Statements	Agree (%)	Unsure (%)	Disagree (%)
4. Once infected with HIV, I will not immediately know whether I am HIV positive.	0	65.6	33.4
5. Once infected with HIV, it can take a few weeks or even longer before I can be definitely sure I am HIV positive.	59.1	31.2	9.7
6. The <i>window period</i> is the period between the onset of HIV infection and developing full-blown AIDS.	23.7	60.2	15.1
7. The earlier I know I have HIV, the better my chances to live a longer life.	87.1	8.6	4.3
8. Once I am HIV positive, tik and alcohol cannot affect me.	4.3	9.7	86.0
9. Exercising when being HIV positive increases your chances of developing full-blown AIDS.	14.0	20.4	65.6

The first item, “once infected with HIV, I will not immediately know whether I am HIV positive,” revealed that two thirds of the participants were unsure of when their HIV status could be determined. Similarly, most respondents (60.2%) were unsure about the window period. Most respondents (59.1%) correctly identified that once infected with HIV, it can take a few weeks or even longer before one can be definitely sure they are HIV positive. The majority of the respondents (87.1%) correctly identified that the earlier one knows they have HIV, the better their chances to live longer. With regards to the interactions of recreational substances and the HIV infection, 86.0% of the participants correctly identified that they could be negatively affected by recreational substances such as Tik even when they are HIV positive. The last item in this category tested the knowledge of the participants with regards to the value of exercising whilst being HIV-positive. According to 14% of the respondents, exercising while HIV positive increases one’s chances of developing full-blown AIDS, while one fifth (20%) of the participants were unsure of the effects of physical exercises on the chances of developing full-blown AIDS. The majority of the respondents answered this question correctly (65%). The full responses to the various items are displayed in Table 4.4.

#### 4.5 Perceived effectiveness of the school sex education programme

This next section focused on the attitudes of the school-going learners between the ages of 15 to 18 towards the HIV-related activities conducted by their educational institution. A quarter of the respondents agreed with item 10, “I think my school’s programme on sex education, and HIV prevention helps to address the needs of learners”. Item 11 revealed that 79% of the respondents agreed that the programme is useful. One tenth (10%) of the respondents were unsure and the last 8.7% think that the school programme on sex education is not important. When asked if the participants think they have learned a lot from the school’s programme on sex education and HIV prevention, 87.1% agreed. The full responses to the various items are displayed in Table 4.5.

**Table 4.5 Perceived effectiveness of the school sex education programme**

Statement	Agree	Unsure	Disagree
10. I think my school’s programme on sex education, and HIV prevention helps to address the needs of learners.	78.5	14.0	7.6
11. I think my school’s programme on sex education, and HIV prevention is useful to address the needs of learners.	79.6	10.8	8.7
12. I think I have learned a lot from my school’s programme on sex education and HIV prevention.	87.1	9.7	3.3

#### 4.6 Beliefs related to condom use

A total of 68.8% of the participants agreed with the statement that it is easy for a girl to ask a boy to use a condom when they plan to have sex. The next question ascertained whether the participants thought most boys and girls who want to have sex will use a condom. Less than half of the participants (45%) agreed with this statement. The majority of respondents (88.1%) agreed with the statement “I think it is easy for boys and girls to get condoms if they want to have protected sex”. The full results are displayed in Table 4.6.



**Table 4.6 Beliefs related to condom use**

Statement	Agree	Unsure	Disagree
13. I think it is easy for a girl to ask a boy to use a condom when they plan to have sex.	68.8	15.1	16.2
14. I think most boys and girls who want to have sex will use a condom.	45.2	32.3	22.6
15. I think it is easy for boys and girls to get condoms if they want to have protected sex.	88.1	7.5	3.3

**4.7 Intentions related to condom use**

When asked if the participants will be willing to encourage their friends who want to have sex, to use condoms, most of the participants agreed (89.2%). In reply to the statement “If I plan to have sex, I will use a condom”, the majority of the participants (92.5%) agreed with the statement. The full results are displayed in Table 4.7.

**Table 4.7 Intentions related to condom use**

Statement	Agree	Unsure	Disagree
16. I will encourage my friends who want to have sex, to use condoms.	89.2	6.5	4.3
17. If I plan to have sex, I will use a condom.	92.5	4.3	3.2

**4.8 Beliefs related to condom availability in school**

Questions 18, 19 and 20 are related to the beliefs of the learners with regards to condom availability in the school. When asked if the participants think condoms in their school will help to reduce unwanted pregnancies in their school, 79.3% of the participants agreed. To the question ‘I think the condoms in my school can help to reduce HIV infection among learners’, the majority of the participants (80.6%) agreed. Finally, when asked if they think condoms can help to promote safe sexual behaviour in

their school, the biggest portion of the participants (81.7%) also agreed. These results are represented in the Table 4.8 below.

**Table 4.8 Beliefs regarding condom availability in school**

<b>Statements</b>	<b>Agree</b>	<b>Unsure</b>	<b>Disagree</b>
18. I think condoms in my school can help to reduce unwanted pregnancies.	79.3	6.5	14.0
19. I think the condoms in my school can help to reduce HIV infection among learners.	80.6	12.9	6.5
20. I think condoms in my school can help to promote safe sexual behaviour.	81.7	9.7	8.7

#### **4.9 Conclusion**

This chapter displays the various responses that were obtained from the respondents and were classified according to the demographics, the knowledge of the learners with regards to HIV and sex education, their attitudes towards condom use, the sex education programme implemented by the school and their beliefs towards condom use. The next chapter will interpret the results obtained in this chapter, with related recommendations.

## CHAPTER FIVE

### DISCUSSION OF RESEARCH RESULTS AND RECOMMENDATIONS

#### 5.1 Introduction

The conclusions, limitations, recommendations of the study and the direction for future research are included in the present chapter.

#### 5.2 Sources of HIV-related information

The first three questions in section B tested the learners' sources of information on HIV and AIDS. It was found that the school programme, on sex education, and HIV prevention played a big role as a source of information to these learners. A large portion (92.5%) of the respondents agreed that they get most of their knowledge about HIV and AIDS from their school's programme on sex education and HIV prevention. Based on this finding, it could be concluded that the sex education and HIV awareness programme play an important role in imparting knowledge on HIV, thus possibly influencing the behaviour of the learners. With a 78.5% of the respondents agreeing to obtain information on HIV from the media units such as TV, radio, etc., and only 45.2% of the participants agreeing that they get most of my knowledge about HIV and AIDS from my friends and family, it could be argued that the school programme stands out as an important source of information for the school-going children between the ages of 15-18. The media also proved to be an important source of information with regards to HIV and AIDS education. Conversely, with only 45% of the respondents agreeing to gaining valuation information on HIV/AIDS from relatives and friends, this source of information is not very popular among the school-going children as a valuable source of information.

#### 5.3 Knowledge about HIV-related issues

Six questions were presented to respondents to determine their HIV knowledge levels. The majority of respondents were unsure about when you can tell if you are HIV-

positive as well as being unsure of the definition of the window period. It can be argued that a possible knowledge gap or a lack of understanding exists pertaining to these issues. This overall finding warrants further investigation. It is also possible that the wording of this question could have been ambiguous, creating confusion in the minds of the respondents which could be seen as a limitation to the study.

Most respondents knew that once infected with HIV, it can take a few weeks or even longer before being sure about your HIV status; that exercise is beneficial to the health of an HIV-positive person; that the earlier they know about their HIV status the better their chances of living longer and that alcohol and 'tik' can still affect them despite their HIV status. These findings seem to indicate that the learners have a satisfactory grasp of these HIV-related facets.

#### **5.4 Perceived effectiveness of the school sex education programme**

Items 10, 11 and 12 explored the perceived effectiveness of the school's sex education programme. These items had very positive responses from the participants obtaining scores of over 75% in all three items. These findings seem to indicate that the sex education and HIV-related programmes of the school is highly welcomed, received and appreciated by the learners. These findings seem to vindicate the continued use of current programmes as a method for educating the learners on important public health issues facing them.

#### **5.5 Beliefs related to condom use**

The participants' responses with respect to beliefs toward condom usage as protection against HIV were encouraging. The greater portion indicated that it is easy for a girl to ask a boy to use a condom when they plan to have sex. This might be an indication that girls are gradually breaking the traditional practices in which the males used to dominate the condom negotiation process; dictating whether or not condoms are to be used in a sexual counter. Furthermore, the majority of participants indicated that it is

easy for boys and girls to get condoms if they want to have protected sex. This could imply that, even though condoms are not currently available in schools, condoms are easy accessible elsewhere, possibly at the local clinic. A cause of concern was participants' responses to the item, "I think most boys and girls who want to have sex will use a condom". The aggregate value of those who were unsure and those who do not agree exceeded the percentage of those who agreed with this statement. That is, 54.9% of the respondents seem to doubt the behaviour of their peers with regards to condom use. This finding warrants further investigation.

### **5.6 Intentions related to condom use**

The majority of participants revealed that they will encourage their friends who want to have sex, to use condoms and that if they plan to have sex, they will use a condom. These responses seem to show that the respondents generally had positive intentions towards encouraging their friends to use condoms as well as using condoms themselves.

### **5.7 Beliefs related to condom availability in school**

The next three questions focused on learners' beliefs on whether the condom availability is a good prevention strategy for HIV in schools. The majority of learners indicated that they felt using condoms can prevent unwanted pregnancies, that condoms in the school can help to reduce HIV infection among learners, and that condoms in the school will promote safe sexual behaviour. These findings are consistent with those of Reddy, Taylor and Jinabhai (2004) in their study at a secondary school in Kwa-Zulu Natal to determine baseline data on STIs including HIV/AIDS. The general consensus was that condoms play a vital role in both the prevention of pregnancy and the transmission of HIV in the school. They also found that condoms have promoted positive sexual behavioural practices among the learners in the school.

### **Limitations of the study**

The study had some limitations that the investigator describes in this section. First and foremost, a non-probability sampling method was used for the selection of the sample population. This poses a problem with regards to the representativeness of the target population in the sample population. This, therefore, impacts on the possibility of generalising the results obtained from this study to include other schools in the Western Cape and in South Africa in general.

The second limitation of the study relates to the measuring instrument that was used to elicit information from the study participants. The instrument that was used was a self-report questionnaire. This means that the findings obtained are based on the personal opinions of the participants and would distort the findings of the study if the participants do not report the actual situation. The Likert-scale the makes allowed some of the participants to be 'unsure' sometimes provides an 'escape route' for those participants who are not willing to report the actual situation based on their knowledge.

### **5.8 Suggestions for future research**

Future studies should go beyond identifying HIV-related knowledge, intentions and beliefs and look at ways of implementing these findings and develop more effective models that can help equip learners with the skills to engage in healthy sexual behaviours by for example using the behavioural change theories discussed in Chapter 2 as a theoretical base for such endeavours.

### **5.9 Recommendations based on the findings of the study**

The results of the present study indicate that the school programme, on sex education, and HIV awareness appears to have an impact on the knowledge levels of learners. The recommendation here is to encourage the schools to continue with the programme and expanding the programme to cover learners of the lower grades. In addition, there is also a need to promote the use of condoms to those who engage in sexual activities

since the learners indicated some doubts with regards to condom use among their peers. Most of the learners indicated that they get most of the information on HIV from the school's programme and the media; hence the Department of Education should continue to communicate most of their HIV campaigns using these channels.

With regards to the fact that the learners showed positive attitudes towards condom use, it is recommended that condom distribution should be considered as part of the HIV educational programme. These condoms could be placed in strategic areas like the toilets and other areas where they can be seen and also accessed by those who would like to use them.

### **5.10 Conclusion**

The primary objective of this study was to assess the perceptions regarding HIV/AIDS and HIV-related activities of school-going learners in the 15-18 year age range. The findings show that the respondents had a good knowledge of HIV, which could possibly be attributed to the effectiveness of the school programme on sex education and HIV awareness. However, there were also some knowledge aspects that many respondents were unsure about e.g. the definition of the window period which should possibly be addressed. Although the majority of the participants revealed that they would encourage their friends to use condoms and would also use condoms should they want to engage in a sexual encounter, the participants did not believe that many of their peers make use of condoms when engaging in sexual activities. Further investigation of this finding is warranted and should possibly be addressed in the current HIV-related curriculum or as part of an additional age tailored programme.

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## APPENDIX A



UNIVERSITEIT•STELLENBOSCH•UNIVERSITY  
jou kennisvennoot • your knowledge partner

### STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

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#### **The knowledge, perceptions and beliefs concerning HIV/AIDS of school-going learners (15-18 years old) at a selected school in the Western Cape Province of South Africa.**

You are asked to participate in a research study conducted by **Kapena Mukenge** from the Africa Centre for HIV and AIDS Management at Stellenbosch University. The results of the research study will contribute toward the researcher's Master's level thesis as part of a requirement for the completion of the MPhil in HIV/AIDS Management programme. You have been selected as a possible participant in this study because as **learner**, you are aware of the many challenges that our youth face regarding sex education and HIV prevention and your contributions are valuable in order to adequately equip our youths with the necessary skills and knowledge to address the challenges posed by HIV.

#### **1. PURPOSE OF THE STUDY**

The purpose of the study is to assess the knowledge, perceptions and beliefs concerning HIV-related issues of school-going learners. This project aims to find out what the current level of knowledge, perceptions and beliefs of learners like you is on HIV and AIDS and what you think about the HIV programmes at your school. This project would also like to find out from you what you think of condoms being provided to schools and the value of condoms as means of protection against HIV-infection.

## **2. PROCEDURES**

If you participate in this study, I would like you to complete a questionnaire containing 20 questions which should not take you more than 20 minutes to complete. You will complete the questionnaire at school, with the consent of the principal and under the supervision of the researcher. The questionnaires will be collected after completion by the researcher at your school. Please note there are no right and wrong answers. Please be as honest as possible.

## **3. POTENTIAL RISKS AND DISCOMFORTS**

Questionnaires will be completed anonymously by learners under supervision by the researcher. No questionnaire will run the risk of being linked to any learner. Although HIV is a sensitive subject, there are no potential risks or discomforts envisaged in this study, as the questions posed in the questionnaire are not of a personal nature. In other words, we are not asking you to tell us anything personal about yourself. The researcher will be present during the answering of the questionnaires to clear up any misunderstandings that might arise. Furthermore, it is important to note that the information obtained from these questionnaires is confidential and only the researcher will have access to it.

## **4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

The findings of the proposed study will give an indication about the level of knowledge of learners on HIV-matters, their perceptions of HIV-related activities presented at the school as well as their beliefs around condom usage as means of protection against HIV-infection. The study should also aim to highlight gaps in HIV related knowledge and challenges as experienced by both learners and educators. The Department of Health and Social Development may benefit because HIV prevention and behaviour change programmes can be adapted and tailored to the needs of young people. A great amount of insight will also be gained on the perceptions of young people with regard to the provision of services i.e. condoms to schools. The school will thus be in a favourable position to adapt their programmes to suit the needs of the learners.

## **5. PAYMENT FOR PARTICIPATION**

No payment will be made to participants.

## **6. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. The meaning of this and how confidentiality will be maintained follows.

The purpose of the study is not only to investigate a potential avenue for HIV prevention, but is to complete an M Phil degree in HIV and AIDS Management, a requirement of which is a thesis for publication. Any information that is obtained in connection with this study will be combined with information received from other people interviewed and collated, analysed and interpreted to be reported on as a research thesis to the University of Stellenbosch where it will be available to other people on the internet.

Information obtained in this study will therefore not be able to be linked to you personally and you will not be able to be identified. You will be anonymous to anyone reading the research, although not to the researcher.

This confidentiality will be maintained by means of the safe storage in a lockable space of data relating to the study. Only the researcher and assistant/observer will have access to the data, and the study supervisor if requested. The computer used in the research is a personal computer and the data will be protected. At all times the need for privacy, confidentiality and anonymity for you will be respected.

## **7. PARTICIPATION AND WITHDRAWAL**

You can choose whether or not to take part in this study. If you consent to this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The researcher may withdraw you from this research if circumstances arise which warrant doing so.

## **8. IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact me, **Kapena Mukenge** (cell: 0835339201) or e-mail: [17342074@sun.ac.za](mailto:17342074@sun.ac.za) or my supervisor, Mr Burt Davis at 021 808 3707 or [burt@sun.ac.za](mailto:burt@sun.ac.za).

## 9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation in this study without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

<b>SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE</b>
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The information above was described to me as a participant in the research by the researcher **Kapena Mukenge** in English and I am in command of this language. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

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**Name of Subject/Participant**

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**Name of Legal Representative (if applicable)**

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**Signature of Subject/Participant or Legal Representative**

**Date**



**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to \_\_\_\_\_  
\_\_\_\_\_ (participant). The participant was encouraged and given  
ample time to ask me any questions. This conversation was conducted in English and no  
translator was used.

\_\_\_\_\_

Signature of Investigator

**Code no...../2014**

**SECTION A: BIOGRAPHICAL INFORMATION**

**1. Please indicate your gender**

2. Male	
3. Female	

**2. Please indicate your age \_\_\_\_\_**

**3. Please tick your ethnic group**

1. Black	
2. Coloured	
3. White	
4. Indian	
5. Other (specify)	

**4. Please indicate your religion**

Christianity	
Islam	
Non-religious	
Other (specify)	

**Q1. Who do you live with?**

1. Both parents	
2. Single parent	
3. Living with a relatives	
4. Living with the friends	
5. Alone renting a room	

**SECTION B1: KNOWLEDGE SOURCE ABOUT HIV**

Statement	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
1. I get most of my knowledge about HIV and AIDS from my school's programme on sex education and HIV prevention.					
2. I get most of my knowledge about HIV and AIDS from my friends and family.					
3. I get most of my knowledge about HIV and AIDS from the media e.g. radio, TV or social media.					

**SECTION B2: KNOWLEDGE OF HIV**

Statement	Agree	Unsure	Disagree
4. Once infected with HIV, I will not immediately know whether I am HIV positive.	<b>0</b>	<b>65.6</b>	<b>33.4</b>
5. Once infected with HIV, it can take a few weeks or even longer before I can be definitely sure I am HIV positive.	<b>59.1</b>	<b>31.2</b>	<b>9.7</b>
6. The <i>window period</i> is the period between the onset of <i>HIV</i> infection and developing full-blown AIDS.			
7. The earlier I know I have HIV, the better my chances to live a longer life.			

8. Once I am HIV positive, tik and alcohol cannot affect me.			
9. Exercising when being HIV positive increases your chances of developing full-blown AIDS.			

**SECTION C: PERCEIVED EFFECTIVENESS OF HIV SCHOOL PROGRAMME AND BELIEFS ABOUT CONDOM AVAILABILITY IN SCHOOL**

Statement	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
10. I think my school's programme on sex education and HIV prevention helps to address the needs of learners.					
11. I think my school's programme on sex education and HIV prevention is useful to address the needs of learners.					
12. I think I have learned a lot from my school's programme on sex education and HIV prevention.					
13. I think condoms in my school can help to reduce unwanted pregnancies.					
14. I think the condoms in my school can help to reduce HIV infection among learners.					
15. I think condoms in my school can help to promote safe sexual behaviour.					

**SECTION D: BELIEFS AND INTENTIONS RELATED TO CONDOM USE**

Statement	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
16. I think it is easy for a girl to ask a boy to use a condom when they plan to have sex.					
17. I think most boys and girls who want to have sex will use a condom.					
18. I think it is easy for boys and girls to get condoms if they want to have protected sex.					
19. I will encourage my friends who want to have sex, to use condoms.					
20. If I plan to have sex, I will use a condom.					

**Thank you for taking part in this study**