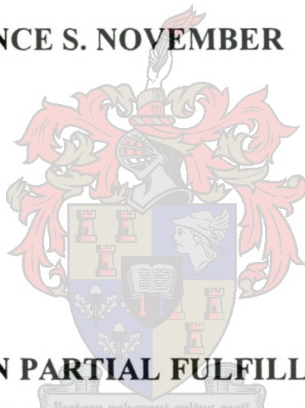


**THE CONTRIBUTION OF ADULT LEARNING CENTRES IN EDUCATING
COMMUNITIES ON HIV/AIDS AND RELATED ISSUES.**

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**THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE M.PHIL in EDUCATION AT
THE UNIVERSITY OF STELLENBOSCH**

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature.

Date.

ABSTRACT

Most people infected with the human immunodeficiency virus (HIV) do not know they carry the virus. HIV is the virus that causes acquired immunodeficiency syndrome (more commonly known as AIDS). Many people know nothing or too little about HIV to protect themselves against it.

Mainstream educational and some private sector services currently expose their learners or workers to HIV/AIDS education and training. Despite these services there are three groups of adults who would not benefit from the available HIV/AIDS education services. They are the unemployed (including dropouts from the mainstream schooling system), those working in the informal sector (e.g. hawkers, taxi drivers, chars, etc.) and those working for companies that do not see HIV/AIDS education as a priority.

The aim of this study is to see if a HIV/AIDS training programme targeting adult learners leads to a greater awareness about HIV/AIDS and related issues.

This study utilised an experimental design. The study was based on the *two group pre-test, post-test, post-post-test* design. The data-collection instruments used in this study were questionnaires, interviews and literature reviews.

During the pretest there were no statistically significant differences between the experimental group and the control group. However, at the posttest, there was a significant difference between the experimental group and the control group, e.g. on issues like the difference between HIV and AIDS, the window period, that mosquitoes cannot pass on the HIV to humans, and that there is no cure for HIV/AIDS. At the post-post test stage the experimental group still knew more about HIV/AIDS and related issues compared to the control group. The participants, who were part of the experimental group, were also able to share HIV/AIDS information with family members, friends and

colleagues, and they realized the importance of HIV/AIDS education for all, which would reduce or eradicate stigmatization and discrimination against infected people.

It is recommended that the HIV/AIDS training should not only be knowledge-based, but rather be coupled with skills training and development. The latter combination will allow learners to be even more effective and better equipped to share important and relevant HIV/AIDS information with significant others. Parents who will be able to talk to their children about HIV/AIDS issues will create an environment of trust between them and at the same time their children can also verify information they had gotten from the 'street'. In order to reach more people regarding HIV/AIDS education it is thus recommended that ALCs (Adult Learning Centres) and the private sector should start negotiations about how they can complement each other in terms of educating not only their workers, but also their workers' family members.

Hoping for a vaccine or cure for HIV/AIDS at this stage is an unsound strategy. We might not have a medical vaccine, but our only vaccine against HIV is education. The relevant South African government departments (Education, Health and Labour) together with the private sector and NGOs (Non-Governmental Organisations) need to start negotiations in order to share a common goal and vision regarding HIV/AIDS education and training. Further research regarding HIV/AIDS and related issues remains of the utmost importance.

OPSOMMING

Die meeste mense wat besmet is met die menslike immuuniteitsgebreksvirus (MIV) weet nie dat hulle draers is van die virus nie. MIV is die virus wat die verworwe immuuniteitsgebreksindroom (meer algemeen bekend as VIGS) veroorsaak. Baie mense weet niks of te min van VIGS om hulle daarteen te beskerm.

Hoofstroomonderwys en sommige privaatsektor dienste is huidiglik besig om hul leerders of werknemers bloot te stel aan MIV/VIGS onderwys en opleiding. Ten spyte van hierdie dienste is daar drie groepe volwassenes wat nie sal baat vind by die beskikbare MIV/VIGS onderwysdienste nie. Die drie groepe volwassenes is die werkloses (insluitende diegene wat nie hulle skoolloopbane voltooi nie), diegene in die informele sektor (bv. smouse, huurmotorbestuurders, huishulpe, ens.) en diegene wat werk vir sake-ondernemings wat nie MIV/VIGS as 'n prioriteit sien nie.

Die doel van hierdie studie is om te sien of 'n MIV/VIGS opleidingsprogram sal lei tot 'n groter bewustheid aangaande MIV/VIGS en verwante sake.

Die studie maak gebruik van 'n eksperimentele ontwerp. Die studie was gebaseer op die twee groep voortoets, natoets, post-natoets ontwerp. Die data-insamelingsinstrumente wat in hierdie studie gebruik was, was vraelyste, onderhouds en literatuurstudies.

Gedurende die voortoets was daar geen statisties-beduidende verskil tussen die eksperimentele groep en die kontrole groep nie. Daar was egter 'n statisties-beduidende verskil te bespeur tussen die eksperimentele groep en die kontrole groep by die natoets stadium, byvoorbeeld oor sake aangaande die verskil tussen MIV en VIGS, die venster periode, dat muskiete nie die MIV kan oordra aan mense nie en dat daar geen

geneesmiddel is vir MIV/VIGS nie. By die post-natoets stadium het die eksperimentele groep nog steeds meer geweet van MIV/VIGS en verwante sake as die kontrole groep. Die deelnemers wat deel was van die eksperimentele groep kon ook MIV/VIGS informasie met familie, vriende en kollega's deel; en het hulle ook die belangrikheid van MIV/VIGS opleiding vir almal besef, wat dit die stigma en diskriminasie teen mense wat besmet is met die virus sal verminder of uitskakel.

Daar word aanbeveel dat die MIV/VIGS opleiding nie net kennis-gebaseer moet wees nie, maar ook gekoppel word aan vaardigheidsopleiding en -ontwikkeling. Laasgenoemde kombinasie sal leerders selfs effektiewer en beter toerus om belangrike en relevante MIV/VIGS inligting met ander te kan deel. Ouers wat in staat sal wees om met hul kinders te praat oor MIV/VIGS verwante sake sal 'n omgewing van vertroue skep tussen hulle en hul kinders en terselfdertyd sal hul kinders ook inligting kan verifieer wat hulle van die 'straat' kry. Om meer mense te kan bereik aangaande MIV/VIGS opleiding, word dus aanbeveel dat volwasse-onderwysentra en die privaatsektor onderhandelinge aanknoop oor hoe hulle mekaar kan aanvul, nie net in terme van die opvoeding van hul werkers nie, maar ook hul werkers se gesinslede.

Om te hoop op 'n entstof of geneesmiddel vir MIV/VIGS op hierdie stadium is nie 'n goeie benadering om die probleem aan te spreek nie. Ons mag geen mediese entstof hê nie, maar ons enigste entstof teen VIGS is opvoeding. Die relevante Suid Afrikaanse regeringsdepartemente (Onderwys, Gesondheid en Arbeid) tesame met die privaatsektor en NROs (Nie-Regering Organisasies) moet daadwerklike onderhandelinge begin, sodat hulle 'n gemeenskaplike doel en visie deel rakende MIV/VIGS onderwys en opleiding. Verdere navorsing rakende MIV/VIGS en verwante sake bly van kardinale belang.

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TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION AND OVERVIEW 1-23

1.1 INTRODUCTION	1
1.2 MOTIVATION FOR THE STUDY	3
1.3 STATEMENT OF THE PROBLEM	7
1.4 AIM OF THIS STUDY	8
1.5 THESIS STATEMENT	9
1.6 RESEARCH GOAL	9
1.7 DEFINITION OF TERMS	10
1.8 THE CONTEXT OF THE STUDY	11
1.9 RELATED LITERATURE TO THE RESEARCH TOPIC	16
1.10 RESEARCH DESIGN AND METHODOLOGY	16
1.10.1 Research design	17
1.10.2 Research Methodology	17
1.11 ETHICAL ISSUES	20
1.12 DELIMITATIONS OF THE STUDY	21
1.13 LIMITATIONS OF THE STUDY	21
1.14 FURTHER DEVELOPMENT OF THE STUDY	22
1.14 CONCLUSION	23

CHAPTER 2

LITERATURE REVIEW 24-50

2.1 INTRODUCTION	24
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2.2	THE ROLE ALCs CAN PLAY IN PROVIDING HIV/AIDS EDUCATION	25
2.3	ROLE OF ADULTS REGARDING HIV/AIDS EDUCATION	28
2.4	THE IMPACT OF HIV/AIDS ON EDUCATION	31
2.5	GLOBAL AND REGIONAL OVERVIEW OF HIV/AIDS	32
2.5.1	South Africa's HIV/AIDS Epidemic	34
2.6	THE IMPACT OF HIV/AIDS ON THE SOUTH AFRICAN ECONOMY	37
2.7	ORGANISED LABOUR AND HIV/AIDS	40
2.8	DROPOUT RATE AT THE ALC	42
2.9	ORPHANS DUE TO HIV/AIDS	42
2.10	BASIC HIV/AIDS INFORMATION	43
2.10.1	The difference between HIV and AIDS	43
2.10.2	The window period	44
2.10.3	Modes of transmission	45
2.10.4	How you cannot become infected	45
2.10.5	Myths surrounding HIV/AIDS	46
2.10.6	Stigmatization	46
2.11	KNOWLEDGE AND EDUCATION REGARDING HIV/AIDS	48
2.12	COMPLACENCY REGARDING HIV/AIDS EDUCATION	49
2.13	CONCLUSION	49

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY 51-70

3.1	INTRODUCTION	51
3.2	RESEARCH DESIGN	53
3.3	THE SAMPLING OF SUBJECTS	56
3.4	METHODS OF SELECTING A SAMPLE	56
3.5	SAMPLING STRATEGIES	57

3.6	INSTRUMENTS FOR DATA COLLECTION	57
3.6.1	The questionnaire	58
3.6.2	Questionnaire Construction	58
3.6.3	The interview	60
3.7	DATA ANALYSIS AND INTERPRETATION	62
3.7.1	Data analysis	62
3.7.2	Interpretation of data	64
3.8	THE RELIABILITY AND VALIDITY OF THE RESEARCH METHODS USED IN THIS STUDY.	65
3.8.1	Reliability	65
3.8.2	Validity	65
3.9	LIMITATIONS AND ADVANTAGES OF THE MEASURING INSTRUMENTS	67
3.10	PILOT STUDY	68
3.11	IMPLEMENTATION OF THE QUESTIONNAIRES.	69
3.12	CONCLUSION	69

CHAPTER 4

PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS 71-140

4.1	INTRODUCTION	71
4.2	SECTION A of QUESTIONNAIRE: PERSONAL DETAILS	72
4.2.1	Gender and age of participants	72
4.2.2	Gender composition of participating NQF-level 4 learners	73
4.2.3	Age groupings of participating NQF-level 4 learners	75
4.2.4	Employment status and previous HIV/AIDS education	78

4.2.5	Parental status and marital status	80
4.3	SECTION B of QUESTIONNAIRE: HIV/AIDS RELATED QUESTIONS	82
4.3.1	The interpretation of the questionnaires	82
4.3.1.1	Comparing the experimental group with the control group at the pretest stage	82
4.4	KNOWLEDGE GAINED FROM THE PRETEST TO THE POSTTEST	91
4.4.1	Comparing the experimental group with the control group at knowledge gained stage	95
4.4.1.1	Statistically significant results yielded by the experimental group at the knowledge gained stage	108
4.4.2	Gender performance in the experimental group at the knowledge gained stage	110
4.4.3	Gender performance in the control group at the knowledge gained stage	118
4.4.4	Performance of age groups in the experimental group at the knowledge gained stage	119
4.4.5	Performance of age groups in the control group at the knowledge gained stage	122
4.5	RETENTION OF KNOWLEDGE FROM THE POSTTEST TO THE POST-POSTTEST	122
4.5.1	Comparing the experimental group with control group at the retention stage	124
4.5.2	Gender performance in the experimental group at the retention stage	125
4.5.3	Gender performance in the control group at the retention stage	125
4.5.4	Performance of age groups in the experimental group at the retention stage	127
4.5.5	Performance of age groups in the control group at the retention stage	127
4.6	THE NUMBER OF UNSURE RESPONSES	128
4.7	SUMMARY OF QUESTIONNAIRE RESULTS	129

4.8	THE INTERPRETATION OF THE INTERVIEWS	130
4.8.1	The interview data	130
4.8.2	Interview findings interpreted according to the themes and sub themes	136
4.9	CONCLUSION	140

CHAPTER 5

FINDINGS, SUMMARY, CONCLUSIONS AND RECOMMENDATIONS 141-156

5.1	INTRODUCTION	141
5.2	FINDINGS FROM THE QUESTIONNAIRES	141
5.3	FINDINGS FROM THE INTERVIEWS	144
5.4	CONCLUSIONS BASED ON THE FINDINGS	147
5.5	RECOMMENDATIONS	150
5.6	CONCLUSION	155

REFERENCES 157

APPENDICES

APPENDIX A	Questionnaire	164
APPENDIX B	Interview transcripts	167

LIST OF TABLES

TABLE 1.1 : THE ROLE INFORMED ADULTS COULD PLAY SPREADING CORRECT INFORMATION ABOUT HIV/AIDS	5
TABLE 1.2 : THE GLOBAL HIV INFECTION RATE FOR THE PAST FOUR YEARS	12

TABLE 1.3 : NUMBER OF PEOPLE FROM THE SUB-SAHARAN AFRICA REGION, COMPARED TO THE GLOBAL NUMBER OF HIV/AIDS SUFFERERS	13
TABLE 1.4 : NATIONAL HIV PREVALENCE RATE BY AGE GROUP	14
TABLE 2.1 : STRUCTURE OF THE NATIONAL QUALIFICATIONS FRAMEWORK (NQF)	26
TABLE 2.2 : REGIONAL HIV/AIDS STATISTICS AND FEATURES, DECEMBER 2001	33
TABLE 2.3 : PROVINCIAL HIV PREVALENCE ESTIMATES: ANTENATAL CLINIC ATTENDEES, SOUTH AFRICA 1999-2001	34
TABLE 2.4 : OVERALL HIV PREVALENCE BY PROVINCE, SOUTH AFRICA 2002	36
TABLE 2.5 : THE DEMOGRAPHIC, ECONOMIC, SOCIAL AND DEVELOPMENTAL IMPACTS HIV/AIDS WILL HAVE ON SOUTH AFRICA.	39
TABLE 4.1 : EXPERIMENTAL GROUP AND CONTROL GROUP'S GENDER COMPOSITION OVER ALL THREE STAGES	72
TABLE 4.2 : CROSS-TABULATION OF PARTICIPANTS' EMPLOYMENT, GENDER AND PREVIOUS HIV/AIDS EDUCATION STATUS	78
TABLE 4.3 : CROSS-TABULATION OF PARTICIPANTS' AGE, GENDER AND PARENTAL STATUS	80
TABLE 4.4 : CROSS-TABULATION OF PARTICIPANTS' PARENTAL, AGE AND MARITAL STATUS	81
TABLE 4.5 : PRE TO POST COMPARISON BETWEEN EXPERIMENTAL AND CONTROL GROUPS	92
TABLE 4.6 : PARTICIPANT'S SCORE, GROUP AND STAGE	94
TABLE 4.7 : POST TO POST-POST COMPARISON OF THE RETENTION OF KNOWLEDGE BETWEEN EXPERIMENTAL AND CONTROL GROUPS	123

TABLE 4.8 : PARTICIPANTS UNSURE RESPONSES OVER ALL THREE STAGES.	128
TABLE 4.9 : THEMES OF THE INTERVIEW	130

LIST OF FIGURES

FIGURE 1.1 : THE DIFFERENT SECTORS THAT ARE MAKING PEOPLE AWARE OF HIV/AIDS IN SOUTH AFRICA	4
FIGURE 1.2 : HIV PREVALENCE BY WESTERN CAPE DISTRICTS: 2001	15
FIGURE 1.3 : THE TWO-GROUPS BEFORE-AFTER DESIGN APPLIED IN THIS STUDY	19
FIGURE 2.1 : A RANGE OF POSSIBLE SOCIOECONOMIC IMPACTS OF AIDS ON POOR, URBAN FAMILIES	41
FIGURE 2.2 : STAGES OF HIV/AIDS	44
FIGURE 4.1 : GENDER COMPOSITION OF PARTICIPATING ADULT LEARNERS AT THE PRETEST STAGE	73
FIGURE 4.2 : GENDER COMPOSITION OF PARTICIPATING ADULT LEARNERS AT STAGES: PRE, POST AND POST- POST	74
FIGURE 4.3 : AGE GROUPS' RESULTS AT PRETEST-STAGE	75
FIGURE 4.4 : AGE GROUPS' RESULTS AT POST-STAGE	76
FIGURE 4.5 : AGE GROUPS' RESULTS AT POST POST-STAGE	77
FIGURE 4.6 : PERCENTAGE OF PRETEST PARTICIPANTS WHO HAD PREVIOUS EXPOSURE TO HIV/AIDS EDUCATION VERSUS THOSE WHO HAVE NOT BEEN EXPOSED	79
FIGURE 4.7 : EXPERIMENTAL AND CONTROL GROUP COMPARISON AT THE PRETEST STAGE	84
FIGURE 4.8 : COMPARING THE EXPERIMENTAL AND CONTROL GROUPS AT THE KNOWLEDGE GAINED STAGE	93
FIGURE 4.9 : COMPARING THE EXPERIMENTAL GROUP WITH CONTROL GROUP DURING PRE AND POST RESULTS	97

FIGURE 4.10: COMPARING THE EXPERIMENTAL AND CONTROL GROUPS AT THE RETENTION STAGE	124
FIGURE 4.11: COMPARING THE EXPERIMENTAL GROUP WITH CONTROL GROUP DURING POST AND POST-POST RESULTS	126

LIST OF ABBREVIATIONS USED

ALCs	:	Adult Learning Centres
ABET	:	Adult Basic Education And Training
AIDS	:	Acquired Immunodeficiency Syndrome
CBO	:	Community Based Organisation
CLCS	:	Community Learning Centres
COSATU	:	Congress Of South African Trade Unions
EFA	:	Education for All
FETC	:	Further Education And Training Certificate
FHALC	:	Forest Height's Adult Learning Centre
GETC	:	General Education And Training Certificate
HIV	:	Human Immunodeficiency Virus
ILO	:	International Labour Office
KAB	:	Knowledge, Attitudes and Behaviour Intervention
NGO	:	Non-Governmental Organisation
NQF	:	National Qualifications Framework
PWA	:	Person Living With AIDS
SANYS	:	South African National Youth Survey
SPSS	:	Statistical Package for the Social Sciences
UNAIDS	:	Joint United Nations Programme on HIV/AIDS
UNICEF	:	United Nations Children's Fund
UNESCO	:	United Nations Educational, Scientific and Cultural Organization
WCED	:	Western Cape Education Department
WHO	:	World Health Organization

CHAPTER 1

INTRODUCTION AND OVERVIEW

1.1 INTRODUCTION

Most people infected with the human immunodeficiency virus (HIV) do not know they carry the virus. HIV is the virus that causes acquired immunodeficiency syndrome (more commonly known as AIDS). “Many millions more know nothing or too little about HIV to protect themselves against it” (UNAIDS/WHO, 2001: 2). It is against this background that Archie-Booker, Cervero and Langone’s (1999) argument will stay valid, namely that until a vaccine or cure is available, education offers the primary means by which HIV infection can be controlled. South Africa has the largest number of people living with HIV/AIDS, namely 4.7 million people. Approximately 1 out of 5 South African adults are infected with HIV or 19.9% of adults according to UNAIDS/WHO (2001).

In education there is a definite policy regarding HIV/ AIDS and the previous Minister of Education, Professor Kader Asmal has made it clear that HIV/ AIDS is one of the five core programme areas the education departments in all nine provinces have to focus on as set out in the *Tirisano* document (Department of Education, 2000). It is thus appropriate that the National Education Department took the lead in trying to fight HIV/AIDS in South Africa. The HIV/AIDS and Lifeskills programme is high on the priority list of our National Education Department. The South African government has published the national policy on HIV/AIDS for learners and educators in public schools, and students and educators in further education and training institutions in the *Government Gazette* (1999). The policy does not include Adult Learning Centres (in future referred to as

ALCs), also referred to as Community Learning Centres (in future referred to as CLCs). The focus of the study will be the role ALCs can play in fighting HIV/AIDS.

The Western Cape Education Department (in the future referred to as WCED) has implemented a HIV/AIDS and Lifeskills programme in the high schools in 1998. The primary school educators were to be trained over a three-year period. It started in the 2000 – 2001 financial year with 20% of all primary school educators (usually two or more educators per school) who had to be trained; and in the 2001 – 2002 financial year 40% of educators should have been trained and by 2002 – 2003 the last 40% of educators had to be trained.

From 2003 all high and primary school learners should be aware and hopefully equipped with the necessary Lifeskills to deal with HIV/AIDS. By 2003/2004 all the schools should have representatives that are trained, but it does not mean all educators are trained. The latter statement is due to the fact that two different training models are being used. In some areas the *saturation training model* (all the educators and even non-teaching staff willing to attend the training are being trained) is being used versus the *cascade model* (the numbers might vary, but usually 2-4 educators are trained per school and they in turn have to train the rest of their colleagues). The latter model is being used in the majority of cases although the WCED knows it is not a successful model in terms of getting the rest of the colleagues trained. Regardless of which model is being used in training the educators in the next few years the assumption is that learners at primary and high school level should be well equipped to deal with HIV/AIDS issues.

In the private sector however there is no policy from government to guide or compel employers to train their staff and themselves about HIV/AIDS. There are not many employers who have a HIV/AIDS policy or who have gone to great length in implementing such a policy; however there is an assumption that some companies do have a HIV/AIDS policy and programme. Finding resources to indicate the percentage of HIV/AIDS education or the implementation of a HIV/AIDS policy in the private sector are non-existent. One of the reasons why it might be difficult to acquire the above

information is the fact that “...the law does not require an employer to develop a workplace AIDS policy and programme...”(Smart, 1999: 5). The Congress of South African Trade Unions (in future referred to as COSATU): (2000) and Smart and Strode (1999) deal with the South African labour law and HIV/AIDS. These two articles look at all the laws pertaining to HIV/AIDS in the South African context and nowhere is it mentioned that an employer should develop a workplace AIDS policy and programme.

Taking the above into account it is obvious that some adults are perhaps not going to get the benefit of HIV/AIDS education services. The three groups of adults who come to mind are the unemployed, those working in the informal sector (e.g. hawkers, taxi drivers, chars, etc.) and those working for companies that do not see HIV/AIDS education as a priority. Adult Learning Centres are already educating adults who are part of these above-mentioned sectors, but who are not educated about HIV/AIDS. The researcher will focus on the WCED’s HIV/AIDS programme initiatives, because the Forest Height’s Adult Learning Centre (in future referred to as FHALC) falls in the broader Cape Town region, which is part of the Western Cape province. The latter is one of the nine provinces in South Africa.

1.2 MOTIVATION FOR THE STUDY

According to the UNAIDS / WHO about one-in-nine South Africans (adults and children) are living with HIV/AIDS (that is 4.7 million people). They also make us aware of “...a troubling rise in prevalence among South Africans aged 20-34, highlighting the need for greater prevention efforts targeted at older age groups, and tailored to their realities and concerns” (UNAIDS/WHO, 2001:16). Bearing the above age group in mind it is important to look at the following illustration (see Figure 1.1) if you want to focus on the different sectors that are making people aware of HIV/AIDS in South Africa; and the role ALCs can play in educating these prospective learners.

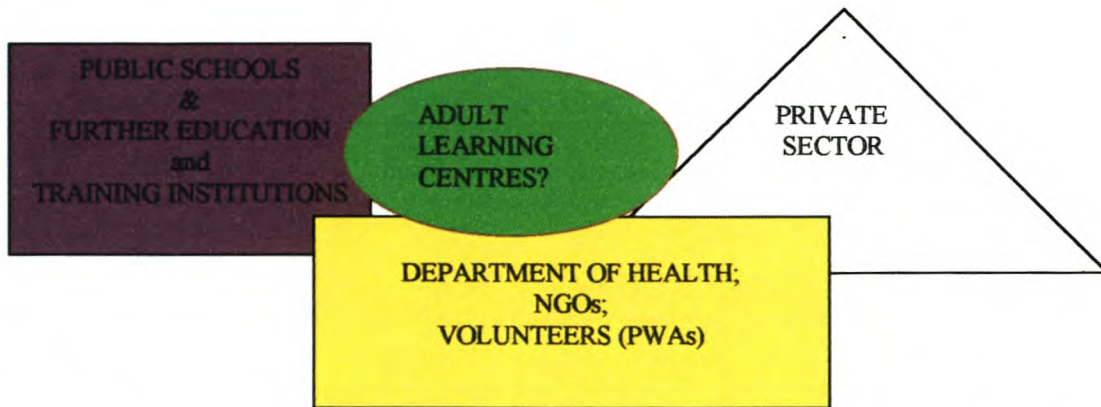


FIGURE 1.1: THE DIFFERENT SECTORS THAT ARE MAKING PEOPLE AWARE OF HIV/AIDS IN SOUTH AFRICA

Taking the above scenario into account and bearing in mind that:

- in the next three years all learners in public schools should have been exposed to the HIV/AIDS and Lifeskills programme;
- certain companies in the private sector are educating their workers, but not all, because they are not bound by law to do so; and
- there remains some concerns in reaching the rest of our people (South Africans), who are not catered for in the first two scenarios.

It is here where the *community education* or *adult learning centres (ALCs)* can play a meaningful role in trying to address this problem of making HIV/AIDS education more accessible to the community. It will give the unemployed, as well as the employed people who have not been exposed to HIV/AIDS education a chance to understand this disease better, and how they can help to prevent it from spreading. Educating their workers about AIDS presently is the *exception rather than the rule* for employers in the private sector.

The unemployed group on the other hand has no real exposure to AIDS education, except through the media (television, newspapers, pamphlets). Whether these media campaigns work is debatable, because no research could be found to indicate what the real impact of these campaigns have in terms of prevention. Hambridge and Whiteside (as cited in Haldenwang, 1993) raise the concern that although a growing number of firms are already considering AIDS in their strategic planning and offering education packages, videos and condom vending machines, they face a problem as there is no point in educating the workers if their families and communities are not also educated. Today, nearly ten years later, it seems the latter has not been addressed. Hambridge and Whiteside's (as cited in Haldenwang, 1993) argument can be addressed if community/ adult learning centres are empowered and capacitated to offer HIV/AIDS and Lifeskills programmes at these community institutions. The reality is however that the Western Cape Education Department is not offering such a programme at its Adult Learning Centres, which fall under the Adult Basic Education And Training (in future referred to as ABET) sub-directorate. To further support Hambridge and Whiteside's argument it will make sense if we look at the role informed adults could play (see Table 1.1) regarding the spreading of correct information about HIV/AIDS.

TABLE 1.1:

THE ROLE INFORMED ADULTS COULD PLAY SPREADING CORRECT INFORMATION ABOUT HIV/AIDS

<i>In their sites:</i>	<i>Roles as:</i>
<i>Homes</i>	<i>Parents, brothers, sisters, etc.</i>
<i>Communities</i>	<i>Neighbours, friends, community members</i>
<i>Workplace</i>	<i>Colleagues, friends</i>

From the above it is clear that these adults (who are properly educated about HIV/AIDS) reach a large audience and can only be an asset for our country in the fight against AIDS.

Adding further value to this argument Smart (1999) says that the most powerful change agents are our friends and peers.

There are however some concerns in dealing with HIV/AIDS issues in making the above-mentioned a reality and relevant in fighting the war against AIDS, namely that:

- not all educators attached to ALC's are educated and trained to offer HIV/ AIDS training;
- not all workers or even employers are educated and trained to offer HIV/AIDS training to their peers or staff;
- none of the early school leavers and the unemployed are educated and trained; and
- most of the Department of Health's information comes in the form of booklets and pamphlets, but it would be difficult to reach the illiterate if they cannot read it; the same applies to the radio and television guides that are supposed to inform them (illiterate) about when HIV/AIDS information programmes will be broadcast. In the latter scenario the illiterate can be accommodated at ALCs or educated by peers, taking their specific level of education into account.

To further highlight the role ALC's can play in fighting HIV/AIDS it is important to look at the research findings of the Kaizer Family Foundation and Kaufman Levin Associates (2000). It is important to be aware of the following two aspects:

- "over three-quarters (78%) of all sexually experienced young people say they had a sexual experience by the age of 15, which represents 24% of all South African youth (aged 12 –17 years);
- fourteen percent of youth say they first learned about sex from a family member. This includes those who first learned about sex (not HIV/AIDS) from their mother only (7%), their father only (1%) or both parents (4%)" (Kaizer Family Foundation and Kaufman Levin Associates, 2000: 12 - 13).

The research further revealed that young people whose first lesson about HIV from one or both of their parents constitute only eight percent (8%). There is a need to reverse the

latter and drastically increase the involvement of parents in sexuality and HIV/AIDS. One way of doing that is to educate adults (parents) about HIV/AIDS. Taking the above-mentioned statistics into account it would be advisable to complement the HIV/AIDS programme with a sexuality and Lifeskills programme (with specific emphasis on parental skills) at all community and adult learning centres. The first prerogative of this study however is to research the basic HIV/AIDS knowledge of the adult learners at FHALC. Further recommendations can only really be justified on the outcome of what they know about HIV/AIDS. The motivation for this study is to see how HIV/AIDS education can be made accessible to every adult, whether they are employed or not.

1.3 STATEMENT OF THE PROBLEM

There is an important role adults can play in helping to slow the spreading of the disease. This large pool of potential help is however not being educated about HIV/AIDS and thus cannot be expected to help prevent the disease by protecting themselves or others. The researcher is however concerned about those people who are unemployed, those who are working at companies where no AIDS policies exist and those in the informal sector. To accommodate these groups the ALC can be utilized to play a meaningful role in educating them. This is in line with the UNAIDS and WHO's (2000) research evidence that more-educated people are better equipped to act on prevention information, and because they have more options in life in general, they are now exposing themselves less to the risk of HIV.

People are either infected or affected by the AIDS pandemic. The virus (HIV) does not discriminate against anyone whether you are rich or poor, literate or illiterate, young or old, ... it can infect or affect every part of our society. "The epidemic has an impact not only on the sick individual, but also on families, communities and entire nations" (United Nations, 1998:2).

The major problem in South Africa according to the researcher is that not enough is being done to educate all adults about HIV/AIDS, because every individual who is

“irresponsibly” sexually active (not faithful to one partner and at the same time having unprotected sex) is putting himself or herself at risk of contracting HIV. The problem the researcher is trying to address is therefore to make HIV/AIDS education available and accessible for the majority, if not all adults in order to slow down the spread of HIV in South Africa (more specifically in the Western Cape), by allowing them to be educated about HIV related issues at ALCs.

1.4 AIM OF THIS STUDY

AIDS can infect and affect anyone, which is why it is important for us to target all sectors of society to fight this disease. Right now, in 2003, there is no cure for the disease. The only way we can fight this disease is to educate as many people as we can and in so doing they might spread the word rather than the virus. By doing a pilot study at an Adult Learning Centre the researcher could see what the adult learners’ knowledge levels were regarding HIV/AIDS. The study should give the researcher a good indication of whether the implementation of HIV/AIDS and Lifeskills programmes in Adult Learning Centres could be justified. The latter is dealt with in chapter five. ALC’s offer formal courses, which are equivalent to mainstream school courses or curricula. There are however people who do not want to study lengthy full or part-time courses, but who might be interested in short courses (day, week or month courses) or training programmes. ALCs need to accommodate those people who would like to follow short (certified) courses or training programmes. Tobias (1998) echo’s the same sentiment when he suggests that non-formal and informal credential-free adult education (as well as certified, short courses) should continue to be supported and developed as a significant component of any education system in the future. He argues that these programmes should seek to provide resources and support for those who are unlikely to ever make demands on the formal system, but may be, or may become, active independent learners. In conjunction with the above-mentioned statement he urges the following: “(f)or some people from the working class background, it is crucial that the doors to formal credentialed education be kept open throughout the adult years” (Tobias, 1998:139). His motivation for this request is that they are the people who are likely to benefit most from adult entry programmes,

policies that seek to recognize prior learning, and increased opportunities for open learning. “The only influence parents can wield to delay their children’s sexual initiation is through their teaching of values” (Tonks, 1996:6). In order for parents to teach these values they should have a good knowledge base in terms of HIV/AIDS. The aim of this study is to see if the HIV/AIDS training programme leads to a greater awareness about HIV/AIDS and related issues.

1.5 THESIS STATEMENT

An ALC can play a role in HIV/AIDS prevention and support through the implementation of HIV/AIDS education and training programmes and thus empowering adult learners with specific reference to their knowledge levels of HIV/AIDS.

1.6 RESEARCH GOAL

This study will try to provide answers to the following research questions regarding adult learners:

- Did their (adult learners’) knowledge increase through the HIV/AIDS training programme? This was determined by means of a questionnaire.
- Will they be a reliable (in terms of correct information) source for their children, friends, colleagues and others to educate them about *high risk behaviour* (having sex without a condom, intravenous drug users sharing the contaminated needles, using the same instruments for tattooing purposes, especially gangsters) and how not to get HIV infected? This information was obtained by means of an interview with individuals who were part of the experimental group (background information about this group is given further on in this chapter under the heading research design and methodology).

- Will it lead to better understanding and support of *people living with Aids* (in future referred to as PWAs)? This information was obtained by means of an interview with individuals who were part of the experimental group.
- Are they aware of the impact HIV/AIDS will have on the economy in terms of sick leave, medical aid, productivity, retraining of people to fill AIDS victims' positions, orphans and crime? This information was obtained by means of an interview with individuals who were part of the experimental group.
- Is there a difference between the HIV/AIDS knowledge levels of male and female participants? This was obtained by means of the questionnaire.
- Is there a difference in terms of the HIV/AIDS knowledge levels of the different age groups participating in the study? This information the researcher got from the questionnaires.
- How many of the participants were educated about HIV/AIDS prior to this study? This information the researcher got from the questionnaires.
- Do they need further follow-up programmes or not? This information was obtained by means of an interview with individuals who were part of the experimental group.

1.7 DEFINITION OF TERMS

The following terms and concepts are being defined in the context of this study:

Adult Learning Centre / Community Learning Centre : refers to centres that offer Adult Basic Education and Training (ABET) courses, which lead to a General Education and Training Certificate (in future referred to as GETC); and National Qualifications Framework (in future referred to as NQF) levels 2, 3, 4. The latter three NQF levels lead to a Further Education and Training Certificate (in future referred to as FETC).

AIDS: this is the acronym for acquired immunodeficiency syndrome. It is the stage that leads to a progressive weakening of the immune system with the primary cause of infection identified as HIV.

HIV: this is the acronym for human immunodeficiency virus. This is the retrovirus that causes or leads to AIDS.

NQF-level 4 learner: refers to a learner attending an ALC who only has to complete this level (which is the equivalent of matric / grade 12) in order to receive his or her FETC.

HIV/AIDS Programme: the HIV/AIDS programme was a 4-hour programme which addressed key issues, such as the definition of HIV/AIDS, modes of transmission, myths, HIV/AIDS statistics, impact on the economy and role of the parent.

1.8 THE CONTEXT OF THE STUDY

The WHO's projection in 1991 of people who would be living with AIDS by the end of 2000 was more than 50% lower than the 'true' estimates for the end of 2000 (UNAIDS/WHO: 2000). It is estimated that *37.2 million adults* and *2.7 million children* were living with HIV by the end of 2001 (UNAIDS/WHO; 2001:1). HIV/AIDS does not discriminate, it infects the young and old, the rich and the poor, all races, whether you are heterosexual or homosexual. HIV/AIDS has taken on pandemic proportions, especially in some of the African countries.

According to the UNAIDS the HIV prevalence amongst pregnant woman attending antenatal clinics in South Africa jumped from less than 1% (0.7%) in 1990 to 24.5% by the end of 2000 (UNAIDS/WHO, 2001:5). South Africa was experiencing one of the fastest growing epidemics in the world, according to UNAIDS/WHO (2000). South Africa is unfortunately one of those countries with a high infection rate and death rate. In the estimated figures at the end of 1999, South Africa had the highest infection rate in the

world according to UNAIDS/WHO (2000). The main modes of transmission differ from region to region as can be seen in Table 2.2 (page 33). The disturbing fact in sub-Saharan Africa is that the majority of infections are due to heterosexual transmission. It is disturbing, because HIV is preventable. These infections can be attributed to the fact that the majority of infected people did not practice safer sex, were not faithful to one partner and most of them are ignorant about the disease.

In sub-Saharan Africa it was estimated by Bisseker (1999: 111) that 22,5 million people were living with HIV/AIDS out of a global total of 33,4 million people infected at the end of 1998. In Table 1.2 we can see the global infection rate per annum for the past four years of which more than two-thirds are in the sub-Saharan Africa region.

TABLE 1.2:

THE GLOBAL HIV INFECTION RATE FOR THE PAST FOUR YEARS

YEAR	Total of HIV infected people during specific year
1998	5.8 Million
1999	5.4 Million
2000	5.3 Million
2001	5.0 Million
Total number of people living with HIV/AIDS at end of 2001:	
40 Million (37.2 Million are Adults)	

Out of the 40 million people living with HIV/AIDS by the end of 2001 (Table 1.2), 28.1 million are from the Sub-Saharan Africa region.

Looking at Table 1.3 we can see how many people are coming from the sub-Saharan Africa region, compared to the global number of sufferers (Tygerburger, 2001: 18).

TABLE 1.3:

**NUMBER OF PEOPLE FROM THE SUB-SAHARAN AFRICA REGION,
COMPARED TO THE GLOBAL NUMBER OF HIV/AIDS SUFFERERS**

MEN:	6 out of 10
WOMEN:	8 out of 10
CHILDREN:	9 out of 10

Dr Toms, acting head of Cape Town's health services, estimates that by 2009 the life expectancy of blacks in Cape Town would have decreased from 55 to 40 years and that of coloureds from 65 to 55 years according to figures published in the *Tygerburger* (2001: 18). "No data is available for whites as whites usually do not make use of public health facilities" (Tygerburger, 2001: 18).

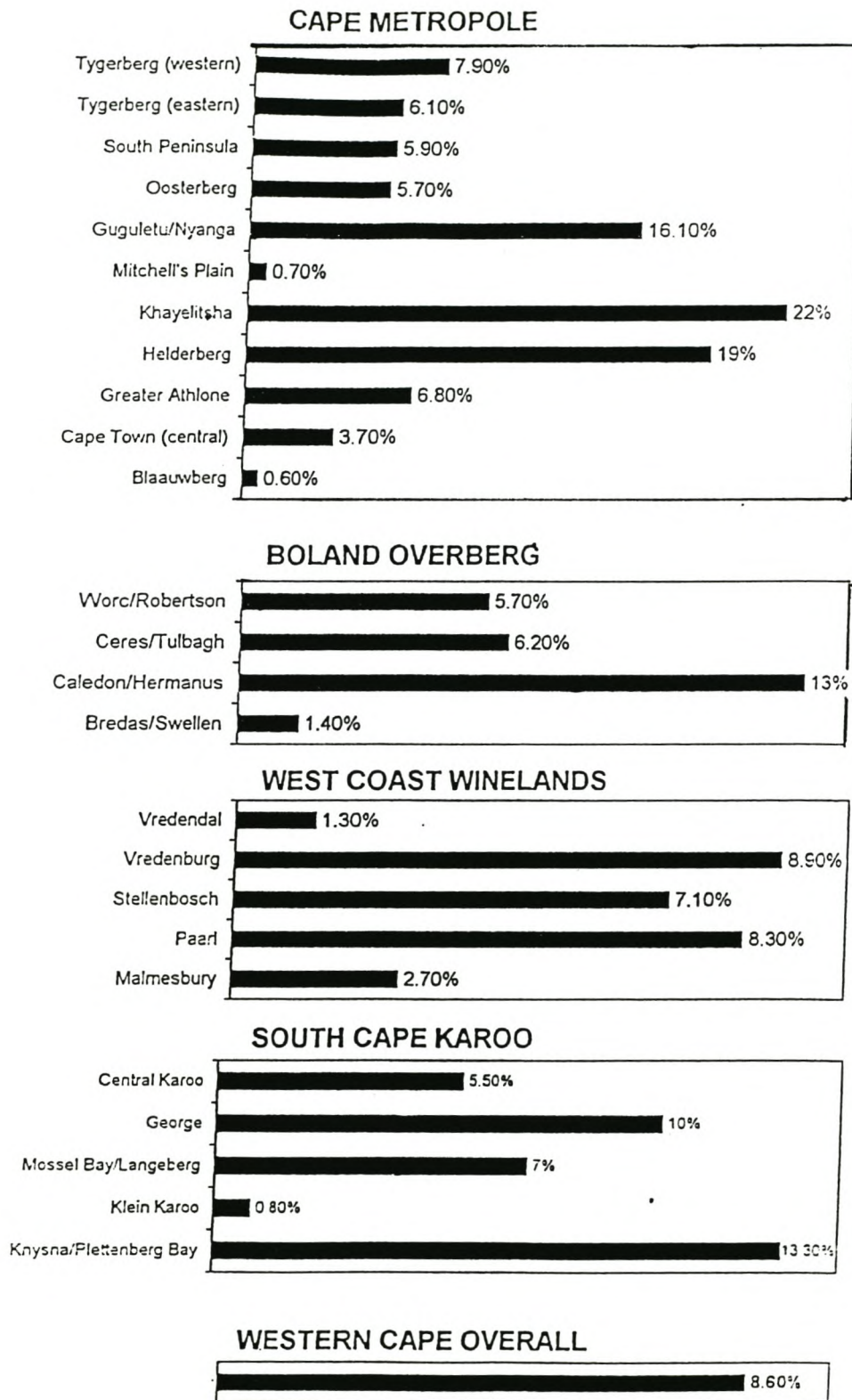
Looking at the national HIV prevalence rate by age group (see Table 1.4) gives us a better picture of how HIV/AIDS impacts on our country as a whole. The Western Cape has the lowest infection rate, but with people who come to this province from other provinces (because of factors like the stronger economy, education system and better health care) this rate can change. The Western Cape is divided into four districts, namely Cape Metropole, Boland Overberg, West Coast Winelands and South Cape Karoo. The FHALC is situated in Eerste River, which is situated near Cape Town and is part of the greater Oostenberg district, which forms part of the West Coast Winelands.

TABLE 1.4:
NATIONAL HIV PREVALENCE RATE BY AGE GROUP

AGE	1998	1999	2000	2001
< 20	21.0	16.5	16.1	15.4
20-24	26.1	25.6	29.1	28.4
25-29	26.9	26.4	30.6	31.4
30-34	19.1	21.7	23.3	25.6
35-39	13.4	16.2	15.8	19.3
40-44	10.5	12.0	10.2	9.1
45-49	10.2	7.5	13.1	17.8

Source: Department of Health, 2002.

Looking at Figure 1.2 for the Western Cape districts in 2001, it should be remembered that the statistics are based on women attending public antenatal clinics in South Africa. Bearing the latter in mind it is important to note Oostenberg's and Mitchell's Plain's low prevalence rate. This might not be a true reflection of the two districts prevalence rates, because most of the women are working in other districts and might attend those clinics nearer to their places of work.



**FIGURE 1.2: HIV PREVALENCE BY WESTERN CAPE
DISTRICTS: 2001**

Source: Department of Health (Western Cape):2001

1.9 RELATED LITERATURE TO THE RESEARCH TOPIC

Although there has been a considerable amount of literature published in the broad area of HIV/AIDS education, South African literature related to the topic is scarce. “Within public health, risk reduction campaigns may be based on one of two paradigms: a *population-based approach* that attempts to decrease risk by changing the behaviour of an entire population and a *risk-based approach* that targets only that subset of the community thought to be at the highest danger for the problem” (Sessions & Cervero, 1999:6). In South Africa the HIV/AIDS rate is one of the highest in the world and it should be a population-based approach that is the priority in this country to lower the infection rate. The risk-based approach might be one of the reasons HIV rates are escalating, because people might not see themselves as part of high-risk groups, like homosexuals, intravenous drug users, prostitutes/ sex workers. The latter might be true, because some people from these so-called high-risk groups might follow the correct safety precautions (using condoms, using clean needles), while others who are not classified as part of the *high-risk group* might be indulging in *high-risk activities* (having sex without a condom, mixing of blood, sharing of needles, alcohol and drug abuse, which can lead to rash and improper decisions). We should rather focus on high-risk activities and less on high-risk groups. This also makes more sense to follow a population-based approach where people can realize that everybody is at risk if they indulge in high-risk activities even if they are not part of a so-called high-risk group. A detailed literature review will be given in chapter two.

1.10 RESEARCH DESIGN AND METHODOLOGY

There is a significant difference between the research design and the research methodology (Mouton, 2001).

1.10.1 Research design

Borg and Gall (1989: 324) define a research design “...as a process of creating an empirical test to support or refute a knowledge claim”. The research design focuses on the end product of the study and the logic of the research (Mouton, 2001: 56). The starting point of the research design is the research problem. In other words the research design is the broader approach and the research methodology is the guidelines or steps you need to follow to achieve the end product.

The researcher conducted quantitative and qualitative research in an interpretive paradigm. “The main function of a research design is to enable the researcher to anticipate what the appropriate research decisions should be so as to maximize the eventual results” (Mouton, 1996:107). The researcher divided his research process into five stages, namely: conceptualisation; operationalisation; sampling; data collection and analysis/interpretation.

The conceptualization stage is part and parcel of the research design and the latter four stages are part of the research methodology.

Conceptualisation: this is the “underlying theoretical framework” that acts as a guide for my research. It was achieved by doing a thorough literature review, which entailed going to written sources and collecting information related to the study. The main outcome of the literature review was to clarify vague, ambiguous and complex concepts and definitions. The intention in using a literature review was to obtain perceptions about the significant role an ALC can play in offering a HIV/AIDS training programme to people who would otherwise not be guaranteed access to such programmes.

1.10.2 Research Methodology

This self-initiated research stems from the already mentioned fact that there are people (those employed in the formal and informal sector and the unemployed) who are not

being educated regarding HIV/AIDS. The majority of them are sexually active and this being one of the main modes of transmission they are also at risk of contracting the disease. At the same time they can also educate others if they know the facts about HIV/AIDS.

The aim was to make a contribution to the existing body of knowledge regarding adult education and thereby make a contribution to the activities that must be provided for adult learners who are not catered for regarding HIV/AIDS education.

Operationalisation: this stage has to do with the development of the measuring instruments that were used in the study. The researcher made use of questionnaires and interviews. Firstly, the pilot study was conducted to try out the constructed questionnaire on respondents who would later not participate in the actual study. Secondly, questionnaires were used to gather the necessary information for data analyzing from the actual participants. The questionnaire was *dual medium* (English and Afrikaans) in order to accommodate English as well as Afrikaans speaking learners. The same questions were used for the control group and the experimental group during the:

- ◇ pre-test,
- ◇ post-test and the
- ◇ post-post-test.

The *experimental group* completed the pre-test and thereafter they were exposed to a four-hour HIV/AIDS awareness programme on March 2, 2002. This was followed by the post-test and three months later they participated in the post-post-test. The *control group* followed the same procedure in terms of time intervals, but without being exposed to the intervention programme.

Sampling: The NQF-level 4 adult learners of the FHALC were the target group for the study. The FHALC offers NQF-level one (ABET-level 4) to NQF-level 4 courses, which are the equivalent of Grade eight to Grade twelve in the mainstream schools. The sample was only the NQF-four adult learners. The *two-groups before-after design* was

used in this study. Dyer (1995:96) describes this design as the participation of two or more: “samples which are each pre-tested before being given different treatments, and then subsequently tested again, using a comparable test to the first.” Look at Figure 1.3 for a graphic illustration of the two-groups before-after design and how it was applied in this study. The time frames followed in the two-groups before-after design are fully explained in chapter 3.

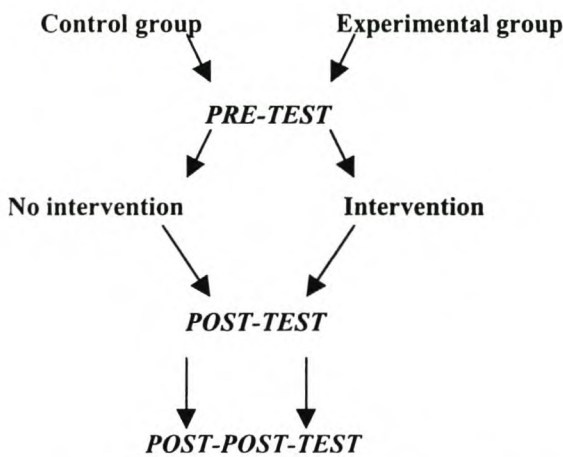


FIGURE 1.3: THE TWO-GROUPS BEFORE-AFTER DESIGN APPLIED IN THIS STUDY

The one group of the sample for this study consisted of 27 NQF-level 4 adult learners from the FHALC. This group comprised the *experimental group* and the other part of the sample (which consisted of the rest of the NQF-level 4 learners) was the *control group*. The experimental group consisted of the learners who were randomly selected to participate in the four-hour HIV/AIDS programme. The participants taking part were asked verbally and by means of a letter if they were interested in participating in the study.

Data Collection: The method used to ascertain the knowledge levels of the NQF-level 4 learners (in the control group and the experimental group) was quantitative. The method employed to determine the success of the HIV/AIDS programme on the experimental group comprised two stages, and combined a qualitative and a quantitative approach. The

quantitative approach for both the control group and the experimental group involved the completion of a pre-test, a post-test and a post-post-test in the form of a questionnaire. The quantitative data are those in which information that is represented by numbers and the qualitative data is represented in the form of verbal descriptions (Dyer, 1995: 23). The qualitative approach was done by means of individual interviews and only focused on the participants who were part of the intervention or the experimental group.

Analysis and Interpretation: After all the relevant data had been collected it had to be analysed in order to interpret it and make the relevant generalizations and recommendations based on the findings of the study. The quantitative component of the research, namely the questionnaires, were analysed and interpreted by making use of the *Statistical Package for the Social Sciences* (SPSS) computer programme. Cross tabulations and the Fisher's exact test were used. The Fisher's exact test, a non-parametric statistical test of significance was used due to the small sample size.

The qualitative component of the study, namely the interviews were analysed and interpreted by means of a descriptive approach of coding participants' responses into different themes and sub-themes.

1.11 ETHICAL ISSUES

Research participants were informed verbally and assured that confidentiality and anonymity would be adhered to. All queries were entertained at this information session held 14 February 2002. In addition to the above mentioned, the following issues were also discussed with the participants, which Dyer (1995) identifies as key points: the research participants were informed about the reason, aims and purpose of the research and they were made aware that they had the right to withdraw from the study at any time.

The research methodology concentrates on the research process and the type of tools and procedures to be utilized. It also focuses on the individual steps in the research process

and tries to use the most objective procedures available (Mouton, 2001). The following stages are part of the research methodology process.

1.12 DELIMITATION OF THE STUDY

The study was limited to all the NQF-level 4 adult learners at the FHALC. The FHALC is situated in the Eerste River area, near Cape Town and falls under the jurisdiction of the Western Cape Education Department. The majority of residents from the above-mentioned area are from the lower income group of which the majority of adults have not completed high school level education.

1.13 LIMITATIONS OF THE STUDY

Eerste River, situated near Cape Town and part of the Oostenberg district, is a predominantly coloured residential area, which in itself is a shortcoming of this study. It is a shortcoming because it inevitable excludes other cultures.

Another limitations of this study is the small sample size, which makes generalisability risky (Mouton, 2001: 156). The purpose of this study is however not to generalize. The study is not intended to measure behavioural change, but to measure the knowledge levels of participants. The researcher acknowledges the fact that knowledge alone is not enough to elicit behavioural change, but it is important to assist in the process of decision making and changing of attitudes. “First, people need to have *knowledge*, then change their *attitudes* and finally alter their *behaviour*” (Whiteside & Sunter, 2000:19). They call this the KAB (knowledge, attitudes and behaviour) intervention. The researcher agrees with the United Nations (1998:ii) document, which states in its preface that attitudes and high-risk behaviour have to be changed, but acknowledge that accurate knowledge on HIV/AIDS has to be increased.

The initial training programme is by no means adequate if we want to empower adult learners regarding HIV/AIDS related issues. The researcher was not trying to change the behaviour of participants, which is a limitation of this study. Changing behaviour would require many more aspects of education and training, for example they should be exposed to decision making skills, problem solving, parental skills and attitude and value clarification workshop. These workshops must be interactive for behavioural change to take place, but it was not the focus of this study. To latch on to the latter, how would you react if your son says he is involved in a gay relationship? Except for facts, your response would involve decision-making, attitudes and values.

The following should be seen as the foundation for any other training to be meaningful in the empowerment process:

- you need to know the facts about HIV/AIDS in order to make informed decisions;
- these facts might influence a person's behaviour and attitude(s), especially if he/she leads a high risk lifestyle (has sex without a condom, intravenous drug users sharing the contaminated needles); and
- these facts might influence a person's values in terms of people (friends, family, colleagues, etc.) being infected or affected by the disease.

The fundamental focus of this study was that it attempted to assess the learner's knowledge and not behavioural change.

1.14 FURTHER DEVELOPMENT OF THE STUDY

The following overview is given for the development of the study:

CHAPTER ONE

This chapter consists of the introduction and background to the study. It includes a motivation for the study, statement of the problem, definition of terms, aims of the study, research design and methodology, delimitations and limitations of the study.

CHAPTER TWO

This chapter tries to provide a theoretical background and framework to the study. A review of previous and relevant research findings in this field is also provided.

CHAPTER THREE

This chapter focuses on the research design and methodology of the study. It includes the collection of data, the selection of participants and a plan for organizing and analysis of data.

CHAPTER FOUR

This chapter concentrates on the analysis and interpretation of data. The main findings of the study are presented and summarized in this chapter.

CHAPTER FIVE

This is the last chapter of this study. It concludes by discussing the findings, and also consists of an overview of conclusions and recommendations.

1.15 CONCLUSION

In this chapter the researcher presented an orientation, overview and problem-formulation. Chapter two will focus on the theoretical background and framework pertaining to the study. A review of previous and relevant research findings will also be presented in this study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter the researcher investigates what has been done regarding the HIV/AIDS education of South African adults. The researcher explores Adult Learning Centres and the role it can play in educating people about HIV/AIDS. The researcher studies the evidence available concerning people being educated about HIV/AIDS in terms of preventing the spread of the disease and also being able to reduce stigma and discrimination surrounding the disease. The literature review also examines research about the impact HIV/AIDS will have on the country's economy and education.

Looking at the previous chapter the researcher highlighted the fact that the Department of Education has a plan of action in terms of educating our children in public schools. The latter does not however guarantee that all children at schools will be equipped to deal with HIV/AIDS and related issues. One of the reasons of concern is that children are being orphaned, due to their mothers or both their parents dying of AIDS related illnesses. The impact on orphans of their parents dying of AIDS related illnesses will be

discussed later on in this chapter. The following issue, namely the dropout rate in public schools in the Western Cape, is also making it difficult to educate all children about HIV/AIDS at mainstream school level. They are the adults and potential leaders of tomorrow. The dropout rate is an alarming 45% from grade 1 to grade 12 according to the director of Metropole South (E. Daniels, personal communication, August 7, 2002). Metropole South is one of seven metropolises in the Western Cape Education Department. Bearing the dropout rate in mind and the fact that a large number of people are unemployed (not forgetting a large number are sexually active), it is essential that an avenue should be created for easy access to HIV/AIDS education and information. The ALC is there to be used as a venue, where unemployed adult learners could be trained and used as HIV/AIDS peer educators.

There is certain basic information all adults should know about HIV/AIDS (e.g. the difference between HIV and AIDS, modes of transmission, the window period, myths and stigmatization, and global statistics of the disease). The researcher acknowledges the fact that education alone is not a guarantee that behavioural change will take place, but that the knowledge should be seen as the foundation for any further HIV/AIDS intervention(s) to take place. This study's main focus is to look at the gaps as well as the positive initiatives that exist in order to improve the accessibility of HIV/AIDS education to all people, especially adults.

2.2 THE ROLE ALCs CAN PLAY IN PROVIDING HIV/AIDS EDUCATION

Adult Learning Centres are ABET (Adult basic education and training) institutions attached to the WCED. These ABET institutions were previously known as “night schools”. They offer ABET courses, which might range from NQF-level 1 (ABET 1 to ABET 4) to NQF-level 4. The participants of this study are NQF-level 4 learners and registered at a ALC. Table 2.1 is a more graphic illustration of the NQF and the different levels a person needs to obtain before he/she can obtain the GETC (General Education & Training Certificate) and the FETC (Further Education & Training Certificate).

**TABLE 2.1: STRUCTURE OF THE NATIONAL QUALIFICATIONS
FRAMEWORK (NQF)**

NQF level	Band	Types of Qualifications and Certificates	Locations of Learning for units and qualifications			
8	Higher Education and Training	Doctorates Further Research Degrees	Tertiary/Research/ Professional Institutions			
7		Higher Degrees Professional Qualifications	Tertiary/Research/ Professional Institutions			
6		First Degrees Higher Diplomas	Universities/Technikons/ Colleges/Private/ Professional Institutions/ Workplace/etc.			
5		Diplomas Occupational Certificates	Universities/Technikons/ Colleges/Private/ Professional Institutions/ Workplace/etc.			
Further Education and Training Certificate						
4	Further Education and Training	School/College/ Trade Certificates Mix of units from all	Formal high schools/ Private/ State schools	Technical/ Community Police/ Nursing/ Private colleges	RDP and Labour Market Schemes/ Industry Training Boards/ Unions/ Workplace, etc.	
3		School/College/ Trade Certificates Mix of units from all				
2		School/College/ Trade Certificates Mix of units from all				
General Education and Training Certificate						
1	General Education And Training	Senior Phase	ABET level 4	Formal Schools (Urban/ Rural/ Farm/ Special)	Occupation/ work-based training/ RDP/Labour Market Schemes/ Upliftment/ Community programmes	NGO's/ Churches/ Night Schools/ ABET programmes/ Private providers/ Industry Training Boards/ Unions/ Workplace etc.
		Intermediate Phase	ABET level 3			
		Foundation Phase	ABET level 2			
		Pre-school	ABET level 1			

Source: Department of Labour, 1998.

ALCs basically offer the following three education scenarios:

- only the NQF-level 1, (the equivalent of primary school);
- others offer only ABET-level 4, (which is last level to obtain NQF-level 4 credit) to NQF-level 4 (the equivalent of high school); and
- others offer all the levels of the GETC band and the FETC band (the equivalent of offering grade 1 to grade 12).

HIV/AIDS can infect anybody, but the fact remains that in South Africa the largest number of people infected come from the predominantly poor, black communities. Whiteside and Sunter (2000:48) make us aware that “...in terms of *absolute numbers*, there are more black people infected than other race groups”. Crewe (1992:45) mentions the fact that AIDS will largely affect (and infect) the poor. The poor is largely from the black community and they are affected more because they are in the majority in this country. Aggleton (1997:11) however states that “(c)ontrary to popular belief, no one ‘group’ of people is intrinsically more vulnerable than any other”. Aggleton’s (1997) view is supported by Whiteside and Sunter (2000), who differ with Crewe in terms of which group AIDS will largely affect, because there is evidence that AIDS is spreading according to them (Whiteside & Sunter) through all groups in South Africa and is transgressing class barriers. The Nelson Mandela/HSRC Study (2002) is the most recent South African study of note, which also supports Whiteside and Sunter’s view.

According to the Nelson Mandela/HSRC Study (2002: 46) “(p)eople living with HIV/AIDS are found in every race group in South Africa...” Whites in South Africa have a much higher HIV prevalence (6.2%) compared to “predominantly white societies, for example in the USA, Australia, France and the UK, which have less than 1%” (Nelson Mandela/HSRC Study, 2002: 59). Whites (6.2%) and coloureds (6.1%) should be consciously incorporated into HIV prevention efforts, because the HIV prevalence indicates a dynamic epidemic is occurring in these groups (Nelson Mandela/HSRC Study, 2002).

It is clear from above-mentioned research that every person has to be educated, but a special focus on poor communities might be a priority in South Africa. The researcher's support for the latter is the fact that if people from the poor communities are infected they cannot afford to have three full meals a day, which is essential if they want to take medication in order to prolong their lives. Some of the medication people living with AIDS (in future referred to as PWAs) have to take before, after or during meals. This is just one scenario that indicates how difficult it is to treat HIV+ people from poverty stricken communities. Poverty does not cause HIV/AIDS, but it makes it difficult to treat and prolong the life of infected people living in poor socio-economic communities. Education as a tool for prevention should thus be a priority. Most, if not all of the ALCs are situated in the working class areas. Unfortunately these are not used, like public schools to educate learners about HIV/AIDS. They however have the potential to offer short courses or programmes (HIV/AIDS education does not have to be part of the formal curriculum at the ALC). Ideally short courses or programmes should be offered on an ongoing basis (e.g. courses might be offered every term or semester). Partnerships should be formed with other role-players (business sector, NGOs, CBOs, religious organizations) to broaden the ALC's capacity in terms of human resources, material resources and finance.

2.3 THE ROLE OF ADULTS REGARDING HIV/AIDS EDUCATION

The word adult can mean many things to many people. Rogers (as cited in Tight, 1996: 13) claims that adult can refer to:

- a *stage* in the life cycle of the individual (first a child, then a youth, then an adult);
- *status*: an acceptance by society that the person has completed his or her novitiate and is now incorporated fully into the community;
- a social *sub-set*: adults and children; and
- a set of *ideals and values*: adulthood.

In order to put the word adult into perspective for this study the researcher preferred the UNESCO (as cited in Harley, Aitchison, Lyster & Land, 1996: 17) definition

which states that “people who are not in the regular school and university system and who are fifteen years and older can participate in adult education and are therefore presumably ‘adults’”. Most of the learners at FHALC are 18 years or older, but there are cases where 16 and 17 year olds attend ALCs. According to UNICEF, over 50% of young people (15-24years) “... have never heard of AIDS or harbour serious misconceptions about how HIV is transmitted” (UNAIDS and WHO, 2001:6). These organisations urge that young people should be provided with candid information and Lifeskills as a prerequisite for success in any AIDS response.

The preceding recommendation is one in which the ALCs/ CLCs can play a vital role in getting the correct information to the adult learners. ALCs are not only catering for the education of learners aged 18 –24 (the age group 15-24 are classified as young people according to UNAIDS), but also for older learners. These learners might be parents, family members, friends and peer educators of community members who are not attending ALCs. Adults can play a role in reducing teenage pregnancies, which is an indication that teenagers are at risk of being infected with HIV. In the Western Cape the teenage pregnancies as proportion of total deliveries increased from 8.2% in 1998 to 9.4% in 1999 (Western Cape Department of Health: 1999). The mere fact that teenagers still fall pregnant, shows that they need guidance in terms of high-risk activities (sex without a condom, alcohol abuse). The role of adults, especially parents to guide and protect their children, is one that needs to be addressed in HIV/AIDS education programmes. This should be seen in the light of the already mentioned fact that research done by the Kaizer Family Foundation and Kaufman Levin Associates (2000: 22) revealed that only eight percent (8%) of young people first learned about HIV from one or both of their parents, and only fourteen percent of youth said they got their first lesson about sex from a family member. This includes those who first learned about sex (not HIV/AIDS) from their mother only (7%), their father only (1%) or both parents (4%). According to Kaizer Family Foundation and Kaufman Levin Associates (2000) who did the South African National Youth Survey (SANYS) found that 91% of all youth heard of HIV/AIDS, but a large number of youth have misconceptions about an AIDS cure. There were two thousand youth aged

between 12-17 who participated in the SANYS. The following three misconceptions indicates the critical gaps in their (the youth) knowledge of HIV/AIDS according to the study:

- traditional African medicine has a cure which will completely heal ones body of AIDS (40% do not know this is not true);
- western medicine has a cure that will completely heal one's body of AIDS (42% do not know this is not true); and
- having sex with a virgin cures you of AIDS (25% incorrectly believe it is true).

Another area of concern is their knowledge about HIV transmission which the SANYS also revealed:

- men cannot get HIV/AIDS from other men (50% incorrectly believe it's true);
- HIV/AIDS is only spread by having sex with someone who is HIV positive or has AIDS (51% incorrectly believe it is true); and
- a person can get HIV/AIDS from condoms (39% incorrectly believe it is true).

The above misconceptions are a further indication of how important it is to educate adult learners about HIV/AIDS and the critical role they can play in educating our youth (not forgetting the roles they can play in educating others as indicated in chapter 1: figure 1.2). All people have the right to education in South Africa as it is seen as a basic human right, but the accessibility of education, especially for adults, remains a concern. It is however a concern that is beyond the scope of this study. The reality is that without the knowledge (concerning HIV/AIDS) adults would neither be able to protect themselves, nor be able to spread the correct information about HIV/AIDS. Even international organizations like UNICEF, UNAIDS and WHO (2002:7) realized the important role adults have to play, because “(p)arents, extended families, communities are critical in guiding and supporting young people to make safe choices about their health and well-being”. The latter can however not be taken for granted that all adults have the knowledge and skills to play that important role. It is however not impossible for adults to play that role if they are educated and trained to do so. HIV/AIDS education should be seen as a golden opportunity for government and the private sector and all other relevant

role players to make the 'lifelong learning' dream a reality in South Africa. The International Labour Office (ILO, 2000: 32) has identified NGOs and CBOs as the driving force behind many HIV/AIDS prevention and care activities at the community level. If this is the case in South Africa, then government and the business sector should strengthen their relationships (in terms of financial, human and material resources) with NGOs and CBOs to reach more people. According to Longworth and Davies (as cited in Maehl, 2000) the European Lifelong Learning Initiative's first Global Conference on Lifelong Learning in Rome (1994), expressed this active definition of Lifelong Learning, that it is " (a) continuously supportive process which stimulates and empowers individuals to acquire all the knowledge, values, skills, and understanding they will require throughout their lifetimes and to apply them with confidence, creativity and enjoyment in all roles, circumstances and environments". This is a fitting definition for the lifelong learning programmes that are needed, especially pertaining to HIV/AIDS education. Illingworth (1990) also stresses the importance of the lifelong learning concept when he warns that individuals need to be empowered with the correct information if it is expected of them to make informed choices regarding HIV/AIDS.

Adult education, according to Tight (1996: 59), does not only refer to the learners' age and status, but also encompasses the notion of participatory learning for its own sake and not for credit. This connects well with the lifelong learning concept and that people do not have to follow a formal accredited course to benefit from it.

2.4 THE IMPACT OF HIV/AIDS ON EDUCATION

According to The World Bank (2002) the AIDS epidemic is going to have the "most devastating and far-reaching" impact on education systems. South Africa is no exception, because educators are already dying from AIDS related illnesses. "HIV/AIDS is draining the supply of education, eroding its quality, weakening demand and access, drying up countries' pools of skilled workers, and increasing the sector's costs" (The World Bank, 2002: xvi). The very educators are dying that are supposed to educate children at school and at the same time they are also parents of children themselves.

According to Coombe (as cited in The World Bank, 2002) at least 12 percent of South Africa's teachers are HIV-positive. HIV/AIDS has a pronounced adverse impact on both the supply and the quality of education (The World Bank, 2002: 11). Adults other than educators will have to educate their children about HIV/AIDS.

2.5 GLOBAL AND REGIONAL OVERVIEW OF HIV/AIDS

According to the UNAIDS (as cited in Whiteside and Sunter, 2000) there is no place on earth untouched by HIV/AIDS. The only thing that differs is the degree of infection, where some regions are worst struck than others. Looking at the different regions (as shown in Table 2.2) it is quite clear that sub-Saharan Africa has the highest number of infected people and South Africa being part of that region has the unfortunate title of the country with the largest number of people infected with HIV/AIDS (UNAIDS/WHO, 2001).

TABLE 2.2:**REGIONAL HIV/AIDS STATISTICS AND FEATURES, DECEMBER 2001**

Region	Epidemic started	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV	Adult prevalence rate (*)	% of HIV-positive adults who are women	Main mode(s) of transmission (#) for adults living with HIV/AIDS
Sub-Saharan Africa	late '70s early '80s	28.1 million	3.4 million	8.4%	55%	Hetero
North Africa & Middle East	late '80s	440 000	80 000	0.2%	40%	Hetero, IDU
South & South-East Asia	late '80s	6.1 million	800 000	0.6%	35%	Hetero, IDU
East Asia & Pacific	late '80s	1 million	270 000	0.1%	20%	IDU, hetero, MSM
Latin America	late '70s early '80s	1.4 million	130 000	0.5%	30%	MSM, IDU, hetero
Caribbean	late '70s early '80s	420 000	60 000	2.2%	50%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	1 million	250 000	0.5%	20%	IDU
Western Europe	late '70s early '80s	560 000	30 000	0.3%	25%	MSM, IDU
North America	late '70s early '80s	940 000	45 000	0.6%	20%	MSM, IDU, hetero
Australia & New Zealand	late '70s early '80s	15 000	500	0.1%	10%	MSM
TOTAL		40 million	5 million	1.2%	48%	

* The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 2001, using 2001 population numbers.

Hetero (heterosexual transmission), IDU (transmission through injecting drug use), MSM (sexual transmission among men who have sex with men).

Source: UNAIDS/WHO. 2001.

The HIV/AIDS estimates in South Africa are based on the interpretation of data from women attending the antenatal clinics in each of the nine provinces. South Africa's HIV infection rate has been increasing for the past three years as can be seen in Table 2.3. The Western Cape has had the lowest rate of infection of all the provinces, but that can change as people from other provinces and even other African countries move to this province. Some of the reasons they are moving to this province is that it has a strong economy, good education system and better medical care than most of the other provinces or African countries.

TABLE 2.3: PROVINCIAL HIV PREVALENCE ESTIMATES: ANTENATAL CLINIC ATTENDEES, SOUTH AFRICA 1999-2001

PROVINCE	pos. 95% CI HIV	pos. 95% CI HIV	pos. 95% CI
	1999	2000	2001
KwaZulu-Natal (KZN)	32.5 (30.1-35.0)	36.2 (33.4-39.0)	33.5 (30.6-36.4)
Mpumalanga (MP)	27.3 (25.2-30.7)	29.7 (25.9-33.6)	29.2 (25.6-32.8)
Gauteng (GP)	23.9 (21.7-26.0)	29.4 (27.2-31.5)	29.8 (27.5-32.1)
Free State (FS)	27.9 (24.7-29.8)	27.9 (24.6-31.3)	30.1 (26.5-33.7)
North West (NW)	23.0 (19.7-26.3)	22.9 (20.1-25.7)	25.2 (21.9-28.6)
Eastern Cape (EC)	18.0 (14.9-21.1)	20.2 (17.2-23.1)	21.7 (19.0-24.4)
Limpopo (LP)	11.4 (9.1-13.5)	13.2 (11.7-14.8)	14.5 (12.2-16.9)
Northern Cape (NC)	10.1 (6.6-13.5)	11.2 (8.5-13.8)	15.9(10.1-21.6)
Western Cape (WC)	7.1 (4.4-9.9)	8.7 (6.0-11.4)	8.6 (5.8- 11.5)
National	22.4 (21.3-23.6)	24.5 (23.4-25.6)	24.8 (23.6 – 26.1)

N.B. The true value is estimated to fall within the two confidence limits, thus the confidence interval is important to refer to when interpreting data.

Source: Department of Health report (2002)

It is interesting to compare the Department of Health study with the Nelson Mandela/HSRC Study (see Table 2.4) in terms of South Africa's HIV estimates. In the Department of Health studies there seem to be a steady increase in the number of HIV infections each year (1999-2001), while the Nelson Mandela/HSRC Study indicates a much lower national infection rate for 2002. One of the reasons why the two studies estimates might differ is due to the fact that the Nelson Mandela/HSRC Study (2002) attempts to study a representative sample of South African people, while the South African Department of Health gather their data from women attending antenatal clinics.

**TABLE 2.4: OVERALL HIV PREVALENCE BY PROVINCE, SOUTH AFRICA
(2002)**

PROVINCE	pos. 95% CI HIV: 2002
KwaZulu-Natal (KZN)	11.7 (8.2-15.2)
Mpumalanga (MP)	14.1 (9.7-18.5)
Gauteng (GP)	14.7 (11.3-18.1)
Free State (FS)	14.9 (9.5-20.3)
North West (NW)	10.3 (6.8-13.8)
Eastern Cape (EC)	6.6 (4.5-8.7)
Limpopo (LP)	9.8 (5.9-13.7)
Western Cape (WC)	8.4 (5.0-11.7)
National	10.7 (6.4-15.0)

N.B. The true value is estimated to fall within the two confidence limits, thus the confidence interval is important to refer to when interpreting data.

Source: Nelson Mandela/HSRC Study (2002)

The Nelson Mandela/HSRC Study (2002) study is the first of its kind in South Africa where all the races were included, unlike the HIV/AIDS prevalence statistics from other South African studies, which were based on data collected from antenatal clinics by the Department of Health. Some of the problems with the latter information were that whites did not attend these antenatal clinics, so there was not sufficient data for whites and the

focus was mainly on pregnant women. The two studies researched different populations and yielded different results. The Nelson Mandela/HSRC Study focused on a representative sample of a broader South African population. The latter study could provide HIV prevalence levels amongst children and adults. The Department of Health study was a better indicator of the HIV prevalence rate amongst sexually active woman. The latter study is not a good study for drawing conclusions for other groups of the South African population, except for the sexually active section of society. “(The) antenatal surveys are the recommended surveillance tool to estimate HIV in populations” (Department of Health, 2001: 1). These antenatal surveys are internationally recognized by WHO and UNAIDS.

There has been a dramatic increase in South Africa’s HIV infection rate since the early 1990’s, especially if you consider that Whiteside (1993) estimated at that time that South Africa’s level of infection was amongst the lowest on the African continent. Nearly a decade later South Africa is the country with the highest number of infections according to UNAIDS (2000). If this country does not stem the tide, HIV/AIDS will not only lead to death, but South Africa is going to have more orphans and at the same time HIV/AIDS will have a negative impact on this country’s economy. To slow the spread of the disease in South Africa the UNAIDS/WHO (2001:16) made a special plea “... for greater prevention efforts targeted at older age groups, and tailored to their realities and concerns”. Talk about HIV/AIDS (e.g. having workshop or conferences) is not going to help unless we start implementing strategies to prevent HIV/AIDS spreading further and faster.

2.6 THE IMPACT OF HIV/AIDS ON THE SOUTH AFRICAN ECONOMY

HIV/AIDS is not only affecting the education sector, but also business. Swanepoel (2002) disclosed that 605 out of 12092 full-time employees are infected with HIV at Old Mutual South Africa. The highest infection group was the 45-50 year age group in this company. This is further proof that we cannot only focus our HIV/AIDS education on school going

children, but people of all ages have to be educated. According to Swanepoel (2002), an actuary of Old Mutual South Africa, was quoted as saying that the survey done at their company showed that HIV/AIDS is not a illness that only occurs amongst the poor, blacks, people from the rural area and people who are single. According to Kok (2002) even big mining companies such as Gold Fields saw the need to educate their workforce, which has an estimated 26% to 28% HIV-positive population. Gold Fields has a prevention programme as well as a care and support network in place. Another big company, DaimlerChrysler South Africa (DCSA) with the approval of the National Union of Metalworkers of South Africa (NUMSA), embarked on a HIV/AIDS awareness and support and care programme (International Partnership against AIDS in Africa (IPAA)/ UNAIDS, 2001). According to Knigge (as cited in IPAA/UNAIDS, 2001), who is a public health advisor and epidemiologist at the German Agency for Technical Co-operation (GTZ) and who helped DCSA to implement their HIV/AIDS scheme, “...(companies that) run extensive HIV/AIDS programmes like DCSA’s are still a minority-not just in South Africa, but across the continent” (IPAA/UNAIDS, 2001:2).

HIV/AIDS will touch us as a nation on different spheres and the sooner more employers realize that they need to invest money in their workers’ well being, specifically HIV/AIDS programmes, the sooner they will be able to curb the negative effect it will have on their businesses rather than turning a blind eye to the HIV/AIDS challenge. Loewenson and Whiteside (1998) warn of the demographic, economic, social and developmental impacts HIV/AIDS will have on South Africa as illustrated in Table 2.5. Naidu (2002) and Quatteck (2000) echo’s roughly the same problems that HIV/AIDS will create for South Africa’s economy as Loewenson and Whiteside. Naidu (2002) raises the concern that there will be a decrease in the number of new clients entering the market due to a drop in the number of children and simultaneously an upsurge in the ageing population sector due to HIV/AIDS. “HIV/AIDS changes the size, structure and composition of the South African population” (Naidu, 2002: 7).

TABLE 2.5: THE DEMOGRAPHIC, ECONOMIC, SOCIAL AND DEVELOPMENTAL IMPACTS HIV/AIDS WILL HAVE ON SOUTH AFRICA.

IMPACTS	IMPLICATIONS	EFFECTS
<i>Demographic</i>	Increase morbidity (many in their reproductive years)	Reduced fertility; Increase orphans
<i>Economic</i>	Increase in medical care and related costs; Increase in social welfare demand; Increase in absenteeism; Increase in training costs to replace skilled workers; Lower productivity	Production and income of household will be reduced; Reduction in labour force; Smaller profit
<i>Social</i>	Higher illness and death of workers	Affect the family, community and country; More orphans
<i>Developmental</i>	Longevity Standard of living Infant, child and maternal mortality Distribution of income	A generation of children may grow up without care and role models; Demographic, economic and social impacts will have effect on development

Naidu (2002) gives ten suggestions to the business sector in order to sidestep the impact of HIV/AIDS. Only three of the suggestions will be highlighted as they pertain directly to this study. He proposes that business should:

- launch a HIV/AIDS policy and implement intervention programmes;
- educate their workers and the community, so doing ensuring that external clients or customers will also be reached; and
- cooperate with suppliers and community based organizations (CBOs) in intervention strategies.

Nothing stops businesses from forming partnerships with an ALC or a CBO and with their financial backing allowing ALCs to be used as HIV/AIDS hubs for their staff and their family members and community members to be educated about HIV/AIDS and related issues. If no well functioning CBO exists in a community, especially where an ALC already exists, then that collaboration between business and the ALC should be a priority in terms of working together to educate the community it serves. Business, together with the government could make access easier by carrying the cost for the unemployed (including those who lost their work, school dropouts and orphans). Education is the only means of slowing the spreading of the disease. The socio-economic impact that HIV/AIDS is starting to have and continues to have is graphically illustrated in Figure 2.1. Looking at the implications of Figure 2.1 (see next page) it makes even more sense why whole communities have to be educated and trained about HIV/AIDS.

2.7 ORGANISED LABOUR AND HIV/AIDS

Crewe (1992: 79) feels that unions have the power to place pressure on employers to educate their workers "... to raise their consciousness about AIDS and to inform them that they can make important and informed choices about their sexuality". In the early nineties the unions regarded the illness as serious, but sustained education programmes were not a priority for them (Crewe, 1992). Unions are now starting to see the important benefits a HIV/AIDS policy and programme holds for its members. COSATU (2000), one of the biggest trade unions in South Africa, published a guide for its shopstewards to assist its members by:

- protecting workers from HIV infection by upgrading health and safety at the workplace;
- protecting workers who are infected; and
- providing support for workers and their families who may be too sick to work due to HIV/AIDS.

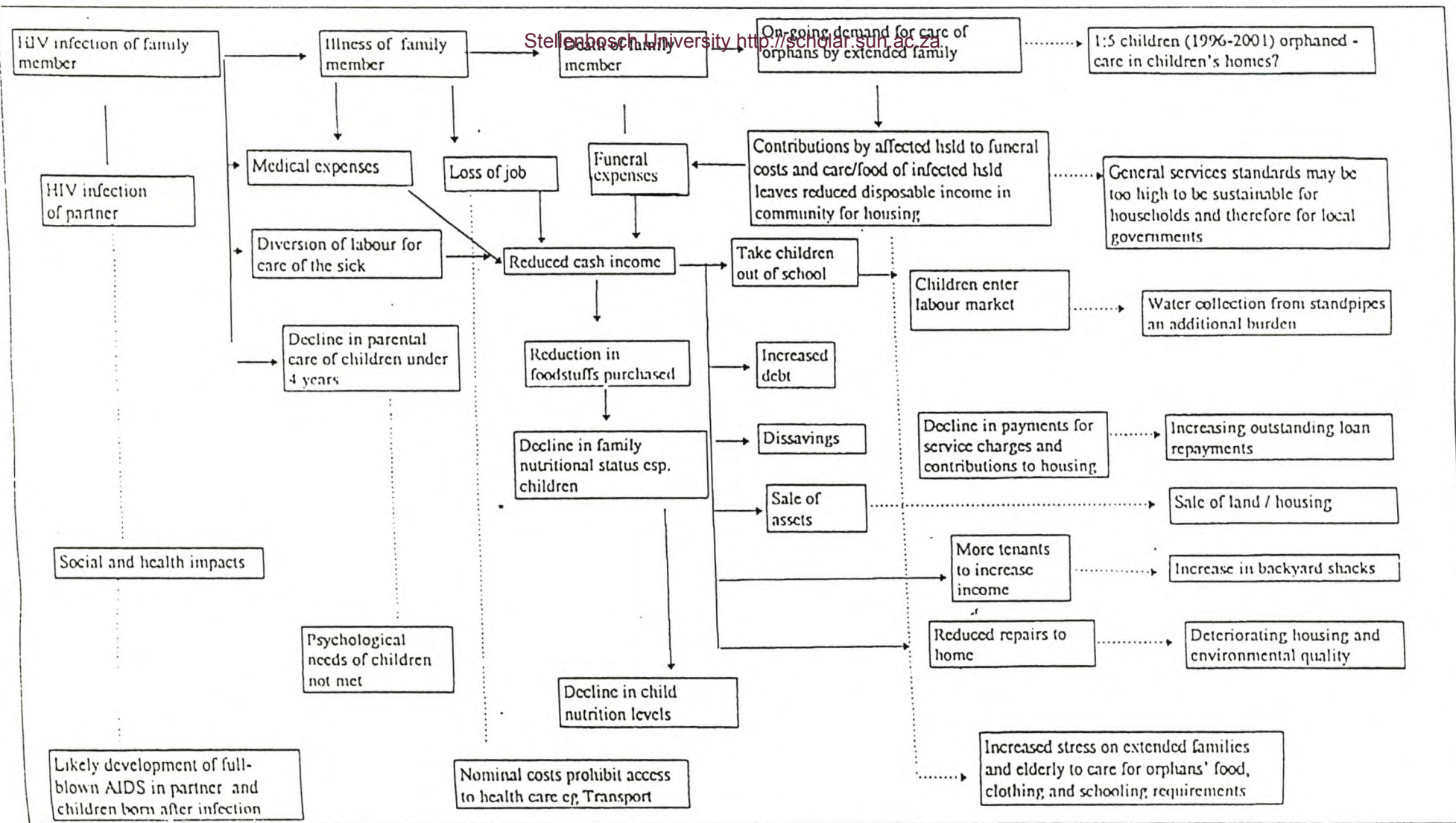


Figure 2.1: A RANGE OF POSSIBLE SOCIOECONOMIC IMPACTS OF AIDS ON POOR URBAN FAMILIES

Source: Whiteside, A. 1998

2.8 DROPOUT RATE AT THE ALC

The dropout rate refers to the number of learners who do not complete the whole school year and quit. According to the centre manager of FHALC, Mr. P. Tekana (personal communication, March 5, 2002) the annual dropout rate at FHALC is between 35% and 45%. Due to the high dropout rate, the researcher is arguing for short courses or training programmes to be offered to adult learners who are interested in a specific topic, like HIV/AIDS for instance. Not forgetting Tobias's (1998) argument in the previous chapter that not all people want to study lengthy courses, it might be more viable and practical to offer short courses or training programmes to communities. This will enhance lifelong learning in the communities where these short courses are offered.

2.9 ORPHANS DUE TO HIV/AIDS

According to UNAIDS, orphans are children who either lost a mother or both their parents due to AIDS. Orphans usually dropout of school. The latter can be due to many factors, like the lack of parental guidance, caring for a sick relative, no food or home, elderly children having to take over the parental role in terms of providing for younger family members. This is not unique to South Africa. According to The World Bank (2002: xviii) "...there is evidence (in some countries) of lower enrollment and higher dropout rates among orphans ...". This will also lead to an escalating crime rate as crime is mainly committed by teenagers and young adults according to Smith (1995) as cited in Schönteich(1999), because most of them will not complete school and will not find legal work due to the Labour Law Act, which prohibits children younger than sixteen from being employed to protect them from exploitation. It will be difficult for orphans even if they are 16 years and older to compete for jobs in a country with an already high unemployment rate. This will force some of them into crime and prostitution. Taking the latter into account it becomes a reality that the risk of HIV infection is bigger, especially if these orphans are not educated about HIV/AIDS. The number of orphans (due to AIDS or not) and out-of-school youth (because of falling pregnant, caring for a sick relative, forced to increase household's income) from the past few years is quite substantial and it

keeps on growing. These groupings are predominantly in the working class communities. There is a need to cater for them in terms of HIV/AIDS education and ALCs can play a big role in providing them with such opportunities. If we do not cater for these groups the spreading of HIV/AIDS and all the negativity that goes with it will just become bigger. Morgan (2000:3) raises the issue that all children will be touched by HIV/AIDS and not only those whose family members are HIV infected. He makes the reader aware that everyone, and more especially the children, will feel the impact of the socio-economic consequences of the epidemic, such as deteriorating levels of education, healthcare and social services. Adults have certain responsibilities towards the children of this country, and one of these is to educate and provide them with the correct information.

2.10 BASIC HIV/AIDS INFORMATION

According to the literature review it is apparent that adults will also have to be educated about HIV/AIDS in order to understand the impact HIV/AIDS will have on all the people of South Africa. Adult Learning Centres can play an important role in educating people about HIV/AIDS, especially basic knowledge about HIV/AIDS, namely:

- what HIV/AIDS is;
- the window period;
- how you can become infected with HIV;
- how you cannot get HIV;
- myths; and
- stigmatization.

2.10.1 The difference between HIV and AIDS.

HIV (Human Immune-deficiency Virus/ Human Immunodeficiency Virus) is not AIDS (Acquired Immune Deficiency Syndrome). HIV causes AIDS.

The immune system that looks after your body is made up of white blood cells (in the future referred to as WBCs). Any foreign body/bodies in the form of germs, which enters your body, will be attacked and ultimately destroyed by WBCs. The WBCs produce

antibodies (germ fighters) to attack germs. The germ HIV however attacks the WBCs themselves. The battle between HIV and WBCs can sometimes last years. HIV destroys most of your WBCs leaving your body defenseless against germs. HIV sets the stage or platform for other germs to attack and kill the body: *Acquired Immuno-Deficiency Syndrome* (AIDS).

At this present moment there is absolutely no cure for AIDS and the only line of defense is to educate people about the disease. The saying 'prevention is better than cure' is very much applicable in the scenario the world is in right now regarding HIV/AIDS.

2.10.2 The window period

This is the time or period (usually 2 weeks to 3 months) where a person who is infected with HIV will test HIV- (negative). During this time the person can infect other people and at the same time look and feel healthy. Figure 2.2 is a graphic illustration of the different stages a person goes through before they die.

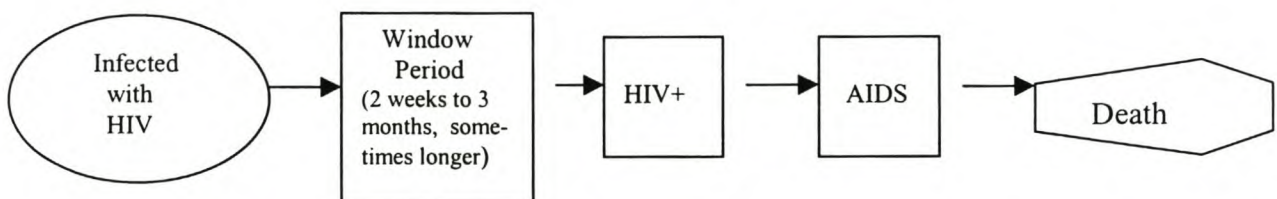


FIGURE 2.2: STAGES OF HIV/AIDS

The time of infection to the time of death can last more or less eight to ten years, but due to the fact that infected people are being educated about their dietary needs, better medical care and support from their families and friends, there are people like David Patient and Jeff Bosacki who are HIV+ for nearly twenty years or more.

2.10.3 Modes of transmission

There are only a few ways a person can be infected with HIV. The virus can only be transmitted in certain ways, thus making it a preventable disease if people are educated about the disease. Whiteside and Sunter (2000) rank the main modes of transmission in order of importance:

- sexual intercourse (anal, oral and vaginal) without a condom;
- infected mother to child;
- intravenous drug use with contaminated needles;
- use of infected blood or blood products; and
- other modes of transmission involving blood including bodily contact involving open bleeding wounds.

The main mode of infection in South Africa is through unsafe sex (sex without a condom). “Fortunately, intravenous drug use is not an issue in South Africa as yet” (Whiteside & Sunter, 2000: 14). Looking at Table 2.2 on page 33 we can see that regions differ in terms of their main mode(s) of transmission.

2.10.4 How you cannot become infected

HIV can only be transmitted from an infected person to another through the above-mentioned modes. The virus cannot be transmitted by animals or insects to a human being. Nor can it be transmitted by shaking hands with an infected person, sharing the same cup or spoon with an infected person. People can hug, play sports, and use the same swimming pool or toilet without fear of getting infected. Due to the known modes of transmission, it is imperative that all people are educated about how HIV is transmitted and not transmitted.

2.10.5 Myths surrounding HIV/AIDS

There are an unbelievable number of myths being spread by people who are not educated about the true facts about HIV/AIDS. One misconception is that to have sex with a virgin will cure you from HIV/AIDS. This leads to an increase in young girls and even babies being raped. Another misconception is that if a HIV+ woman falls pregnant, then a drug like Niveropine will cure her and the baby. The drug however just reduces the chances of the baby becoming infected and in no way cures the mother, in fact it increases the chance of the HIV+ mother infecting her partner if he is HIV-. There are many other myths that are making the fight against AIDS even more difficult, because more people are becoming infected and spreading the virus through ignorance. This topic about myths is covered in more depth in other sources (Whiteside & Sunter, 2000; UNAIDS, 2002a; Crewe, 1992) than the researcher can go into in this study.

2.10.6 Stigmatization

“The Declaration of Commitment, adopted by the United Nations General Assembly Special Session on HIV/AIDS in June 2001, highlights global consensus on the importance of tackling the stigma and discrimination triggered by HIV/AIDS” (UNAIDS, 2002a: 5). UNAIDS attributes the stigma and discrimination activated by HIV/AIDS to “... people (lacking) the education to understand that HIV/AIDS cannot be transmitted through everyday contact, and they may not know that infection can be avoided by the adoption of relatively simple precautions” (UNAIDS, 2002a: 5).

Powell-Cope and Brown (as cited in Derlega & Barbee, 1998) state that family members and friends of the HIV infected person are concerned about being stigmatized by association and often go to great lengths to keep their loved one's HIV status secret. We need to educate as many people as possible about HIV/ AIDS, especially if we do not want people to feel uncomfortable if they meet family or friends who are either infected by the disease or who might be affected by the disease. Derlega and Barbee (1998:28) argue that many people pull back from HIV+ (positive) friends and family out of uncertainty and awkwardness (rather than out of malice or prejudice). They suggest that

educative interventions could provide the public with guidelines that would facilitate interactions with those who are infected. In so doing we can diminish (if not eradicate) discrimination against *people living with AIDS* (PWA's) out of ignorance. People, especially adults need to be educated about HIV/AIDS and related issues, because they have an important role to play in fighting this disease and at the same time destroying the misconceptions surrounding it.

People should not only focus on high risk groups or on people practicing high risk activities, because the ignorant and misinformed masses also need education if the Declaration of Commitment adopted by UNAIDS is seen as a priority. If the education of the masses is not seen as serious the researcher wants to remind people what happened to a South African woman, Ms Gugu Dlamini, after she disclosed her status on World AIDS Day in December 1999. "(She) ...was stoned and beaten to death by neighbours in her township near Durban ..." (UNAIDS, 2002a: 11). Except for the fear of rejection from their own communities HIV-positive status people might also be discriminated against in the workplace, although laws exist to guard against such discriminatory practices. "An airline attendant in South Africa was denied employment based on his HIV-positive status" (UNAIDS, 2002a: 11). These are only two cases of people who were misinformed about HIV/AIDS, but through their actions (killing and denying a person employment) they showed that all people need to be informed and educated about HIV/AIDS. This did not happen in another country, it happened in South Africa and very recently, so there is work to be done in terms of planning and educating.

"AIDS evokes fear, anger social ostracism, and victimization ..., because AIDS often is perceived by society as shameful, mysterious, contagious, and sexually transmitted" (Zlotnik, 1987:2). In the light of the latter Zlotnik (1987) urges that HIV/AIDS education should not only focus on prevention, but also on the eradication of stigmatization of those affected by the disease. The safest way not to discriminate against any person is to treat all people as if they are HIV+, because you cannot see if somebody is HIV+ and the majority of people who are infected do not even know their status.

2.11 KNOWLEDGE AND EDUCATION REGARDING HIV/AIDS

Since the mid 1980's HIV/AIDS became a global problem. There was and still is no cure for HIV/AIDS, so it was clear that unless millions of people were quickly taught about how to avoid HIV, it would spread even faster (AIDS Law Project and AIDS Legal Network, 2001: 32) The members of the United Nations unanimously adopted the Declaration of Commitment, which is a pledge to stop and begin to reverse the spread of HIV/AIDS by 2015. One of the Declaration of Commitment's global goals is "... to ensure (by 2005) that at least 90% of young people aged 15-24 have access to information, education and services necessary to develop the Lifeskills needed to reduce their vulnerability to HIV, and 95% by 2010" (UNAIDS, 2002b: 12). ALCs, CBOs and the business sector will have to be part of the campaign if these targets are to be reached in South Africa. Another powerful global player, the World Bank, is also seeing the important role education can play in minimizing the impact of HIV/AIDS. The World Bank (2002) does not only see education as a major engine of economic and social development, but also as a proven means to prevent HIV/AIDS. Education as a tool for prevention cannot only be focusing on children at primary and high school level, because HIV/AIDS can infect anyone, especially those who are sexually active.

According to Whiteside and Sunter (2000:138) most adults are sufficiently aware of AIDS, but the majority of South Africans do not really understand the epidemic or its nuances and subtleties. "People need to appreciate for example the difference between HIV and AIDS, the scale of the problem and the future trends with and without positive interventions" (Whiteside & Sunter, 2000:138). Abstinence is the safest way to combat the spread of HIV, but Tonks (1996:42) argues that sexually active people will continue to engage in sexual activity and therefore urges the use of condoms to considerably lower the risk of HIV infection.

"The need for capacity building is enormous, as the countries most challenged by Education for All (in the future referred to as EFA) and HIV/AIDS objectives are in many cases the ones least equipped to attract resources, use them effectively, and

demonstrate their effective use” (The World Bank, 2002:62). The goals of EFA envisaged by The World Bank are that education can improve a country’s economy and it (education) can play a vital role in preventing HIV/AIDS. According to the World Bank, education (schools and ALCs) provide the ideal platform or “ready made infrastructure” for supplying HIV/AIDS prevention efforts to schoolchildren, youth and especially adults who are sexually active.

2.12 COMPLACENCY REGARDING HIV/AIDS EDUCATION

Education should not be seen as a ‘once off’ thing and as soon as a subsequent decrease in the spreading of the virus is detected people must not believe they don’t have to talk about HIV/AIDS any more. Aggleton (1997) attributes this mindset to the people in Britain who thought the epidemic was under control and consequently not much was said about AIDS, while the opposite was true ten or more years prior to 1996. The researcher (Aggleton) assures us that HIV/AIDS is definitely not under control and that complacency can cost countries dearly. “No matter where you live, no matter how old you are, and no matter how good a life you have led, you can acquire HIV infection through having unprotected anal or vaginal sex (with oral sex the risk is much lower)” (Aggleton, 1997:11). The moral of the story is that even if the spread of the virus is slowed dramatically, HIV/AIDS education will have to be part and parcel of our prevention strategy.

2.13 CONCLUSION

The largest number of people infected with HIV in our country is from the predominant poor, black community. Organisations like the UNAIDS and WHO are urging countries to educate their people about HIV/AIDS in order to curb the spread of the virus. There already seems to be infrastructure in place in most of our poor communities in the form of ALCs, which could be used as venues for HIV/AIDS education.

HIV/AIDS will not only have a negative impact on our country's economy and education, but also on our country's developmental, social and demographic spheres as has been highlighted in this chapter.

The researcher wants to reiterate the fact that there is no cure for HIV/AIDS, but that education is the only 'vaccine' people have against the disease. The literature review should be strong enough evidence to advocate that HIV/AIDS education should be offered to all people, not only school children or so-called high-risk groups (e.g. prostitutes, homosexuals, long distance truck drivers practicing unsafe sex, intravenous drug users). During the apartheid-era there was a slogan, *education for all*, but now the slogan should be: *HIV/AIDS education for all*. HIV/AIDS education is not only a vehicle to prevent the spread of the disease, but also to reduce the stigma and discrimination triggered by HIV/AIDS. Education as a preventative and awareness tool needs the backing of government, business sector, organized labour, NGOs and community organizations if countries (including South Africa) are serious about the impact HIV/AIDS will have in the long term.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The previous chapter dealt with a review of the literature based on the impact HIV/AIDS will have on South Africa and the role ALCs can play in educating adults about HIV/AIDS. Books, journals, papers, magazines and electronic sources (websites) were used to carry out the review. According to Mouton (2001: 138) there are three kinds of knowledge distinctions that can be made. He classifies them in *three worlds*, namely:

World I: The world of everyday life and lay knowledge

This is the knowledge that we have acquired through learning, experience and self-reflection. This is the knowledge that we use in everyday life to cope effectively with our daily tasks.

World II: The world of science and scientific research

The search for “truth” or “truthful knowledge” is the overriding goal of science. Perhaps the most distinctive feature of the scientific enterprise is that the scientist selects phenomena from *World I* and makes these into objects of inquiry.

World III: The world of meta-science

The world of meta-science consists of the meta-reflective disciplines (philosophy and sociology of science) that make the

world of science into an objective of critical inquiry and reflection. Meta-science is characterised by the critical interest, which is the interest in improving science (Mouton, 1996: 11).

In this study regarding the NQF-level 4 learners of the FHALC the pretest is a reflection of the learners World I knowledge and the actual study (including the literature review, questionnaires and interview data) is part of World II.

The current chapter is a representation of the design and methodology of the study that has been undertaken by the researcher in addressing the research problem. This chapter expands on:

- Research design.
- The sampling of subjects.
- Methods of selecting a sample.
- Sampling strategies.
- Instruments for data collection.
- Pilot study.
- Implementation of the questionnaire.

3.2 RESEARCH DESIGN

There are different approaches to acquiring knowledge (e.g. tenacity, intuition, authority). but the best approach is the scientific method of inquiry. The scientific method as a logic of inquiry must comply with certain characteristics (Christensen, 1988). The first characteristic of the scientific method is control, which allows the researcher to identify causation. The second is operational definition, which simply means that terms must be defined to eliminate confusion in meaning and communication of the steps or operations used in the study. The last characteristic is replication, which refers to the fact that scientific observations that are made must be able to be repeated. Christensen (1988: 219) defines the research design as the outline, plan, or strategy that specifies the procedure to be used in seeking an answer to the research question. In other words the research design should enable the researcher to anticipate what the appropriate research decisions should be so as to maximize the validity of the eventual results.

This study was an experimental design. The possibility of causal inference derives from the use of randomization techniques, experimental and comparison groups, and repeated measures over time (Mouton, 2001: 155). The study involved all the NQF-level 4 learners who were registered before 15 February 2002 at the FHALC. The tools used in this study for information gathering purposes were questionnaires and interviews. One questionnaire was constructed and administered to the NQF-level 4 learners. The questionnaire was bilingual (in English and Afrikaans), although the majority of learners were Afrikaans speaking, there were a few learners whose first language is English.

The unit of analysis refers to the *what* of the study: what “object”, “phenomenon”, “entity”, “process” or “event” I am interested in investigating (Mouton, 2001: 51). The unit of analysis of this study is the NQF-level 4 learners. “...(W)henever (you) study human behaviour, historical or social programmes...(you are)...busy with empirical research” (Mouton, 2001: 52).

The study was based on the *two group pre-test, post-test, post-post-test* design. The latter design is also known as the *before-after research design*, which Christensen (1988: 246) defines as “a true experimental design in which the treatment effect is assessed by comparing the difference between the experimental and the control groups’ pre-...posttest (and post-posttest) scores”. It is important to compare one set of pretest data with the other to reveal the extent to which the two samples are equal. “...(I)f the two groups are demonstrably equal in the crucial respect, and yet responding differently to different treatments, and if one group moreover is an untreated control, then the case for arguing that the difference is caused by the difference in treatments becomes all the stronger” (Dyer, 1995: 96). The before-after research design is a good design, because it minimizes the contamination by extraneous variables (any variable other than the independent variable that influences the dependent variable) like history and maturation (Christensen, 1988).

History refers to an extraneous variable occurring between the first and second measurement of the dependent variable. Maturation “...occurs when the results of research not employing randomization are contaminated by the participants’ having e.g., grown older or wiser...or more experienced between the pretest end the posttest” (Rosenthal & Rosnow, 1991: 622).

In order to avoid biased information the participants were randomly divided into a control group and an experimental group. The first 15 men and first 15 women drawn out of a box were part of the experimental group and the rest of the participants were the control group. This process is called randomization and “... is to control for the possible effects of individual differences” (Mouton, 1996: 143). The control group refers to the group which did not receive the intervention (HIV/AIDS programme), while the experimental group is the one who received the intervention. Christensen (1988) maintains that a control group serves two functions, namely that:

- it serves as a source of comparing the control and experimental group to see if the intervention made a difference, whilst all other variables were controlled; and

- it serves as a control for rival hypotheses, that is that “(a)ll variables operating on the control and experimental groups must be identical, except for the one being manipulated by the experimenter” (Christensen, 1988: 227).

Christensen (1988) further warns that the subjects in the control and experimental groups must be similar.

The initial intervention was scheduled for Saturday, 23 February 2002, but most of the participants had other commitments and the researcher had to postpone the intervention programme to the following Saturday (March 2, 2002). Five (three men and two women) of the original 30 experimental group's participants had to be replaced, because they had other commitments on Saturdays. The researcher had to draw names from the box to replace five experimental group members.

The goal of the study was to obtain an objective view of the learners HIV/AIDS-knowledge levels. The prescribed plan of action that was followed in this study was to administer the questionnaires to the learners at the FHALC. A questionnaire was designed in order to collect data about the study under investigation. All questionnaires were administered at the FHALC in the presence of the researchers. No questionnaires were mailed or given to participants to complete at home. The participants were assured of their confidentiality and at no stage did they object to be part of the process. It was not possible to study all the NQF-level 4 learners in Western Cape, let alone the whole of South Africa. Due to the latter the researcher focused on the learners attached to FHALC.

Generalisations were made on the basis of observation of variables within a small proportion of the population, which is referred to as the sample. The limitation of the experimental design however makes generalisability risky due to the small sample size (Mouton, 2001: 156). All the NQF-LEVEL 4 learners were participants in the study. The researcher used random sampling in choosing the experimental group. Prior to the initial study the researcher did a pilot on ten (NQF-level 4) individuals who completed the studies at the end of 2001 at the FHALC.

3.3 THE SAMPLING OF SUBJECTS

“A sample is the group of individuals, who are selected from within a larger population by means of a sampling procedure, and who actually generate the data for the research” (Dyer, 1995: 89). This means that a sample is a representative subset of a population. Seltiz and Cook (as cited in Mouton, 1996:134) define a population as “the aggregate of all the cases that conform to some designated set of specifications”. Mouton (1996) warns that the population that the researcher is interested in has nothing to do with the “everyday notion of the population in a certain country or city”. A population is always all of the individuals who possess a certain characteristic or set of characteristics (Wallen & Fraenkel, 1991). The population of this study refers to NQF-level 4 adult learners. The NQF-level 4 adult learners at Forest Height’s Adult Learning Centre (FHALC) were select as the sample for the researcher’s study.

3.4 METHODS OF SELECTING A SAMPLE

The selection of a sample for a research study is very important, as it determines the generalisability of the study. “Sampling is a necessary procedure whenever a researcher wishes to draw some conclusions about a group of individuals, but when it is not possible to gather information from each individual member of the group, usually because the group is simply too large for every member to be contacted” (Dyer, 1995: 89). Sampling more often than not results in more adequate data. The information obtained from the sample selected should give results comparable to those that would have been obtained if the entire population were studied. If this is achieved the sample used in the study is seen as truly representative of the population.

The individuals or participants selected subsume a sample and the large group is referred to as a population. The intention of the sample is to acquire information about a population. The participants of this study were selected on the basis that all NQF-level 4 learners who registered before February 15, 2002 would be asked to be part of the study. None of the participants refused to be part of the study.

3.5 SAMPLING STRATEGIES

In order to give each and every member of the population an equal chance of being selected it is best to use a simple random sample according to Wallen and Fraenkel (1991). “The larger a random sample is in size, the more likely it is to be representative of the population” (Wallen & Fraenkel, 1991:133). A large sample size however does not guarantee it to be representative of the population, but increases the likelihood of it being so. The generalization of the results of the study has a direct bearing on the external validity of the study. In other words, “... the aim of research is often to study a representative number of events or people with a view to generalizing the results of the study to a defined population or universe” (Mouton, 1996:133).

Randomisation is a statistical control technique that limits the chances of a biased sample.

3.6 INSTRUMENTS FOR DATA COLLECTION

“The collection of information for a study is called measurement” (Katzenellenbogen & Joubert, 1997: 82). According to Katzenellenbogen and Joubert (1997) it is a key aspect of research, because it is the method by which researchers obtain values for characteristics (variables) of the individuals they study.

Several methods and techniques of data collection were used in this single study. This process is known as triangulation or multiple operationism. Borg and Gall (1989: 411) defines triangulation as “the technique of using several kinds of data-collection instruments to study a single problem”. By making use of various methods of data collection it not only complements each other, but their respective weaknesses can be balanced out (Mouton, 1996). The data-collection instruments used in this study were questionnaires, interviews and literature reviews. According to Merriam (1988: 172) triangulation strengthens reliability as well as internal validity.

The researcher made use of qualitative and quantitative data, which are both interpretations of experience according to Merriam (1988: 68). Qualitative data is mediated through words and quantitative data is mediated through numbers. In this study the qualitative data was obtained through interviews and the quantitative data obtained through the use of questionnaires.

3.6.1 The questionnaire

“The questionnaire is generally regarded as a form distributed through the mail or filled out by the respondent under the supervision of the investigator or interviewer” (Good, 1972: 226). A questionnaire is the basic research tool in the social sciences, which is capable of being tailored to the demands of almost any research topic (Dyer, 1995: 112). The first measurement instrument used in this study was a self-administered questionnaire. Respondents had to read the questionnaires independently and fill in the questionnaire by themselves. Whether a questionnaire is self-administered or posted to respondents, it has to be extremely clear and well laid out, since untrained people will be completing them (Katzenellenbogen and Joubert, 1997).

The pre-test was administered on 18 and 19 February 2002. It was done over two days (Monday and Tuesday), because not all the learners attend classes on the same day. The post-test was done on 4 and 5 March 2002 and the post-post-test on 24 and 25 June 2002. Participants took on average 12-15 minutes to complete the self-administered questionnaire.

3.6.2 Questionnaire Construction

The questionnaire consisted of two parts. The first part focused on demographical information about the participant. The second part focused on the actual knowledge of the individual. Refer to Appendix A for an example of the questionnaire.

Mouton (2001), Dyer (1995), Good (1972), Munn and Drever (1991) point out some principles of questionnaire designing:

- The language used in the questionnaire should be kept as simple as possible.
- Short questions are always better than long ones.
- Questions must not be asked in such a way that the responses will be embarrassing to the individual.
- Each question should be checked for a double-barrelled structure (a question consisting of two or more questions joined together).
- Avoid negative questions (a question is posed in a negative rather than in a positive form).
- Avoid leading or biased questions (a question which points the respondent to a certain answer).
- Avoid using jargon, slang or abbreviations in items.
- Research has shown that the length of the questionnaire or test has a direct and often negative impact on the quality of the responses (Mouton, 2001: 104).
- The ideal questionnaire must not be too suggestive or too unstimulating, especially with reference to choices.
- There should be a balance of both negative (inviting a 'no' response) and positive (inviting a 'yes' response) questions in the questionnaire.
- Questions should be asked in such a way as to allay suspicion on the part of the respondent concerning hidden purposes in the questionnaire.

Mouton (2001: 103) also warns against fictitious constructs, which occurs when researchers sometimes measure constructs or attitudes that do not exist, e.g. asking people about matters of which they have no knowledge.

Questions in a questionnaire could either be open-ended or close-ended. "Open-ended questions are those which do not limit the nature of the response in any way" (Dyer, 1995: 116). The response to a open-ended question is infinitely wide and should be taken into account when planning the data analysis. Such questions are usually used in focused and in-depth questionnaires and interviews, with the added burden of it being time

consuming and expensive in terms of data analyzing. The close-ended question provides a "...range of possible responses to a question (and) is completely determined by the researcher" (Dyer, 1995: 115). All that is required from the respondent is to select one response from a range of possible answers. Close-ended questions are ideal for collecting straightforward factual information such as particulars of the sex, age, or the marital status of a respondent.

The questions were arranged in a specific sequence, from the easy ones to start with to the more difficult ones at the end. The items were designed such that it would make it possible for the respondents to answer honestly without fear of embarrassment. Dyer (1995) suggests that any open-ended questions should be towards the end of the questionnaire.

For the purpose of this study the researcher used closed-ended questions. The section where their knowledge were tested, gave the respondent three options, namely *yes*, *unsure* and *no*. The *unsure*-option was also included to minimize guessing, and at the same time gave the researcher an indication that the respondent was not sure about the answer.

3.6.3 The interview

The other form of data collection was an interview. The majority of interviews were done at the FHALC. A few interviews were done at participants' homes or at their place of work, because of circumstances that did not allow them to be accommodated at the ALC (e.g. working night shift, arrived late for classes and could not stay after classes).

The interviewing process averaged about 12 minutes. The interviewer asked individual participants the questions in a structured way by using the same wording, with the same probes and clarifications. "The essential difference between a questionnaire and an interview is that data are usually collected from fewer individuals in an interview, but the information is far more detailed" (Wallen & Fraenkel, 1991: 290). Dyer (1995: 58)

identifies two types of interview, namely the structured interview (*in which the questioning process is tightly organized in advance by the interviewer*) and unstructured interview (*in which virtually nothing is decided by the interviewer before meeting an informant*). In this study the structured interview was used. The researcher made use of the person-to-person encounter, in which the researcher evoked information from participants on an individual basis. No telephone interviews were conducted. only personal interviews. An interview is not just a conversation, but a conversation with a purpose (Merriam, 1988). The main purpose of an interview is to assemble information that researchers cannot directly observe (e.g. feelings, thoughts, opinions, intentions, how people interpret the world around them). The interview questions were thus based on the insights, experience, knowledge, feelings and opinions of the participants as adult learners. The repetition of questions and answers according to Dyer (1995) has two important functions:

- it enables the interviewer to check that the informant is reliable (i.e. informant gives similar answers to similar questions asked at different times); and
- rephrasing similar questions can recall new information which might otherwise have remained hidden.

The researcher tape-recorded each interview in order to preserve everything that had been said for analysis. A total of 18 interviews were conducted and the tape-recordings were transcribed for this study. Refer to Appendix B for an example of the interviewing questions and transcribed responses.

Tape-recording the interview session can have certain drawbacks, for example the audio-cassette recorder malfunctioning or the respondent might feel uneasy being recorded. The researcher was also aware of factors that could have an influence on the data collected using interviewing. The following variables can have an influence on the type of information obtained from an interview according to Dexter (1970) as cited by Merriam (1988: 74):

- the personality and skill of the interviewer;
- the attitudes and orientation of the interviewee; and

- the definition of both (and often by significant others) of the situation.

The informant's perception (personal perspective) is what is sought in qualitative research (Merriam, 1988: 84). "Interviews permit researchers to verify, clarify, or alter what they thought happened, to achieve a full understanding of an incident, and to take into account the 'lived' experience of the participants" (Hutchinson, 1990: 125).

3.7 DATA ANALYSIS AND INTERPRETATION

3.7.1 Data analysis

According to Mouton (2001: 108) the aim of data analysis is:

- to understand the various constitutive elements of one's data through an inspection of the relationships between concepts, constructs or variables; and
- to see whether there are any patterns or trends that can be identified or isolated; or
- to establish themes in the data.

This study is a combination of qualitative (interviews) and quantitative (questionnaires) research methods and techniques. The use of multiple methods and techniques is actually one of the best ways to improve the quality of research (Mouton, 1996: 39).

Analysing any quantitative data, which you generate through your research basically means that you use the numbers to find answers to the questions which interest you (Dyer, 1995: 261). According to Mouton (1996) quantitative analysis would normally also include mathematical techniques and computer simulation studies, but for this study the focus will be on statistical data analysis. The domain of statistics has traditionally been divided according to two main functions, namely descriptive statistics and inferential statistics. *Descriptive statistics* is concerned with organizing and summarizing the data at hand, to render it more comprehensible. *Inferential statistics* deals with the kinds of inferences that can be made when generalizing from data, as from sample data to the entire population.

Descriptive statistics can be further divided according to the number of variables that the researcher focuses on: if a single variable is studied the process is known as univariate analysis, when two variables are studied we refer to this as bivariate analysis and when more than two variables are studied we refer to it as multivariate analysis (Mouton, 1996: 163).

The researcher made use of a bivariate analysis to determine the relationship between two variables. In other words bivariate analysis is used if the researcher wants to know how much of an effect or influence does one variable have on the other (Mouton, 1996: 165). This study's quantitative data was expressed in the form of nominal scale variables and presented in tables. When the tables analysed have only a few categories, as in many nominal level measurements, bivariate data is presented in tables. Such tables are known as cross-tabulations or contingency tables (Mouton, 1996: 165).

In this study the researcher collected the quantitative data by means of a questionnaire. The same questions were given over three different time intervals, namely the pre-test, post-test and the post-post-test.

According to Mouton (1996:168) qualitative analysis focuses on:

- understanding rather than explaining social actions and events within their particular settings and contexts;
- remaining true to the natural setting of the actors and the concepts they use to describe and understand themselves;
- constructing, with regard to the social world, stories, accounts and 'theories' that retain the internal meaning and coherence of the social phenomenon rather than breaking it up into its constituent 'components'; and
- contextually valid accounts of social life rather than formally generalisable explanations.

Because of this emphasis on the integrated, meaningful and contextual nature of social phenomena, qualitative researchers have had to develop new methods and strategies of

‘analysing’, or even better, of ‘interpreting’ and ‘understanding’ the social world (Mouton, 1996: 168). Examples of these approaches are:

- the grounded theory approach;
- analytic induction;
- phase analysis;
- phenomenological analysis;
- discourse analysis; and
- conversation analysis.

In qualitative research, the investigator usually works with a wealth of rich descriptive data, collected through methods such as participant observation, in-depth interviewing and document analysis. This implies a focus on the individual case in its specific context of meanings and significance. Analysis in these cases means reconstructing the inherent significance structures and the self-understanding of individuals by staying close to the subject. This approach is known as the insider perspective. The overall coherence and meaning of the data is more important than the specific meaning of its parts (Mouton, 1996: 169).

In this study the researcher tape-recorded and transcribed each interview as accurately as possible.

3.7.2 Interpretation of data

Interpretation involves the synthesis of one’s data into larger coherent wholes. One interprets observations or data by formulating hypotheses or theories that account for observed patterns and trends in the data (Mouton, 2001: 109). How the interview data was interpreted in this study is detailed in section 4.8. The interpretation of the questionnaire data is fully discussed from section 4.3 to section 4.7.

3.8 THE RELIABILITY AND VALIDITY OF THE RESEARCH METHODS USED IN THIS STUDY.

The credibility of the findings of a study is subject to the reliability and validity of the study. In order to achieve the latter or to enhance the validity and reliability of this study the researcher attempted to utilize methods to make the findings reliable and valid.

3.8.1 Reliability

According to Christensen (1988: 129) reliability refers to the extent to which the same results are obtained when responses are measured at different times. Reliability is hence synonymous with consistency or stability over time (Mouton, 1996: 111). In this study the unit of analysis was individuals or human beings and reliability is problematic because human behaviour is never static (Merriam, 1988: 170).

The researcher strived to be consistent in collecting data by using the same items in the questionnaires and the same questions in the interviews. The approach in the contact sessions, filling in of questionnaires by participants and all the interviews was informal. All the participants were informed about the aim and purpose of the questionnaires and the interviews.

Piloting the questionnaire, as indicated in section 3.10, further enhanced the reliability of the study.

3.8.2 Validity

Validity refers to whether you are measuring what you want to measure (Christensen, 1988: 129). According to Mouton (1996: 109) validity is an epistemic criterion, which means that it is a quality of the elements (data, statements, hypotheses, theories and methods) of knowledge. Mouton (1996: 110) also emphasizes that a number of methodological criteria ought to be followed during the process of data collection. These

include suspension of personal prejudices and biases, systematic and accurate recording of the observations, establishment of trust and rapport with the interviewee and creating optimal conditions in terms of location or setting for the collection of data.

Good (1972: 377) distinguishes between internal validity and external validity. “External validity is concerned with the extent to which the findings of one study can be applied to other situations” (Merriam, 1988: 173). External validity thus ask the question: how generalizable are the results of a research study?

Internal validity refers to the degree of validity of statements made about whether *X* causes *Y*. Internal validity is primarily concerned with ruling out plausible rival hypotheses (Rosenthal and Rosnow, 1991: 64).

According to Mouton (1996: 112) the dimensions of validity are:

- theoretical validity;
- measurement validity;
- representativeness;
- reliability; and
- inferential validity.

He also mentions the corresponding *invalidity* or *error* of these dimensions, namely:

- conceptual vagueness;
- measurement error;
- biased samples;
- unreliable data; and
- invalid conclusions.

The main aim of a research design is, after all, to employ various measures to control for systematic bias, confounding variables and other sources of error (Mouton, 1996: 176).

3.9 LIMITATIONS AND ADVANTAGES OF THE MEASURING INSTRUMENTS

The researcher is aware of the fact that each method he used in this study is limited in some way, but at the same time they also have benefits. The self-administered questionnaire has a few advantages and weaknesses. Some of the advantages of this method are that:

- the researcher can collect information from a fairly large number of people in one go;
- it is inexpensive to collect the data;
- it allows the respondent to stay anonymous;
- unlike the low return rates of postal questionnaires, the self-administered questionnaires offer the possibility of a high return rate;
- it is good at producing undisguised descriptive information; and
- all respondents are presented with the same questions (standardized questions).

Some of the limitations of the self-administered questionnaires are that:

- time is needed to think about the purpose of the questionnaire, drafting questions and piloting;
- care is needed to make questions clear and even if it is clear the responses can be superficial; and
- it is more difficult to get at explanations as set variables are collected.

Just like the self-administered questionnaires the structured interview also has its own limitations and advantages. Some of the advantages are that:

- it increases the consistency from one interview to another;
- personal contact can facilitate response and quality information;
- it accommodates respondents who are illiterate; and

- it allows the researcher to collect data from people who are otherwise not reachable, for example people from rural or informal areas (Katzenellenbogen and Joubert, 1997: 84).

Some of the limitations of the structured interview are that:

- the information obtained from an interview will consist mostly of interpretations or paraphrases of the respondent's words, which makes it inherently unreliable as a source of information about human behaviour or experience (Dyer, 1995: 64);
- it is time-consuming;
- it can be expensive;
- interviewer variation or direct interaction can affect reliability;
- note taking may result in missed information and thus influence the validity of the interview results;
- some research participants (adult learners) may be uncomfortable when electronic recording devices are used;
- interpersonal dynamics may interfere with data collection, for example suspicion (Katzenellenbogen and Joubert, 1997: 84); and
- it does not allow the opportunity to explore all eventualities.

3.10 PILOT STUDY

A pilot study (questionnaire) was done in November 2001, with ten adult learners who wrote their final 'matric examination' at Forest Height's ALC. The pilot for the interview questions was done in July 2002, with four NQF-level 4 learners who were not part of the study (registered after 15 February 2002). Munn and Drever (1991: 32) assert that it is important to pilot your questionnaire (and interview questions) with people similar to those who are going to be completing it. The pilot studies (questionnaire and interview) lead to the revision of certain questions (e.g. ambiguous questions or leading questions), cancellation of useless questions, and the addition of new items.

Munn and Drever (1991) emphasize the importance of piloting, especially when the researcher is drafting questions for a questionnaire. The respondent cannot depend on the

interviewer to clarify the meaning of questions and there is no scope for negotiating the meaning of questions. By piloting the questionnaire the researcher could get an indication of:

- approximately how long it took to answer the questionnaire; and
- which items were not clear, had unfamiliar terms or were ambiguous (and make the necessary alterations to make sure items are interpreted by respondents as the researcher would expect it).

The pilot study is consequently important to increase the reliability and the validity of the actual study.

3.11 IMPLEMENTATION OF THE QUESTIONNAIRES.

The measuring instruments used in this study were to confirm or validate the data gained through the literature review. The researcher introduced himself to the NQF-level 4 learners and explained the research topic and the aim of the study to them. As indicated previously the questionnaires were not mailed and no telephonic interviews were held. The questionnaires and the interviews were administered personally. The advantage was that the return rate of questionnaires was high. The self-administered questionnaire (survey) was used in this study, in other words the respondents were required to fill it in themselves.

3.12 CONCLUSION

The researcher believes that the methods used to collect the relevant data for the study were reliable and valid. Reliability demands consistency over time, which is seen as a vital validity criterion for data collection. The only drawback concerning this study was that some of the participants in the control as well as the experimental group dropped out or discontinued their studies during the year. Although new learners also joined the ALC, they could not be part of the study because they missed the pre-test.

In the next chapter the presentation and detailed analysis of the data collected is undertaken, showing how the findings on each and every question contribute towards significant conclusions in the study.

CHAPTER 4

PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS

4.1 INTRODUCTION

The presentation, analysis and interpretation of results are the pinnacle of any research study. This study is no exception. This chapter endeavours to clarify the issues that have been discussed throughout the study and where necessary to present it in graphic form.

The study had one major limitation and that was the high dropout rate of learners at the adult learning centre. The high dropout rate was however expected, as the centre manager of the FHALC had made the researcher aware of the high dropout rate experienced annually. In the pretest there were 78 participants, in the posttest there were 67 participants, and in the post-posttest 48 participants. The overall number of participants who dropped out from the pretest to the post-posttest was 30 participants. The highest dropout was in the control group who dropped from 51 in the pretest to 23 participants in the post-posttest, which constitutes a drop of 54.9%. The experimental group on the other hand dropped from 27 participants to 25 participants, which reflect a drop of 7.4%. In Table 4.1 the gender composition over the three different stages is indicated. The highest dropout occurred in the female control group from the pretest (33 female participants) to the post-posttest (12 female participants). However, the female experimental group was the most stable of all gender groups, as can be seen in Table 4.1 on the following page.

**TABLE 4.1: EXPERIMENTAL GROUP AND CONTROL GROUP'S
GENDER COMPOSITION OVER ALL THREE STAGES**

STAGE	Experimental		Control	
	Male	Female	Male	Female
PRE	13	14	18	33
POST	13	14	11	29
POST-POST	11	14	11	12

As indicated in chapter three, the NQF-level 4 learners at the FHALC were chosen for this study. They were divided into two groups, namely a control group and an experimental group. Both groups had to complete questionnaires as part of a pretest, posttest and a post-posttest.

The questionnaire consisted of the following sections:

Section A: Personal details;

Section B: HIV/AIDS related questions (Questions 1-22)

4.2 SECTION A of QUESTIONNAIRE: PERSONAL DETAILS

The demography of the NQF-level 4 learners who participated in this study is diverse in terms of gender, age, employment status, marital status, parental status and whether they have been exposed to previous HIV/AIDS education. The information in *section A* discloses the type of NQF-level 4 learners that studies at the FHALC. These issues offer insight into the participant's level of HIV/AIDS education.

4.2.1 Gender and age of participants

To understand the composition and age of the participants, it was essential to know which gender and age groups were represented in the NQF-four group of learners at the FHALC.

The initial number of 30 participants was randomly selected to be part of the experimental group. On 2 March 2002, only 27 of the 30 participants were exposed to the intervention. The two males and one female who could not be part of the intervention session due to circumstances beyond their control, were provided with an explanation as to why they could no longer be part of the experimental group. They were happy to be part of the study as participants in the control group, because the three of them had been part of the initial pretest stage.

4.2.2 Gender composition of participating NQF-level 4 learners

The composition of the NQF-level 4 learners at the FHALC by gender is depicted in Figure 4.1 below.

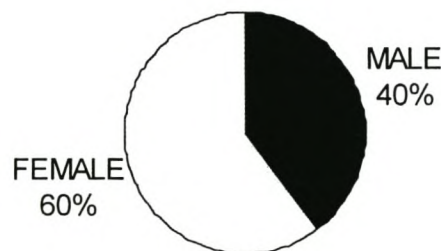


FIGURE 4.1: GENDER COMPOSITION OF PARTICIPATING ADULT LEARNERS AT THE PRETEST STAGE (n=78)

Figure 4.1 indicates that 40 % of the participants were males and 60% were females. It was clear that the majority of the participants were females at the pretest stage.

The gender composition of the experimental (indicated as E) and the control groups (indicated as C) over the three different stages can be seen in Figure 4.2 in terms of percentages.

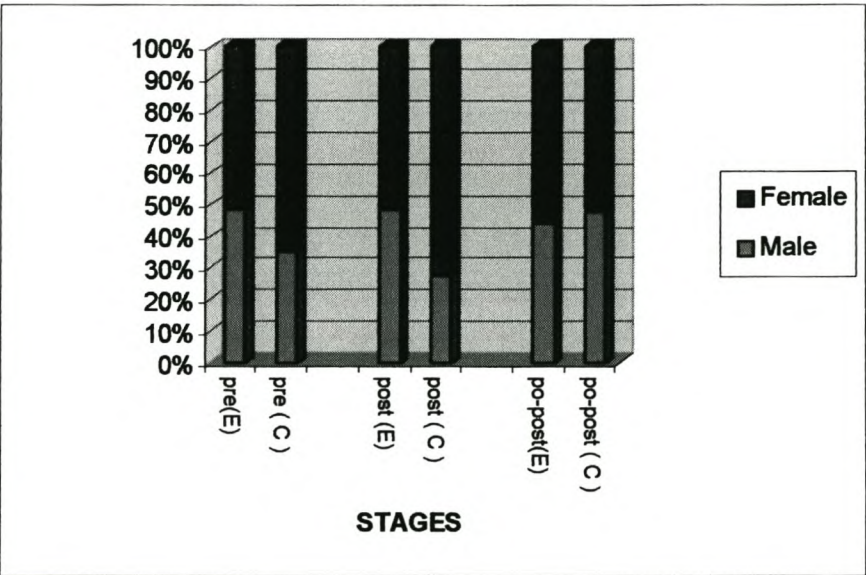


FIGURE 4.2: GENDER COMPOSITION OF PARTICIPATING ADULT LEARNERS AT STAGES: PRE (n=78), POST (n=67) AND POST- POST (n=48)

Closely associated with gender were the age groups of the participants of this study. The groups were diverse in terms of age, which ranged from 18years to 50 + (one person was over 60 years).

4.2.3 Age groupings of participating NQF-level 4 learners

In order to explain the results of the study, it was important to show which age groups were represented by the NQF-level 4 learners at the FHALC. This is presented in three different figures representing the three different stages of the study. Figure 4.3 represents the pretest stage, which indicates that the *age group 18-24* had the highest representation (10 males and 19 females) followed by the *age group 35-39* (nine males and 11 females), while the *age group 45-49* (three females) and *age group 50+* (two males) had the lowest number of participants.

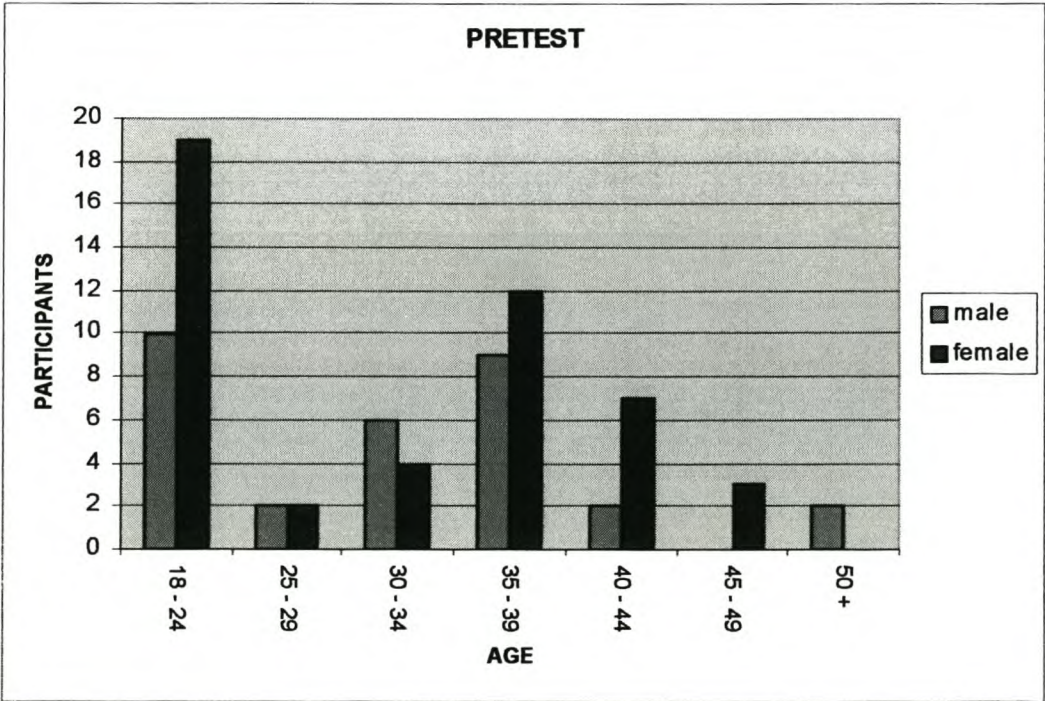
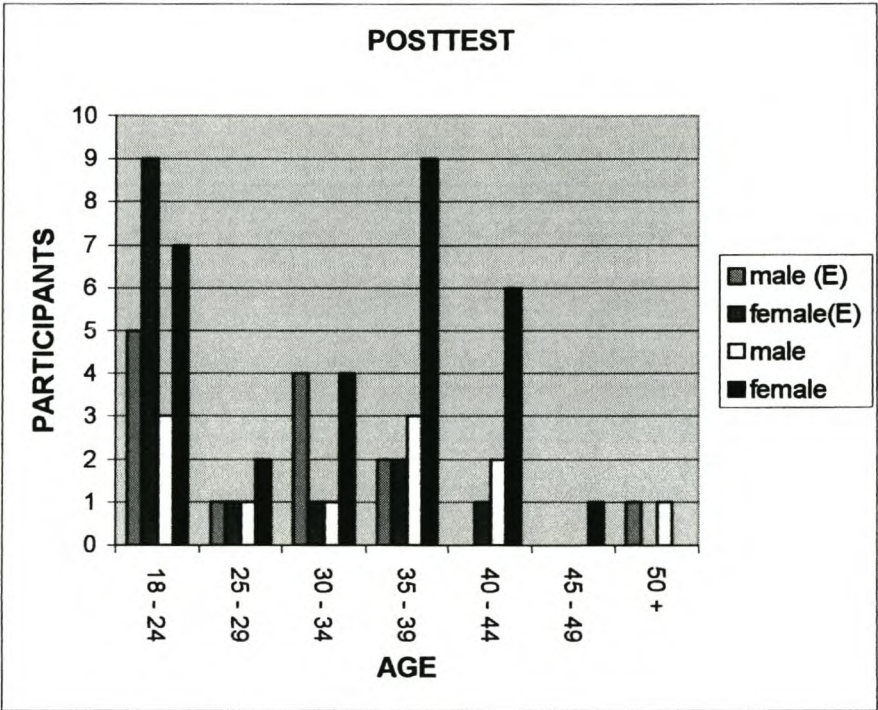


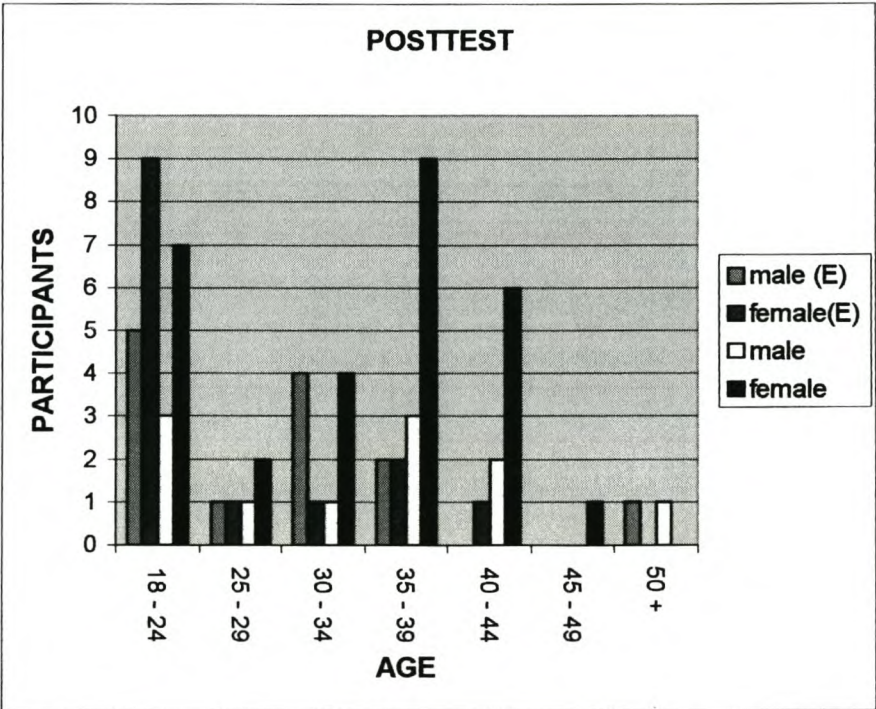
FIGURE 4.3: AGE GROUPS' RESULTS AT PRETEST-STAGE (n=78)

Figure 4.4 represents the posttest stage, which indicates that the *age group 18-24* (eight males and 16 females) was the still the highest represented age group in this study and that the *age group 45-49* (one female) and *age group 50+* (two males) still had the lowest number of participants. Figure 4.4 also highlights the gender representation in the experimental group (indicated as E) and in the control group.



**FIGURE 4.4: AGE GROUPS' RESULTS AT POST-STAGE
EXPERIMENTAL GROUP (n=27); CONTROL (n=40)**

Figure 4.4 represents the posttest stage, which indicates that the *age group 18-24* (eight males and 16 females) was the still the highest represented age group in this study and that the *age group 45-49* (one female) and *age group 50+* (two males) still had the lowest number of participants. Figure 4.4 also highlights the gender representation in the experimental group (indicated as E) and in the control group.



**FIGURE 4.4: AGE GROUPS’ RESULTS AT POST-STAGE
EXPERIMENTAL GROUP (n=27); CONTROL (n=40)**

Figure 4.5 represents the post-posttest stage, which indicates that the *age group 18-24* (seven males and 16 females) was the still the highest represented *age group* and that the *age group 50+* (one male) had the lowest number of participants. Participants in the *age group 45-49* had all dropped out at the post-posttest and thus had no representatives. The *age group 35-39* reflected a dropout from 20 participants in the pretest to eight in the post-posttest.

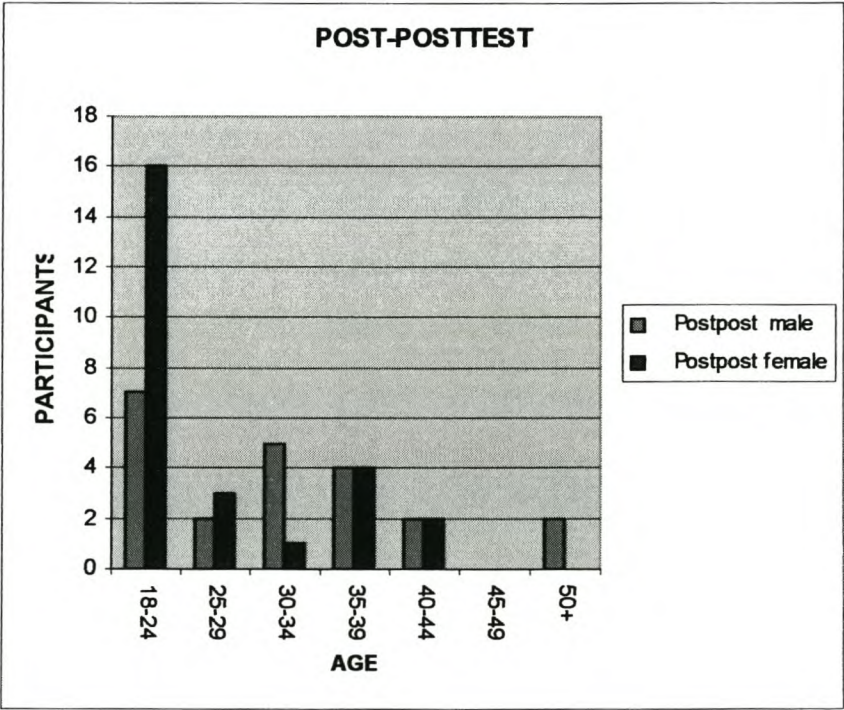


FIGURE 4.5: AGE GROUPS' RESULTS AT POST POST-STAGE
(n=48)

4.2.4 Employment status and previous HIV/AIDS education

The determination of the employment status and exposure of participants' to previous HIV/AIDS education were essential to find out how many participants who were employed had already been educated about HIV/AIDS. During the pretest stage 13 participants in the experimental group were employed of whom two had been exposed to previous HIV/AIDS education, and 14 participants were unemployed of whom only one had been exposed to previous HIV/AIDS education. Whereas in the control group during the pretest stage 32 participants were employed, of whom eight had been exposed to previous HIV/AIDS education, and 19 participants were unemployed of whom only four had been exposed to previous HIV/AIDS education.

Table 4.2 is a cross-tabulation of the participants' employment status, gender and whether they have had previous HIV/AIDS education. The cross-tabulation thus highlights the following information:

- the number of participants who have previously been exposed to HIV/AIDS education versus those who have not;
- their gender status; and
- their employment status.

**TABLE 4.2: CROSS-TABULATION OF PARTICIPANTS' (n=78)
EMPLOYMENT, GENDER AND PREVIOUS HIV/AIDS EDUCATION STATUS**

Previous HIV/AIDS Education	EMPLOYMENT STATUS	GENDER		Total
		Male	Female	
Yes	Employed	5	5	10
	Unemployed		5	5
	Total	5	10	15
No	Employed	16	19	35
	Unemployed	10	18	28
	Total	26	37	63

The number of participants who were exposed to HIV/AIDS education before the study was 15 out of 78 participants. The latter is expressed in Figure 4.6 to illustrate that less than one fifth of adults at the FHALC were exposed to HIV/AIDS education. In total three (two male and one female) out of 27 participants in the experimental group were previously exposed to HIV/AIDS education and 12 (three males and nine females) out of 51 participants in the control group.

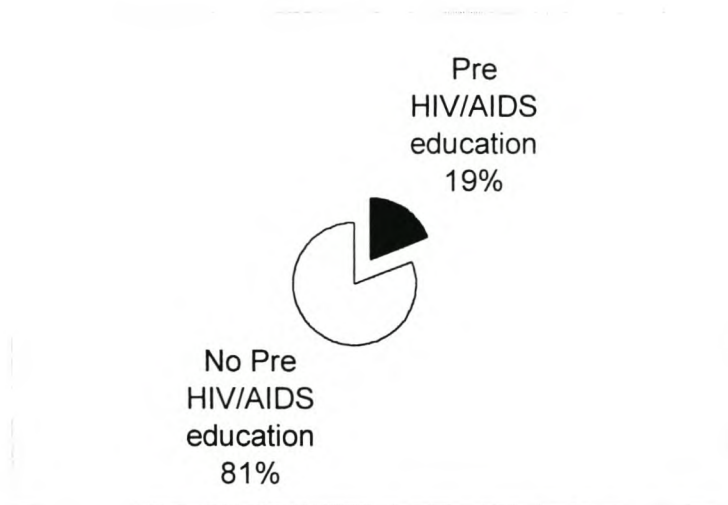


FIGURE 4.6: PERCENTAGE OF PRETEST PARTICIPANTS (n=78) WHO HAD PREVIOUS EXPOSURE TO HIV/AIDS EDUCATION VERSUS THOSE WHO HAVE NOT BEEN EXPOSED

The pretest results indicate that there were no significant differences between the 15 participants' results who have had previous exposure to HIV/AIDS education and those participants who had none.

The one limitation regarding the participants who were exposed to HIV/AIDS education was that the quality and length of the programmes they were exposed to previously were not known and therefore no comparisons could be made between this intervention and previous ones to which they were exposed.

4.2.5 Parental status and marital status

The researcher sought information on whether learners were married or single; and whether they had children. These issues offered insight:

- into the learner's level of influence in terms of educating his or her spouse and /or their children about HIV/AIDS; and
- it also gave us an idea of how many parents were single, which in turn gave us an idea of how many people indulged in unsafe sex.

Looking at the cross-tabulation in Table 4.3 you can see the age group and gender of participants who participated in the pretest, and who have children.

**TABLE 4.3: CROSS-TABULATION OF PARTICIPANTS' (n=78)
AGE, GENDER AND PARENTAL STATUS**

CHILDREN	AGE	GENDER		TOTAL
		Male	Female	
Yes	18-24		12	12
	25-29	1	2	3
	30-34	6	4	10
	35-39	9	11	20
	40-44	2	5	7
	45-49		3	3
	50+	1		1
	Total	19	37	56
No	18-24	10	7	17
	25-29	1	1	2
	40-44		2	2
	50+	1		1
	Total	12	10	22

The cross-tabulation in Table 4.4 gives us an overview of the participants' marital status, age group and their parental status (whether they have children). Sixteen of the participants who had children were single, of which ten were in the 18-24 age group. Not only can they play an important role in educating their children, but also some, if not all of them need HIV/AIDS education in order not to practice unprotected sex.

**TABLE 4.4: CROSS-TABULATION OF PARTICIPANTS' (n=78)
PARENTAL, AGE AND MARITAL STATUS**

CHILDREN	AGE	MARITAL STATUS			TOTAL
		Married	Divorced	Single	
Yes	18-24	2		10	12
	25-29	3			3
	30-34	9		1	10
	35-39	17	1	2	20
	40-44	5		2	7
	45-49	2		1	3
	50+	1			1
	Total	39	1	16	56
No	18-24			17	17
	25-29	2			2
	40-44		1	1	2
	50+		1		1
	Total	2	2	18	22

4.3 SECTION B of QUESTIONNAIRE: HIV/AIDS RELATED QUESTIONS

In section B, the questions are divided into close-ended questions, namely one to 20, and open-ended questions, that being the last two items 21 and 22. Questions two to 22 have specific answers that are deemed to be correct. Question one on the other hand is based on the perception of the participant in terms of what he/she thinks he/she knows about HIV/AIDS. The participants had a choice of three possible responses for the close-ended questions, namely *yes*, *no* and *unsure*. Copperud (1979: 45) warns that participants find it easy to guess or cheat when they take true-false (yes-no) tests. The unsure response was thus added to minimise guessing. The unsure response scored as an incorrect answer when scoring the items. An incomplete answer, that is where no indication was given, was also scored as an incorrect answer.

4.3.1 The interpretation of the questionnaires

In this section, the findings obtained from the questionnaires that were issued to the participants of the two groups at three different stages over time (from the pretest to the post-posttest) are interpreted. Firstly, a comparison between the two groups had to be made at the pretest stage. Secondly, an assessment had to be made to see whether knowledge was gained from the pretest to the posttest. Thirdly, the results from the posttest to the post-posttest had to be scrutinized. The latter stage is referred to as the *retention stage* in this study.

4.3.1.1 Comparing the experimental group with the control group at the pretest stage

The number of participants at the pretest stage was 78 (Experimental group=27; Control group=51). To compare the two groups the actual response count as well as the percentage will be displayed in order to get a better picture of how the two groups compared. Only the correct answers were counted and expressed in percentages. The following 22 questions are interpreted individually, but Figure 4.7 on page 84 gives a

graphic illustration of the pretest with all 78 participants and how they compare as experimental and control group members.

Question 1

Do you think your knowledge about HIV/AIDS is adequate to make informed decisions regarding the disease?

Dink jy dat jou kennis rakende MIV/VIGS genoegsaam is om ingeligte besluite te kan neem aangaande die siekte?

This question was based on the participants' perception of what they they knew about HIV/AIDS. Only nine participants (or 33.3%) from the experimental group (n=27) thought they knew enough about HIV/AIDS to make informed decisions regarding the disease. In the control group 20 participants (or 39.2%) from the control group (n=51) thought they knew enough about HIV/AIDS to make informed decisions regarding the disease. In total 29 out of 78 participants said *yes* they knew enough about HIV/AIDS and that is 37.2% of the participants, as illustrated in Figure 4.7 (page 84).

Question 2

Is there a difference between HIV and AIDS?

Is daar 'n verskil tussen MIV en VIGS?

The correct answer is *yes*. Only 19 participants in the experimental group (70.4%) said *yes* there is a difference between HIV and AIDS, while 32 participants (62.7%) said *yes* in the control group. In total that reflected 65.4% of 78 participants, as illustrated in Figure 4.7 (page 84).

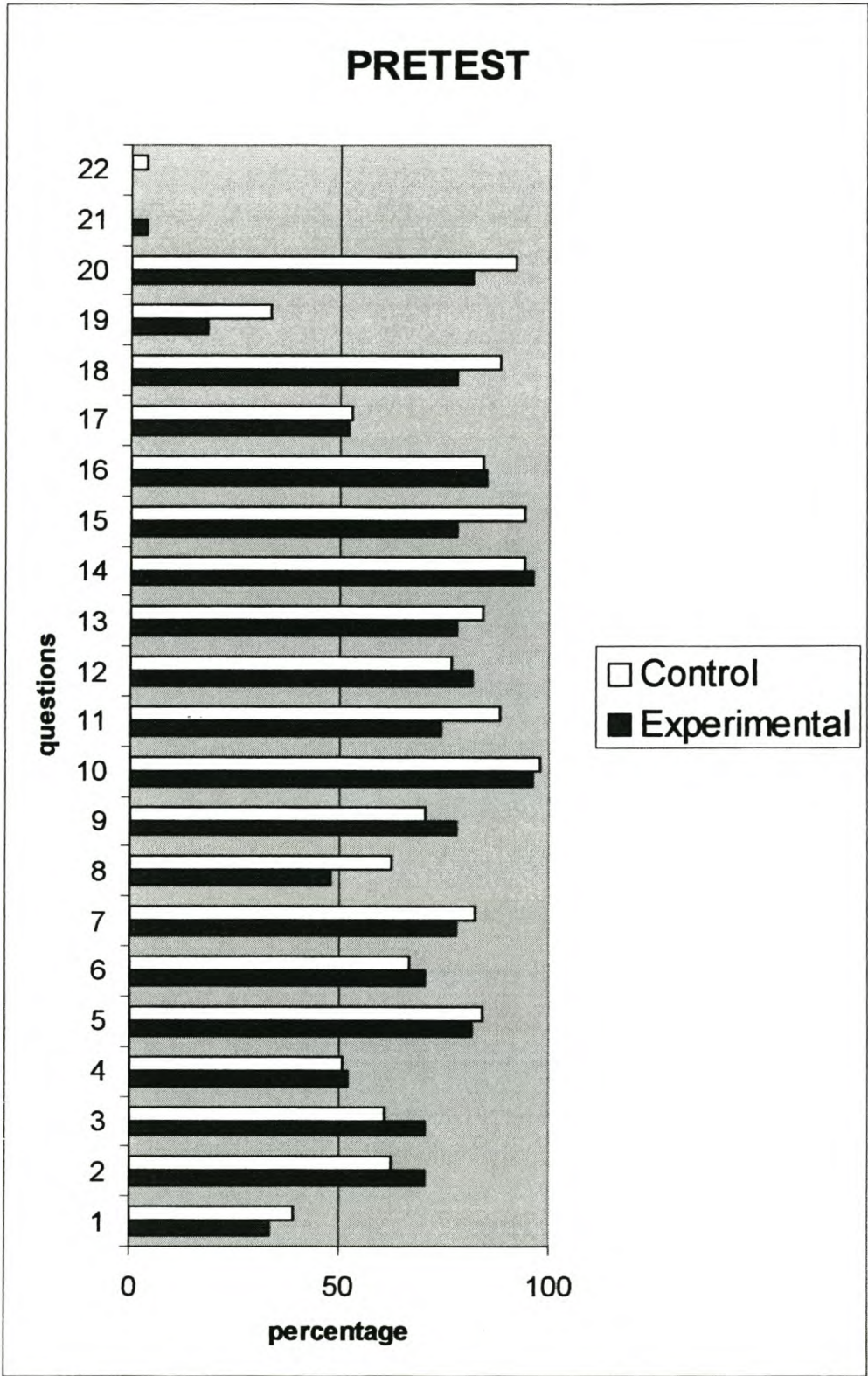


FIGURE 4.7: EXPERIMENTAL (N=27) AND CONTROL GROUP (N=51) COMPARISON AT THE PRETEST STAGE

Question 3

If a person becomes infected with HIV, does this mean he or she has AIDS?

As 'n persoon besmet word met MIV, beteken dit dat hy of sy VIGS het?

The correct answer was *no*. In the experimental group 19 participants (70.4%) and in the control group 31 participants (60.8%) knew the correct answer. In total that reflected 64.1% of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 4

Can AIDS be cured if it is treated within the first month?

Kan VIGS genees word as dit binne die eerste maand behandel word?

The correct answer was *no*. In the experimental group 14 participants (51.9%) and in the control group 26 participants (51%) knew the correct answer. In total that reflected 51.3% of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 5

Can a person become infected with HIV by having unprotected sex (without a condom) with someone who is infected by HIV?

Kan 'n persoon besmet word met MIV deur onbeskermde seks (sonder 'n kondoom) te hê met iemand wie besmet is met MIV?

The correct response was *yes*. In the experimental group 22 participants (81.5%) and in the control group 43 participants (84.3%) knew the correct answer. In total that reflected 83.3% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 6

Can mosquitoes pass on HIV just like they pass on malaria?

Kan muskiete MIV versprei, net soos hulle malaria versprei?

The correct response was *no*. In the experimental group 13 participants (48.1%) and in the control group 32 participants (62.7%) knew the correct answer. In total that reflected 57.7% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 7

Can a person who has sex only with healthy looking partners become infected with HIV?

Kan 'n persoon wie slegs seks het met persone wat gesond lyk, besmet word met MIV?

The correct response was *yes*. In the experimental group 19 participants (70.4%) and in the control group 34 participants (66.7%) knew the correct answer. In total that reflected 67.9% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 8

Is HIV a disease that mainly affects homosexuals?

Is MIV 'n siekte wat hoofsaaklik homoseksuele mense raak?

The correct response is *no*. In the experimental group 21 participants (77.8%) and in the control group 36 participants (70.6%) knew the correct answer. In total that reflected 73.1% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 9

Can you get HIV from hugging someone who is HIV positive (HIV+)?

Kan jy met MIV besmet word as jy iemand omhels wat MIV positief (MIV+) is?

The correct response is *no*. In the experimental group 26 participants (96.3%) and in the control group 50 participants (98%) knew the correct answer. In total that reflected 97.4% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 10

People who are sharing the same house with someone who is HIV+ are also infectious and can pass on the virus to other people.

Mense wie dieselfde huis deel met iemand wat MIV+ is, kan ook ander mense aansteek met die virus.

The correct response is *no*. In the experimental group 20 participants (74.1%) and in the control group 45 participants (88.2%) knew the correct answer. In total that reflected 83.3% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 11

Is it safe to only have unprotected sex with a person you know?

Is dit veilig om slegs onbeskermd seks te hê met 'n persoon wie jy ken?

The correct response is *no*. In the experimental group 22 participants (81.5%) and in the control group 39 participants (76.5%) knew the correct answer. In total that reflected 78.2% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 12

Can you become infected with HIV the first time you have sex?

Kan jy besmet word met MIV die eerste keer as jy seks het?

The correct response is *yes*. In the experimental group 21 participants (77.8%) and in the control group 42 participants (82.4%) knew the correct answer. In total that reflected

80.8% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 13

People who are HIV+ should not be allowed to socialise with healthy people.

Mense wie MIV+ is moet nie toegelaat word om met gesonde mense te sosialiseer nie.

The correct response is *no*. In the experimental group 21 participants (77.8%) and in the control group 43 participants (84.3%) knew the correct answer. In total that reflected 82.1% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 14

Is it a shame to be friends with a person who is HIV+ ?

Is dit 'n skande om bevriend te wees met 'n persoon wat MIV+ is?

The correct response is *no*. In the experimental group 26 participants (96.3%) and in the control group 48 participants (94.1%) knew the correct answer. In total that reflected 94.9% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 15

Is it true that a person who is HIV+ can be cured if he has sex with someone who is a virgin?

Is dit waar dat 'n persoon wie MIV+ is, genees kan word deur seks te hê met 'n persoon wat nog 'n maagd is?

The correct response is *no*. In the experimental group 21 participants (77.8%) and in the control group 48 participants (94.1%) knew the correct answer. In total that reflected

88.5% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 16

Can you see if somebody is HIV+?

Kan jy sien of 'n persoon MIV+ is?

The correct response is *no*. In the experimental group 23 participants (85.2%) and in the control group 43 participants (84.3%) knew the correct answer. In total that reflected 84.6% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 17

Are men at greater risk to HIV infection than women in South Africa?

Is mans se kansse groter om besmet te word met MIV as vroue in SA?

The correct response is *no*. In the experimental group 14 participants (51.9%) and in the control group 27 participants (52.9%) knew the correct answer. In total that reflected 52.6% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 18

Is it safe to share the same razorblade with someone else?

Is dit veilig om dieselfde skerplem met iemand anders te deel?

The correct response is *no*. In the experimental group 21 participants (77.8%) and in the control group 45 participants (88.2%) knew the correct answer. In total that reflected 84.6% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 19

Is the 'window period' the stage where you can see the person is physically ill?

Is die 'venster periode' (window period) die stadium waar jy kan sien die persoon is fisies siek?

The correct response is *no*. In the experimental group 5 participants (22.7%) and in the control group 17 participants (33.3%) knew the correct answer. In total that reflected 28.2% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 20

Is it true that it is good for the country's economy if more people are HIV+?

Is dit waar dat dit goed vir ons land se ekonomie is as meer mense MIV+ is?

The correct response is *no*. In the experimental group 22 participants (81.5%) and in the control group 47 participants (92.2%) knew the correct answer. In total that reflected 88.5% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 21

Please provide us with the telephone number of the **AIDS HELPLINE**

Kan u ons asseblief voorsien van die VIGS HULPLYN (AIDS HELPLINE) telefoonnommer

The correct response is 0800012322, which is indicated as *yes* if *correct* and *no* if *incorrect*. In the experimental group as well as in the control group none of the participants (0%) knew the correct answer. In total that reflected 0% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

Question 22

What does the acronym AIDS stand for?

Waarvoor staan die afkorting VIGS?

The correct response is *Acquired immuno-deficiency syndrome*, which is indicated as *yes* if *correct* and *no* if *incorrect*. In the experimental group none of the participants (0%) knew the correct answer and in the control group only two of the participants (3.9%) knew the correct answer. In total that reflected 2.6% of the correct responses out of 78 participants, as illustrated in Figure 4.7 (page 84).

In the above-mentioned 22 questions, there were no statistically significant difference between the experimental and the control group. The Fisher's exact test, which falls under the number of chi-squared tests' options in the SPSS computer programme, was used to test for statistical significance. The SPSS computer programme was also used to compute the cross-tabulations in this chapter. The reasons why the Fisher's exact test was used can be seen under 4.5.1 in this chapter.

4.4 KNOWLEDGE GAINED FROM THE PRETEST TO THE POSTTEST

In order to compare the two groups from the pretest to the posttest it was necessary to eliminate the participants in the pretest who did not partake in the posttest. The latter process was followed to determine whether knowledge has been gained or not, especially in the experimental group who were exposed to the intervention. The dropping out of participants in the posttest did not affect the experimental group, but the control group dropped from 51 participants (pretest) to 40 participants in the posttest. The results of the pretest showed that the control group scored higher than the experimental group. However, after the intervention the experimental group scored higher than the control group.

The overall percentage results of the pretest for questions 2-22 for the experimental group was 65.08% (n=27; 369 correct responses out of 567) compared to the control group's 68.21% (n=40; 573 correct responses out of 840). The results for the post test for the experimental group was 89.59% (508 correct responses out of 567) and for the control group 66.07% (555 correct responses out of 840). The experimental group thus showed a gain in knowledge after receiving the intervention and improved by 24.54%. The control group on the other hand showed a slight drop from the pretest to the posttest of 2.14%.

Table 4.5 below, shows how the two groups compared in terms of percentages in question 1, which is seen as the learners perceptions, and questions 2 to 22 together, which are seen as the actual questions pertaining to their knowledge.

TABLE 4.5: PRE TO POST COMPARISON BETWEEN EXPERIMENTAL AND CONTROL GROUPS (n=67)

Question	Pre-EX	Post-EX	Pre-CON	Post-CON
1	33.30%	85.20%	37.50%	42.50%
2 to 22	65.05%	89.59%	68.21%	66.07%

A graphic comparison between the experimental and control group at the *knowledge gained stage* (the pretest to posttest results), for question 1 and questions 2 to 22 respectively, can be seen in Figure 4.8.

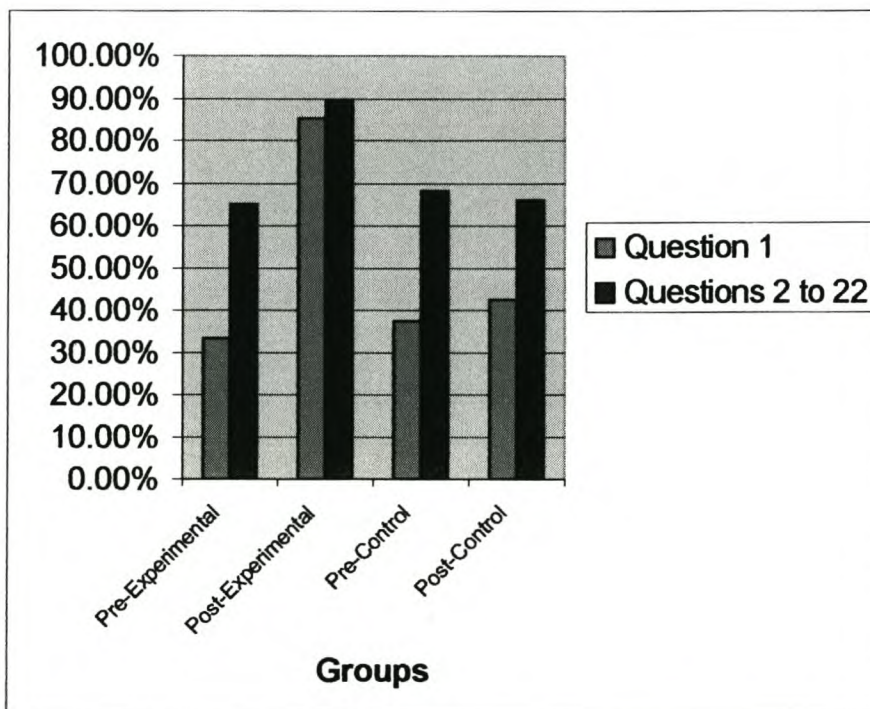


FIGURE 4.8: COMPARING THE EXPERIMENTAL (n=27) AND CONTROL (n=40) GROUPS AT THE KNOWLEDGE GAINED STAGE

A cross-tabulation, Table 4.6 on the following page, shows how the experimental group and control group scored (top score = 22) in the pretest and the posttest. In the experimental group at the pretest their two highest scores were 17 (6 participants) and 18 (only one participant) compared to the control group's two top scores of 19 (only one participant) and 20 (only one participant). At the posttest, that is after the experimental group received the intervention, their two top scores were 21 (8 participants) and 22 (7 participants). The control group's two top scores were still 19 (3 participants) and 20 (2

TABLE 4.6: PARTICIPANT'S SCORE. GROUP & STAGE

STAGE				GROUP		Total
				Experimental	Control	
pretest	SCORE	7.00	Count			
			% within GROUP	1		1
		8.00	Count	3.7%		1.5%
			% within GROUP	1		1
		9.00	Count	3.7%		1.5%
			% within GROUP		2	2
		10.00	Count		5.0%	3.0%
			% within GROUP	2	2	4
		11.00	Count	7.4%	5.0%	6.0%
			% within GROUP	2	2	4
		12.00	Count	7.4%	5.0%	6.0%
			% within GROUP	1	8	9
		13.00	Count	3.7%	20.0%	13.4%
			% within GROUP	5	2	7
		14.00	Count	18.5%	5.0%	10.4%
			% within GROUP	1	1	2
		15.00	Count	3.7%	2.5%	3.0%
			% within GROUP	2	2	4
		16.00	Count	7.4%	5.0%	6.0%
			% within GROUP	5	5	10
		17.00	Count	18.5%	12.5%	14.9%
			% within GROUP	6	9	15
		18.00	Count	22.2%	22.5%	22.4%
			% within GROUP	1	5	6
		19.00	Count	3.7%	12.5%	9.0%
			% within GROUP		1	1
		20.00	Count		2.5%	1.5%
			% within GROUP		1	1
	Total		Count		2.5%	1.5%
			% within GROUP	27	40	67
post	SCORE	7.00	Count	100.0%	100.0%	100.0%
			% within GROUP		2	2
		9.00	Count		5.0%	3.0%
			% within GROUP		1	1
		10.00	Count		2.5%	1.5%
			% within GROUP		2.5%	1.5%
		11.00	Count		3	3
			% within GROUP		7.5%	4.5%
		12.00	Count		1	1
			% within GROUP		2.5%	1.5%
		13.00	Count		9	9
			% within GROUP		22.5%	13.4%
		14.00	Count	3	2	5
			% within GROUP	11.1%	5.0%	7.5%
		15.00	Count		7	7
			% within GROUP		17.5%	10.4%
		16.00	Count		7	7
			% within GROUP		17.5%	10.4%
		17.00	Count	3	1	4
			% within GROUP	11.1%	2.5%	6.0%
		18.00	Count		1	1
			% within GROUP		2.5%	1.5%
		19.00	Count	4	3	7
			% within GROUP	14.8%	7.5%	10.4%
		20.00	Count	2	2	4
			% within GROUP	7.4%	5.0%	6.0%
		21.00	Count	8		8
			% within GROUP	29.6%		11.9%
		22.00	Count	7		7
			% within GROUP	25.9%		10.4%
	Total		Count	27	40	67
			% within GROUP	100.0%	100.0%	100.0%

4.4.1 Comparing the experimental group with the control group at the knowledge gained stage

The Fisher's exact test, which falls under the number of chi-squared tests' options in the SPSS computer programme, was used to test for statistical significance. The SPSS computer programme was also utilised to compute the cross-tabulations in this chapter. Looking at each question individually, cross-tabulation results and Fisher's exact test were used to see if there was statistical significance to the results of the experimental and control groups from the pretest to the posttest. The Fisher's exact test was used because some of the columns and rows had cells with expected frequencies of less than five. The Fisher's exact test is a nonparametric test for analyzing count data when the sample sizes are small (Ott, Mendenhall and Larson, 1978:330). The McNemar test was also used and yield the same results as the Fischer's exact test.

Dyer (1995: 346) states that *statistical significance* refers to a difference (for example between two sample means) that may be so great that it is unlikely to have occurred by chance (probability level for this study being 0.05 and smaller), but is more likely to have been the result of one variable influencing another. A probability value (p) of 0.05 and smaller thus indicates that there is a statistically significant relationship between variables, whilst a probability value larger than 0.05 indicates that there is no statistically significant relationship between variables in this study. In this study, the two-tailed p -values were used. The two-tailed or two-sided test takes into account both tails of the distribution (Runyon and Haber, 1980:184).

Question 1

Question one focuses on the perception rather than the knowledge of the participant and that is why it is dealt with separately. At the pretest the overall percentage for question one for the experimental group was 33.3% (9 correct responses out of 27) compared to the control group's 37.5% (15 correct responses out of 40). The results for the post test for the experimental group was 85.2% (23 correct responses out of 27) and for the control group 42.5% (17 correct responses out of 40). The experimental group thus showed a

gain after receiving the intervention and increased by 51.9% (85.2%-33.3%). The control group on the other hand showed a smaller increase from the pretest to the posttest of 5% (42.5%-37.5%). A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

The probability value (p) for the experimental group ($p=0.000$) is smaller than 0.05, which means that there is a statistically significant relationship, whilst the control group's probability value ($p=0.820$) is larger than 0.05, which means that there is no statistically significant relationship.

Question 2

During the pretest the overall percentage of correct responses to question two for the *experimental group* was 70.4% (19 correct responses out of 27) compared to the *control group's* 60% (24 correct responses out of 40). The results for the posttest for the *experimental group* was 96.3% (26 correct responses out of 27) and for the *control group* 65% (26 correct responses out of 40). The experimental group thus showed a gain after receiving the intervention and increased by 25.9%. The control group on the other hand showed a smaller increase from the pretest to the posttest of 5%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability value (p) for the experimental group ($p=0.024$) is smaller than 0.05, which means that there is a statistically significant relationship, whilst the control group's probability value ($p=0.818$) is larger than 0.05, which means that there is no statistically significant relationship.

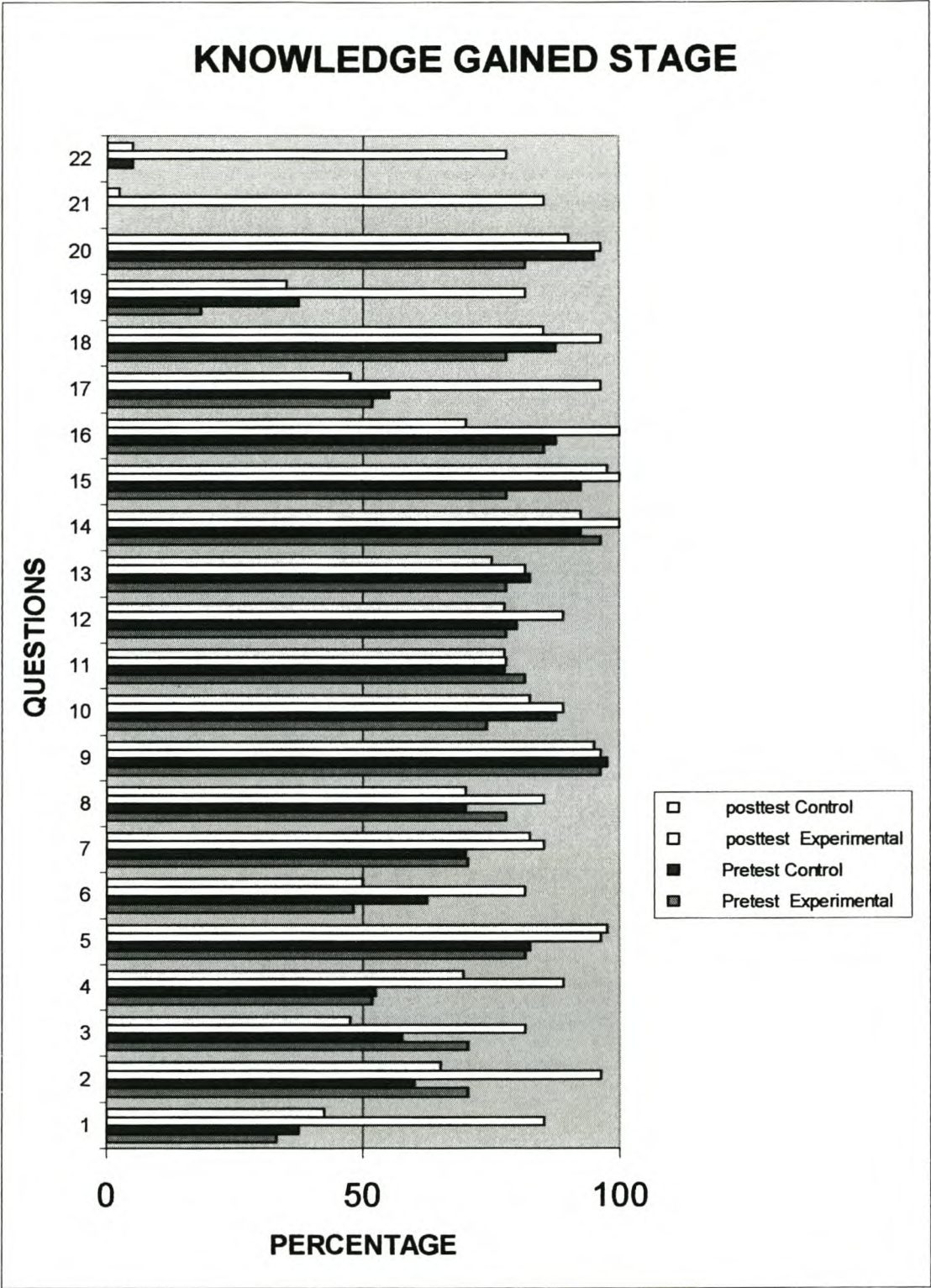


FIGURE 4.9: COMPARING THE EXPERIMENTAL GROUP WITH CONTROL GROUP DURING PRE AND POST RESULTS

Question 3

During the pretest the overall percentage of correct responses to question three for the *experimental group* was 70.4% (19 correct responses out of 27) compared to the *control group's* 57.5% (23 correct responses out of 40). The results for the posttest for the *experimental group* was 81.5% (22 correct responses out of 27) and for the *control group* 47.5% (19 correct responses out of 40). The experimental group thus showed a gain after receiving the intervention and increased by 11.1%. The control group on the other hand showed a decrease from the pretest to the posttest of 10%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability values (p) for both the experimental group ($p=0.526$) and the control group ($p=0.502$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 4

During the pretest the overall percentage of correct responses to question four for the *experimental group* was 51.9% (14 correct responses out of 27) compared to the *control group's* 52.5% (21 correct responses out of 40). The results for the posttest for the *experimental group* was 88.9% (24 correct responses out of 27) and for the *control group* 42.5% (17 correct responses out of 40). The experimental group thus showed a gain after receiving the intervention and increased by 37%. The control group on the other hand showed a decrease from the pretest to the posttest of 10%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability value (p) for the experimental group ($p=0.006$) is smaller than 0.05, which means that there is a statistically significant relationship, whilst the control group's probability value

($p=0.502$) is larger than 0.05, which means that there is no statistically significant relationship.

Question 5

During the pretest the overall percentage of correct responses to question five for the *experimental group* was 81.5% (22 correct responses out of 27) compared to the *control group's* 82.5% (33 correct responses out of 40). The results for the posttest for the *experimental group* was 96.3% (26 correct responses out of 27) and for the *control group* 97.5% (39 correct responses out of 40). The experimental group thus showed a gain after receiving the intervention and increased by 14,8%. The control group on the other hand also showed an increase from the pretest to the posttest of 15%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability value (p) for the experimental group ($p=0.192$) is larger than 0.05, which means that there is no statistically significant relationship, whilst the control group's probability value ($p=0.057$) indicates a marginal difference, but not strong enough to say there is a statistically significant relationship.

Question 6

During the pretest the overall percentage of correct responses to question six for the *experimental group* was 48.1% (13 correct responses out of 27) compared to the *control group's* 62.5% (25 correct responses out of 40). The results for the posttest for the *experimental group* was 81.5% (22 correct responses out of 27) and for the *control group* 44.4% (20 correct responses out of 40). The experimental group thus showed a gain after receiving the intervention and increased by 33.4%. The control group on the other hand showed a decrease from the pretest to the posttest of 12.5%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability value (p) for the experimental group ($p=0.021$) is smaller than 0.05, which means that there is a statistically significant relationship, whilst the control group's probability value ($p=0.367$) is larger than 0.05, which means that there is no statistically significant relationship.

Question 7

During the pretest the overall percentage of correct responses to question seven for the *experimental group* was 70.4% (19 correct responses out of 27) compared to the *control group's* 70% (28 correct responses out of 40). The results for the posttest for the *experimental group* was 85.2% (23 correct responses out of 27) and for the *control group* 82.5% (33 correct responses out of 40). The experimental group thus showed a gain after receiving the intervention and increased by 14.8%. The control group on the other hand also showed an increase from the pretest to the posttest of 12.5%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability values (p) for both the experimental group ($p=0.327$) and the control group ($p=0.293$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 8

During the pretest the overall percentage of correct responses to question eight for the *experimental group* was 77.8% (21 correct responses out of 27) compared to the *control group's* 70% (28 correct responses out of 40). The results for the posttest for the *experimental group* was 85.2% (23 correct responses out of 27) and for the *control group* 70% (28 correct responses out of 40). The experimental group thus showed a gain after receiving the intervention and increased by 7.4%. The control group on the other hand stayed constant with a 0% increase from the pretest to the posttest. A graphic comparison

between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability values (p) for both the experimental group ($p=0.728$) and the control group ($p=1.000$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 9

During the pretest the overall percentage of correct responses to question nine for the *experimental group* was 96.3% (26 correct responses out of 27) compared to the *control group's* 97.5% (39 correct responses out of 40). The results for the posttest for the *experimental group* was 96.3% (26 correct responses out of 27) and for the *control group* 95% (38 correct responses out of 40). The experimental group stayed constant, thus showing 0% increase after receiving the intervention. The control group on the other hand showed a decrease from the pretest to the posttest of 2.5%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability values (p) for both the experimental group ($p=1.000$) and the control group ($p=1.000$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 10

During the pretest the overall percentage of correct responses to question ten for the *experimental group* was 74.1% (20 correct responses out of 27) compared to the *control group's* 87.5% (35 correct responses out of 40). The results for the posttest for the *experimental group* was 88.9% (24 correct responses out of 27) and for the *control group* 82.5% (33 correct responses out of 40). The experimental group thus showed a gain after receiving the intervention and increased by 14.8%. The control group on the other hand showed a decrease from the pretest to the posttest of 5%. A graphic comparison between

the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability values (p) for both the experimental group ($p=0.293$) and the control group ($p=0.755$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 11

During the pretest the overall percentage of correct responses to question eleven for the *experimental group* was 81.5% (22 correct responses out of 27) compared to the *control group's* 77.5% (31 correct responses out of 40). The results for the posttest for the *experimental group* was 77.8% (21 correct responses out of 27) and for the *control group* 77.5% (31 correct responses out of 40). The experimental group thus showed a decrease of 3.7% after receiving the intervention. The control group on the other hand stayed constant with a 0% increase from the pretest to the posttest. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability values (p) for both the experimental group ($p=1.000$) and the control group ($p=1.000$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 12

During the pretest the overall percentage of correct responses to question twelve for the *experimental group* was 77.8% (21 correct responses out of 27) compared to the *control group's* 80% (32 correct responses out of 40). The results for the posttest for the *experimental group* was 88.9% (24 correct responses out of 27) and for the *control group* 77.5% (31 correct responses out of 40). The experimental group thus showed an increase of 11.1% after receiving the intervention. The control group on the other hand showed a decrease from the pretest to the posttest of 2.5%. A graphic comparison between the

experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability values (p) for both the experimental group ($p=0.467$) and the control group ($p=1.000$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 13

During the pretest the overall percentage of correct responses to question thirteen for the *experimental group* was 77.8% (21 correct responses out of 27) compared to the *control group's* 82.5% (33 correct responses out of 40). The results for the posttest for the *experimental group* was 81.5% (22 correct responses out of 27) and for the *control group* 75% (30 correct responses out of 40). The experimental group thus showed an increase of 3.7% after receiving the intervention. The control group on the other hand showed a decrease from the pretest to the posttest of 2.5%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability values (p) for both the experimental group ($p=1.000$) and the control group ($p=0.293$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 14

During the pretest the overall percentage of correct responses to question fourteen for the *experimental group* was 96.3% (26 correct responses out of 27) compared to the *control group's* 92.5% (37 correct responses out of 40). The results for the posttest for the *experimental group* was 100% (27 correct responses out of 27) and for the *control group* 92.5% (37 correct responses out of 40). The experimental group thus showed an increase of 3.7% after receiving the intervention. The control group on the other hand stayed constant with a 0% increase from the pretest to the posttest. A graphic comparison

between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability values (p) for both the experimental group ($p=1.000$) and the control group ($p=1.000$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 15

During the pretest the overall percentage of correct responses to question fifteen for the *experimental group* was 77.3% (21 correct responses out of 27) compared to the *control group's* 92.5% (37 correct responses out of 40). The results for the posttest for the *experimental group* was 100% (27 correct responses out of 27) and for the *control group* 97.5% (39 correct responses out of 40). The experimental group thus showed an increase of 22.7% after receiving the intervention. The control group on the other hand also showed an increase from the pretest to the posttest of 5%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability value (p) for the experimental group ($p=0.023$) is smaller than 0.05, which means that there is a statistically significant relationship, whilst the control group's probability value ($p=0.615$) is larger than 0.05, which means that there is no statistically significant relationship.

Question 16

During the pretest the overall percentage of correct responses to question sixteen for the *experimental group* was 85.2% (23 correct responses out of 27) compared to the *control group's* 87.5% (35 correct responses out of 40). The results for the posttest for the *experimental group* was 100% (27 correct responses out of 27) and for the *control group* 70% (28 correct responses out of 40). The experimental group thus showed an increase of

14.8% after receiving the intervention. The control group on the other hand also showed a decrease from the pretest to the posttest of 17.5%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability values (p) for both the experimental group ($p=0.111$) and the control group ($p=0.099$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 17

During the pretest the overall percentage of correct responses to question seventeen for the *experimental group* was 51.9% (14 correct responses out of 27) compared to the *control group's* 55% (22 correct responses out of 40). The results for the posttest for the *experimental group* was 96.3% (26 correct responses out of 27) and for the *control group* 47.5% (19 correct responses out of 40). The experimental group thus showed an increase of 44.4% after receiving the intervention. The control group on the other hand also showed a decrease from the pretest to the posttest of 7.5%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability value (p) for the experimental group ($p=0.000$) is smaller than 0.05, which means that there is a statistically significant relationship, whilst the control group's probability value ($p=0.655$) is larger than 0.05, which means that there are no statistically significant relationships.

Question 18

During the pretest the overall percentage of correct responses to question eighteen for the *experimental group* was 77.8% (21 correct responses out of 27) compared to the *control group's* 87.5% (35 correct responses out of 40). The results for the posttest for the

experimental group was 96.3% (26 correct responses out of 27) and for the *control group* 85% (34 correct responses out of 40). The experimental group thus showed an increase of 18.5% after receiving the intervention. The control group on the other hand also showed a decrease from the pretest to the posttest of 2.5%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability values (p) for both the experimental group ($p=0.100$) and the control group ($p=1.000$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 19

During the pretest the overall percentage of correct responses to question nineteen for the *experimental group* was 18.5% (5 correct responses out of 27) compared to the *control group's* 37.5% (15 correct responses out of 40). The results for the posttest for the *experimental group* was 81.5% (22 correct responses out of 27) and for the *control group* 35% (14 correct responses out of 40). The experimental group thus showed an increase of 63% after receiving the intervention. The control group on the other hand also showed a decrease from the pretest to the posttest of 2.5%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability value (p) for the experimental group ($p=0.000$) is smaller than 0.05, which means that there is a statistically significant relationship, whilst the control group's probability value ($p=1.000$) is larger than 0.05, which means that there is no statistically significant relationship.

Question 20

During the pretest the overall percentage of correct responses to question twenty for the *experimental group* was 81.5% (22 correct responses out of 27) compared to the *control group's* 95% (38 correct responses out of 40). The results for the posttest for the *experimental group* was 96.3% (26 correct responses out of 27) and for the *control group* 90% (36 correct responses out of 40). The experimental group thus showed an increase of 14.8% after receiving the intervention. The control group on the other hand also showed a decrease from the pretest to the posttest of 5%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability values (p) for both the experimental group ($p=0.192$) and the control group ($p=0.675$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 21

During the pretest the overall percentage of correct responses to question twenty-one for the *experimental group* was 0% (zero correct responses out of 27) compared to the *control group's* 0% (zero correct responses out of 40). The results for the posttest for the *experimental group* was 85.2% (23 correct responses out of 27) and for the *control group* 2.5% (1 correct response out of 40). The experimental group thus showed an increase of 85.2% after receiving the intervention. The control group on the other hand also showed an increase from the pretest to the posttest of 2.5%. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability value (p) for the experimental group ($p=0.000$) is smaller than 0.05, which means that there is a statistically significant relationship, whilst the control group's probability value

($p=1.000$) is larger than 0.05, which means that there is no statistically significant relationship.

Question 22

During the pretest the overall percentage of correct responses to question twenty-two for the *experimental group* was 0% (zero correct responses out of 27) compared to the *control group's* 5% (2 correct responses out of 40). The results for the posttest for the *experimental group* was 77.8% (21 correct responses out of 27) and for the *control group* 5% (2 correct responses out of 40). The experimental group thus showed an increase of 77.8% after receiving the intervention. The control group on the other hand stayed constant at 5% at both the pretest and the posttest. A graphic comparison between the experimental and control group at the *knowledge gained stage* (pretest to posttest results) can be seen in Figure 4.9 (page 97).

To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables. The probability value (p) for the experimental group ($p=0.000$) is smaller than 0.05, which means that there is a statistically significant relationship, whilst the control group's probability value ($p=1.000$) is larger than 0.05, which means that there is no statistically significant relationship.

4.4.1.1 Statistically significant results yielded by the experimental group at the knowledge gained stage

At the *knowledge gained stage* the following nine questions yielded a statistically significant relationship in the experimental group: questions 1; 2; 4; 6; 15; 17; 19; 21 and 22, while the control group yielded no statistically significant relationships. Each of the above-mentioned nine questions are discussed individually in the following section.

▪ Question 1

- Do you think your knowledge about HIV/AIDS is adequate to make informed decisions regarding the disease?

There was a definite improvement in question one, namely the perception of what participants thought they knew about HIV/AIDS after the intervention in the experimental group.

The experimental group also improved significantly on the following questions from the pretest to the posttest:

- **Question 2**

- Is there a difference between HIV and AIDS?

It is important that people understand that there is a difference between HIV and AIDS. Most people think it is the same thing and maybe that is why some people think you can see if someone is HIV+, which is of course not true. Stop looking for a sick person, with AIDS symptoms, because healthy looking people can be HIV-infected and infect you.

- **Question 4**

- Can AIDS be cured if it is treated within the first month?

People need to understand that there is no cure to date (2003) for HIV/AIDS.

- **Question 6**

- Can mosquitoes pass on HIV just like they pass on malaria?

People need to understand how HIV is transmitted and that it can only be passed on from human to human and not from insect or animal to human.

- **Question 15**

- Is it true that a person who is HIV+ can be cured if he has sex with someone who is a virgin?

This is a myth that has already lead to the rape of innocent children, and that is why it is important that as many people as possible are educated about the disease. They must realize there is no cure for the disease to date (2003).

- **Question 17**

- Are men at greater risk of HIV infection than women in South Africa?

Although women are at greater risk of infection it does not mean that men are not in danger of being infected.

- **Question 19**

- Is the *window period* the stage where you can see the person is physically ill?

This concept is one that most of the participants need to understand, because a negative HIV test result does not mean you are safe and can have unprotected sex, especially within three months of the initial test.

- **Question 21**

- Please provide us with the telephone number of the *AIDS HELPLINE*

The help-line telephone number is valuable if you would like to get information or you are unsure about certain HIV/AIDS related issues. It is also free of charge to use the service and confidential.

- **Question 22**

- What does the acronym AIDS stand for?

Although it is not critical that people know what AIDS stands for, it makes the explanation of how AIDS *operates* clearer for participants in a training set up.

4.4.2 Gender performance in the experimental group at the knowledge gained stage

Looking at each question individually cross-tabulation results were used and Fisher's exact test to see if there was statistical significance between the results of the males and females in the experimental group at the *knowledge gained stage*. Dyer (1995: 346) states that *statistical significance* refers to a difference (for example between two sample means) that may be so great that it is unlikely to have occurred by chance (probability level for this study being 0.05 and smaller), but may instead have been the result of one variable influencing another. A probability value of 0.05 and smaller thus indicates that there is a statistically significant relationship between variables, whilst a probability value larger than 0.05 indicates that there is no statistically significant relationship between

variables in this study. The Fisher's exact test was used because some of the columns and rows had cells with expected frequencies of less than five responses.

Question 1

This question was based on the participants' perception of what they knew about HIV/AIDS. In terms of percentage, a higher number of males thought they knew enough about HIV/AIDS to make informed decisions regarding the disease. The percentage of males who said yes was 38.5% in the pretest and 92.3% in the posttest versus the females who scored 28.6% in the pretest and increased to 78.6% in the posttest. To see if there was a statistically significant change the Fisher's exact test was used (to show if there is a relationship between the variables). The probability value (p) of both the males ($p=0.011$) and females ($p=0.021$) is smaller than 0.05, which means that there are statistically significant relationships.

Question 2

The correct answers by the male participants in the experimental group increased from nine (69.2%) to 12 (92.3%), while correct responses by female participants in the experimental group increased from 10 (71.4%) to 14 (100%). To see if there was a statistically significant change the Fisher's exact test was used (to show if there is a relationship between the variables). The probability value (p) for both male ($p=0.322$) and female ($p=0.098$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 3

The correct answers by the male participants in the experimental group increased from 10 (76.9%) to 11 (84.6%), while correct responses by female participants in the experimental group increased from 9 (64.3%) to 11 (78.6%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=1.0$) and female ($p=0.678$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 4

The correct answers by the male participants in the experimental group increased from seven (53.8%) to 12 (92.3%), while correct responses by female participants in the experimental group increased from seven (50.0%) to 12 (85.7%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.073$) and female ($p=0.103$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 5

The correct answers by the male participants in the experimental group increased from 11 (84.6%) to 13 (100%), while correct responses by female participants in the experimental group increased from 11 (78.6%) to 13 (92.9%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.480$) and female ($p=0.596$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 6

The correct answers by the male participants in the experimental group increased from seven (53.8%) to 12 (92.3%), while correct responses by female participants in the experimental group increased from six (42.9%) to 10 (71.4%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.073$) and female ($p=0.252$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 7

The correct answers by the male participants in the experimental group increased from eight (61.5%) to 10 (76.9%), while correct responses by female participants in the experimental group increased from 11 (78.6%) to 13 (92.9%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.673$) and female ($p=0.596$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 8

The correct answers by the male participants in the experimental group increased from nine (69.2%) to 12 (92.3%), while correct responses by female participants in the experimental group decreased from 12 (85.7%) to 11 (78.6%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.322$) and female ($p=1.000$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 9

The correct answers by the male participants in the experimental group stayed constant at 13 (100%), as well as the female participants who scored 13 (92.9%) in both stages. To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male (no statistics are computed because Question 9 is a constant) and female ($p=1.000$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 10

The correct answers by the male participants in the experimental group increased from 10 (76.9%) to 12 (92.3%), while correct responses by female participants in the experimental group increased from 10 (71.4%) to 12 (85.7%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.593$) and female ($p=0.648$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 11

The correct answers by the male participants in the experimental group increased from nine (69.2%) to 10 (76.9%), while correct responses by female participants in the experimental group decreased from 13 (92.9%) to 11 (78.6%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=1.000$) and female ($p=0.596$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 12

The correct answers by the male participants in the experimental group increased from 10 (76.9%) to 12 (92.3%), while correct responses by female participants in the experimental group increased from 11 (78.6%) to 12 (85.7%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.593$) and female ($p=1.000$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 13

The correct answers by the male participants in the experimental group decreased from 11 (84.6%) to 10 (76.9%), while correct responses by female participants in the experimental group increased from 10 (71.4%) to 12 (85.7%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=1.000$) and female ($p=0.648$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 14

The correct answers by the male participants in the experimental group increased from 12 (92.3%) to 13 (100%), while correct responses by female participants in the experimental group stayed constant at 14 (100%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=1.000$) and female (no statistics are computed because Question 14 is a constant) are larger than 0.05, which means that there are no statistically significant relationships.

Question 15

The correct answers by the male participants in the experimental group increased from 10 (76.9%) to 13 (100%), while correct responses by female participants in the experimental group increased from 11 (78.6%) to 14 (100%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.220$) and female ($p=0.222$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 16

The correct answers by the male participants in the experimental group increased from 10 (76.9%) to 13 (100%), while correct responses by female participants in the experimental group increased from 13 (92.9%) to 14 (100%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.220$) and female ($p=1.000$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 17

The correct answers by the male participants in the experimental group increased from eight (61.5%) to 13 (100%), while correct responses by female participants in the experimental group increased from six (42.9%) to 13 (92.9%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.039$) and female ($p=0.013$) are smaller than 0.05, which means that there are statistically significant relationships.

Question 18

The correct answers by the male participants in the experimental group increased from seven (53.8%) to 12 (92.3%), while correct responses by female participants in the experimental group stayed constant at 14 (100%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for the male participants ($p=0.073$) is larger than 0.05, which means that there is no statistically significant relationship; and female (no statistics are computed because Question 18 is a constant) there is no statistically significant relationship.

Question 19

The correct answers by the male participants in the experimental group increased from two (15.4%) to 11 (84.6%), while correct responses by female participants in the experimental group increased from 3 (21.4%) to 11 (78.6%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.001$) and female ($p=0.007$) are smaller than 0.05, which means that there are statistically significant relationships.

Question 20

The correct answers by the male participants in the experimental group increased from nine (69.2%) to 12 (92.3%), while correct responses by female participants in the experimental group increased from 13 (92.9%) to 14 (100%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.322$) and female ($p=1.000$) are larger than 0.05, which means that there are no statistically significant relationships.

Question 21

The correct answers by the male participants in the experimental group increased from zero (0%) to 11 (84.6%), while correct responses by female participants in the experimental group increased from zero (0%) to 12 (85.7%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.000$) and female ($p=0.000$) are smaller than 0.05, which means that there are statistically significant relationships.

Question 22

The correct answers by the male participants in the experimental group increased from zero (0%) to 8 (61.5%), while correct responses by female participants in the experimental group increased from zero (0%) to 13 (92.9%). To see if there was a statistically significant change the Fisher's exact test was used to show if there is a relationship between the variables.

The probability value (p) for both male ($p=0.002$) and female ($p=0.000$) are smaller than 0.05, which means that there are statistically significant relationships.

The only statistical significant results when comparing males and females in the experimental group were yielded in exactly the same questions for both gender groups, namely questions 1, 17, 19, 21 and 22. The latter thus indicates that there was no significant difference between males and females in the experimental group, as both gender groups showed significant improvements in exactly the same questions.

4.4.3 Gender performance in the control group at the knowledge gained stage

Looking at each question individually, cross-tabulation results and the Fisher's exact test were used to analyse the data and see if there were statistical significance in the results of the males and females in the control group. The Fisher's exact test was used because some of the columns and rows had cells with expected frequencies of less than five responses. In the control group at the *knowledge gained stage* (pretest to posttest), there were no statistically significant relationships between male and female participants in any of the 22 questions at the *knowledge gained stage*, except for question five.

Question 5

During the pretest for the control group the overall percentage for question five for the *male group* was 81.8% (9 correct responses out of 11) compared to the *female group's* 82.8% (24 correct responses out of 29). The results for the posttest for the *male group* was 90.9% (10 correct responses out of 11) and for the *female group* 100% (40 correct

responses out of 40). The male group thus showed a gain from the pretest to the posttest and increased by 9.1%. The female control group on the other hand also showed an increase from the pretest to the posttest of 17.2%.

To see if there was a statistically significant change in the relationship between the variables the Fisher's exact test was used. The probability value (p) for the male group ($p=1.000$) is larger than 0.05, which means that there is no statistically significant relationship, whilst the female group's probability value ($p=0.052$) is more or less equal to 0.05, which means that there is a marginal possibility of a statistically significant relationship.

4.4.4 Performance of age groups in the experimental group at the knowledge gained stage

Looking at each question individually, cross-tabulation results were used and the Fisher's exact test to see if there were statistical significance in the results of the six different age groups in the experimental group at *knowledge gained stage*. There are no age representatives in *age group 45-49*, which would make it seven age groups. The Fisher's exact test was used because some of the columns and rows had cells with expected frequencies of less than five. Only the age groups and the relevant questions, which indicated statistically significant results, will be reported on in this section.

Question 1

This question was based on the participants' perceptions of what they knew about HIV/AIDS. Comparing the six age groups of the experimental group from the pretest to the posttest, yielded the following results. The percentage of participants in the age group '18 to 24' who said yes was 0% (zero out of 2 participants) in the pretest and 100% (2 out of 2) in the posttest. This age group (age 18-24) was the only group out of the six age groups who yielded a statistically significant result.

To see if there was a statistically significant change the Fisher's exact test was used to determine a relationship between the variables. The probability value (p) for the 18-24

age group ($p=0.006$) is smaller than 0.05, which means that there is statistically significant relationship. The other age groups showed no statistically significant results in answering this specific question at the *knowledge gained stage*.

Question 6

Comparing the six age groups (there is no age representative in the *age group 45-49*, which would make it seven age groups) of the experimental group from the pretest to the posttest yielded the following results. The correct answers by the age group 30-34 in the experimental group increased from 1 (20%) to 5 (100%).

The Fisher's exact test was used to determine if there was a statistically significant change. The probability value (p) for the *30-34 age group* ($p=0.048$) is smaller than 0.05, which means that there is a statistically significant relationship. The other age groups showed no statistically significant results in answering this specific question at the *knowledge gained stage*.

Question 17

Comparing the six age groups of the experimental group with each other from the pretest to the posttest, yielded the following results. There is no age representative in *age group 45-49* in the experimental group, which would make it seven age groups. The correct answers by the age group 18-24 in the experimental group increased from 5 (35.7%) to 13 (92.9%).

The Fisher's exact test was used to determine if there was a statistically significant change. The probability value (p) for the *18-24 age group* ($p=0.004$) is smaller than 0.05, which means that there is a statistically significant relationship. The other age groups showed no statistically significant results in answering this specific question at the *knowledge gained stage*.

Question 19

Comparing the six age groups of the experimental group with each other from the pretest to the posttest, yielded the following results. There is no age representative in *age group 45-49* in the experimental group, which would make it seven age groups. The correct answers by the age group 18-24 in the experimental group increased from 2 (14.3%) to 12 (85.7%).

The Fisher's exact test was used to determine if there was a statistically significant change. The probability value (p) for the *18-24 age group* ($p=0.000$) is smaller than 0.05, which means that there is a statistically significant relationship. The other age groups showed no statistically significant results in answering this specific question at the *knowledge gained stage*.

Question 21

Comparing the six age groups of the experimental group with each other from the pretest to the posttest, yielded the following results. There is no age representative in *age group 45-49* in the experimental group, which would make it seven age groups. The correct answers by the age group 18-24 in the experimental group increased from zero (0%) to 12 (100%).

The Fisher's exact test was used to determine if there was a statistically significant change. The probability value (p) for the *18-24 age group* ($p=0.000$) is smaller than 0.05, which means that there is statistically significant relationship. The following age groups 30-34 and 35-39 in the experimental group also increased from zero (0%) to 5 (100%) and zero (0%) to 4 (100%) respectively. The probability value (p) for both age groups, namely 30-34 ($p=0.008$) and 35-39 ($p=0.29$) are smaller than 0.05, which means that there are statistically significant relationships. The other age groups showed no statistically significant results in answering this specific question at the *knowledge gained stage*.

Question 22

Comparing the six age groups of the experimental group with each other from the pretest to the posttest, yielded the following results. There is no age representative in *age group 45-49* in the experimental group, which would make it seven age groups.

The correct answers by the *18-24 age group* in the experimental group increased from zero (0%) to 12 (85.7%) and the *30-34 age group* increased zero (0%) to 4 (80%).

The Fisher's exact test was used to determine if there was a statistically significant change. The probability value (p) for both age groups, namely *18-24* ($p=0.000$) and *30-34* ($p=0.048$) are smaller than 0.05, which means that there are statistically significant relationships. The other age groups showed no statistically significant results in answering this specific question at the *knowledge gained stage*.

4.4.5 Performance of age groups in the control group at the knowledge gained stage

The control group had representatives of all seven age groups, unlike the experimental group, which only had six age groups at the *knowledge gained stage*. At the *knowledge gained stage* the age groups in the control group yielded no statistically significant results.

4.5 RETENTION OF KNOWLEDGE FROM THE POSTTEST TO THE POST-POSTTEST

The results comparison between the post stage and the post-post stage is known as the *retention stage*. The result comparison between the post stage and the post-post stage are only of those participants who were also part of post-post stage ($n=48$). The retention level reflects a slight drop for the experimental group ($n=25$) in their retention rate. They dropped by 0.76% from 89.14% (468 correct responses out of 525) to 88.38% (464 correct responses out of 525). The control group ($n=23$) on the other hand showed an increase of 7.45% from 63.98% (309 correct responses out of 483) to 71.43% (345 correct responses out of 483).

The comparison of the *retention stage* between the experimental and control group can be seen in Table 4.7. The control group’s increase might be due to the participants of the experimental group sharing information with them and/or other factors (of which maturation is one) that were not controllable in this study. However the latter influence has been identified as one of the limitations of this study.

TABLE 4.7: POST TO POST-POST COMPARISON OF THE RETENTION OF KNOWLEDGE BETWEEN EXPERIMENTAL AND CONTROL GROUPS

Question	Post-EX	Ppost-EX	Post-CON	Ppost-CON
1	88%	92%	34.80%	39.10%
2 to 22	89.14%	88.38%	63.98%	71.43%

A graphic comparison between the experimental and control group at the *retention stage* (posttest to post-posttest results) can be seen in Figure 4.10.

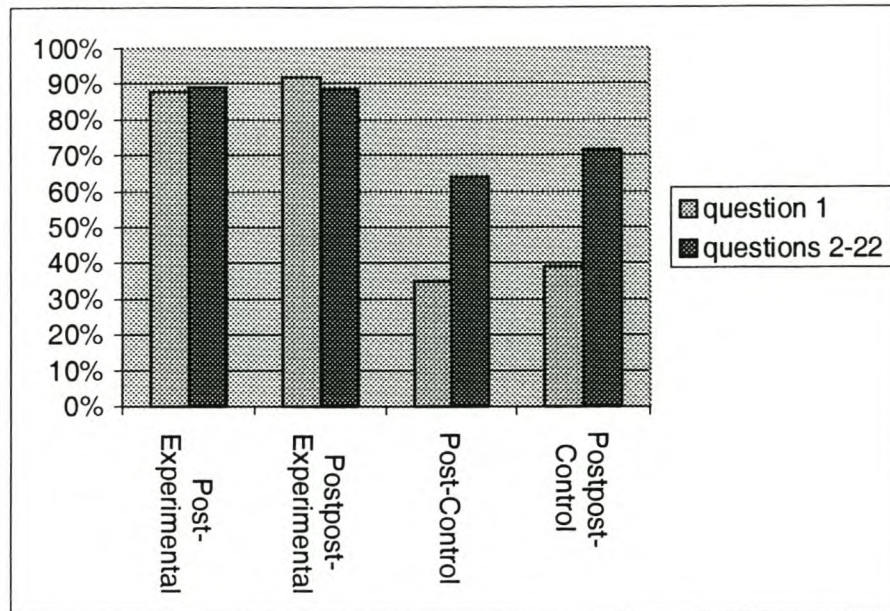


FIGURE 4.10 : COMPARING THE EXPERIMENTAL AND CONTROL GROUPS AT THE RETENTION STAGE (n=48)

4.5.1 Comparing the experimental group with control group at the retention stage

There were no statistically significant relationships in any of the 22 questions at the *retention stage* (posttest to post-posttest results) for both the experimental and the control groups, except for question sixteen.

Question 16

During the posttest the overall percentage for question sixteen for the *experimental group* was 100% (25 correct responses out of 25) compared to the *control group's* 56.5% (13 correct responses out of 23). The results for the post-posttest for the *experimental group* was 100% (25 correct responses out of 25) and for the *control group* 87% (20 correct responses out of 23). The experimental group retained their 100% score. The control

group on the other hand showed an increase from the posttest to post-posttest of 30.5%. A graphic comparison between the experimental and control group at the *retention stage* can be seen in Figure 4.11 (page 126).

To see if there was a statistically significant change the Fisher's exact test was used to determine if there is a relationship between the variables. The probability value (p) for the experimental group was not computed because it is a constant, whilst the control group's probability value ($p=0.047$) is smaller than 0.05, which means that there is a statistically significant relationship.

4.5.2 Gender performance in the experimental group at the retention stage

The Fisher's exact test was used to determine if there is a statistically significant relationship between the variables for each question. There were no statistically significant relationships in any of the 22 questions at the *retention stage* for both the male and female groups in the experimental group.

4.5.3 Gender performance in the control group at the retention stage

The Fisher's exact test was used to determine if there is a statistically significant relationship between the variables for each question. There were no statistically significant relationships in any of the 22 questions in the control group at the *retention stage* for both the male and female groups, except for question three.

Question 3

The correct answers by the male participants in the control group decreased from 8 (72.7%) in the posttest to 3 (27.3%) in the post-posttest and the female participants in the control group increased from 3 (25%) in the posttest to 9 (75%) in the post-posttest.

The probability value (p) for the male participants ($p=0.086$) is larger than 0.05, which means that there is no statistically significant relationship. The probability value for female participants ($p=0.039$) on the other hand is smaller than 0.05, which means that

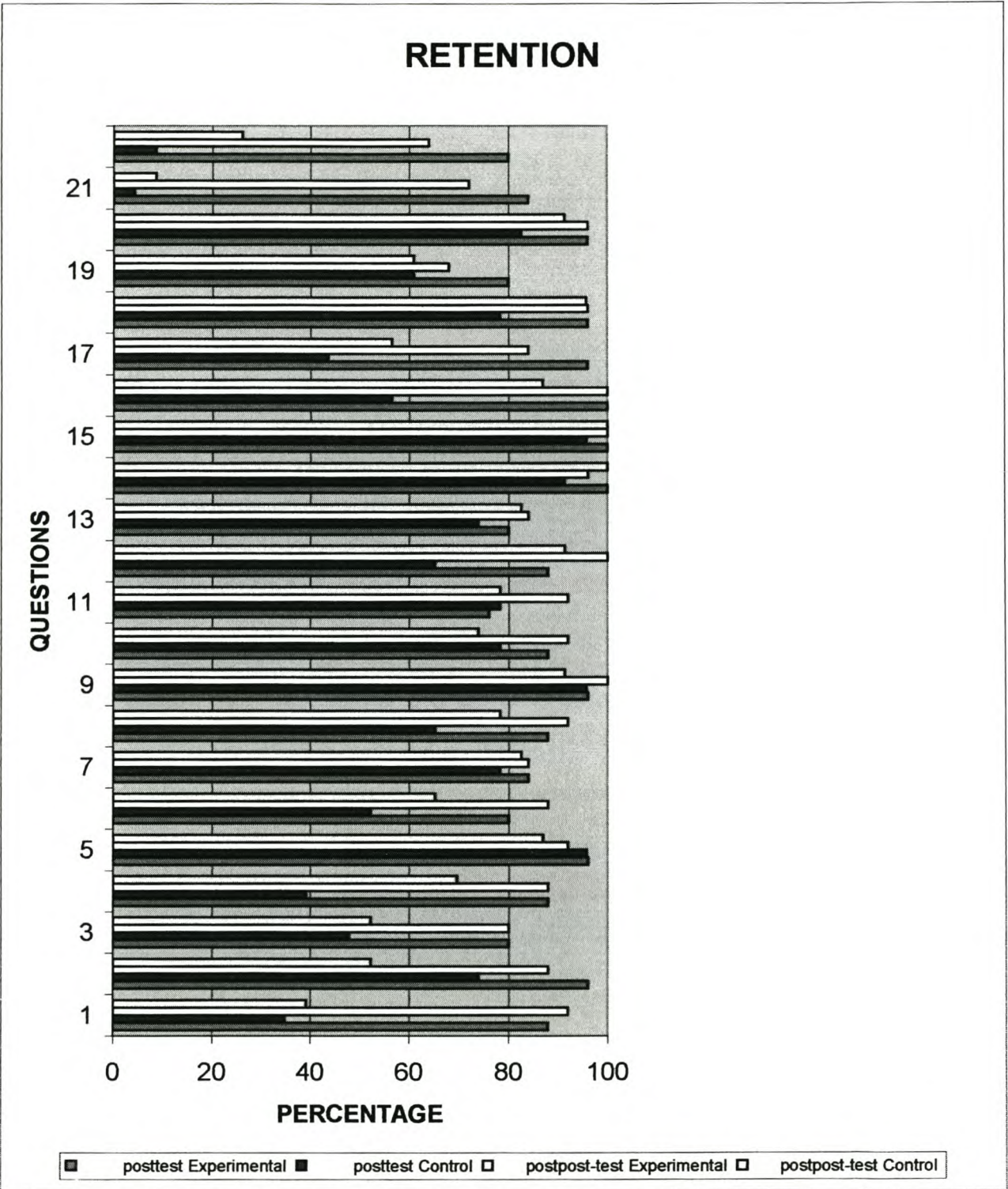


FIGURE 4.11 COMPARING THE EXPERIMENTAL GROUP WITH CONTROL GROUP DURING POST AND POST-POST RESULTS

there is a statistically significant relationship. Pin pointing why there has been an improvement in the female group might not be possible, however a possible reason for the significant improvement of the female group might be due to an extraneous variable, for example information they got from their friends who were part of the experimental group or information they got from other sources, like the media. Christensen (1988: 144) refers to the above-mentioned scenario as *history* (specific events, other than the independent variable, that occur between measurements of the dependent variable).

4.5.4 Performance of age groups in the experimental group at the retention stage

The Fisher's exact test was used to determine if there is a statistically significant relationship between the variables for each question. There were no statistically significant relationships in any of the 22 questions in the experimental group at the *retention stage* for the six age groups.

4.5.5 Performance of age groups in the control group at the retention stage

The Fisher's exact test was used to determine if there is a statistically significant relationship between the variables for each question. There were no statistically significant relationships in any of the 22 questions in the control group at the *retention stage* for the seven age groups, except for question six.

Question 6

The correct answers by the participants in the seven age groups of the control group showed no significant difference, except for the *18-24 age group*, which increased from four (40%) in the posttest to nine (90%) in the post-posttest. To see if there was a statistically significant change between the variables the Fisher's exact test was used. The probability value (p) for the *18-24 age group* ($p=0.057$) indicates a marginal difference, but not strong enough to say there is a statistically significant relationship. The other age groups showed no statistically significant results in answering this specific question at the *retention stage*.

4.6 THE NUMBER OF UNSURE RESPONSES

The number of unsure responses in the experimental group showed a bigger drop compared to the control group over the three stages as can be seen in Table 4.8 below. This comparison is done with the participants who partook in all three stages. The experimental group had 25 participants and the control group had 23 participants over all three stages. At the pretest stage the experimental group had 86 unsure responses versus the control group’s 65 responses. However, after the intervention the experimental group’s unsure responses dropped to nine, while the control group’s responses increased to 84. During the post-posttest the experimental groups unsure responses dropped even further to three, while the control group also showed a drop to 35 responses. After the intervention, the experimental group had less unsure responses than the control group. In fact at the posttest stage the control group’s unsure responses increased while the experimental group’s unsure responses decreased.

TABLE 4.8: PARTICIPANTS UNSURE RESPONSES OVER ALL THREE STAGES. (n=48)

Pre-Ex	Pre-Con	Post-Ex	Post-Con	Ppost-Ex	Ppost-Con
86	65	9	84	3	35

4.7 SUMMARY OF QUESTIONNAIRE RESULTS

The pretest result between the experimental group and the control group yielded no statistically significant results in any of the questions.

In the *knowledge gained stage*, the experimental group performed better than the control group. The latter is indicated by the nine statistically significant results yielded in the following questions by the experimental group: questions 1; 2; 4; 6; 15; 17; 19; 21 and 22. The control group on the other hand yielded no statistically significant results at the *knowledge gained stage*.

There was no statistical significance between gender group from the experimental and control groups during the *knowledge gained stage*, except for questions 1, 17, 19, 21 and 22 in the experimental group and question 5 (although it is marginal) in the control group.

There was no statistical significance between age groups within the experimental and control groups at the *knowledge gained stage*, except for questions 1; 6; 17; 19; 21 and 22 in the experimental group and no questions in the control group.

The study also shows the number of people at the FHALC who were exposed to HIV/AIDS education before this study took place. The less than 20% of NQF-level 4 learners who have already been exposed to HIV/AIDS education is a reflection of the findings in the literature review of this study. A small number of people are educated about HIV/AIDS, especially in the private sector, because employers are not bound by law to do so.

Comparing those participants who were previously exposed to HIV/AIDS education versus those participants who were not exposed to HIV/AIDS education, showed no statistically significant result at the pretest stage. The latter finding can be attributed to many factors, of which the following might be some that should be taken into account:

- when were they (previous HIV/AIDS education group) educated;
- who trained them;

- how long was the HIV/AIDS programme they attended?

4.8 THE INTERPRETATION OF THE INTERVIEWS

In this section the findings obtained from the interviews held with the participants from the experimental group are interpreted. From the original 27 participants only 18 were available for interviews.

The researcher has gone through all the interview data and divided them into representative categories and ideas. By doing this he identified how these can be linked to form larger and more general themes (White, 2000: 110). Categories are often variables that are related to the research question and therefore they form a bridge between the real measurement and the underlying theoretical and conceptual fields (Rossouw, 2000: 166).

The researcher analysed the interview data in a descriptive manner according to different themes and sub themes.

4.8.1 The interview data

The interview findings of each question were interpreted according to the responses of the participants in the themes indicated in Table 4.9.

TABLE 4.9: THEMES OF THE INTERVIEW

Themes	Questions
Accessibility	1; 4; 12
Knowledge	2; 3
Follow-up	5
Impact on economy	6
Initial interest in HIV/AIDS	7
Parental & community involvement	8; 9; 10
Peer education	11
Anti-discrimination & support	13; 14

Theme: Accessibility

Question 1

Do you think similar HIV/AIDS programmes should be offered at all ALCs? Why?

Dink jy soortgelyke MIV/VIGS programme moet aangebied word by alle Volwasse Onderwys Sentra (VOS)? Hoekom?

All 18 participants' answers yes to this question, with motivations ranging from:

- how important it is for everyone to be informed about HIV/AIDS;
- people should not get the information from the street, but from professional people; and
- that the HIV/ AIDS information (education) can save lives.

Theme: Knowledge

Question 2 (*Sub theme: modes of transmission*)

After receiving the HIV/AIDS training do you think you can educate others (friends, family members and colleagues) about how HIV is transmitted? Could you tell me how it is transmitted?

Nadat jy die MIV/VIGS opleiding ontvang het, dink jy dat jy ander (jou vriende, familie en kollega's) kan leer oor hoe MIV oorgedra word? Kan jy vir my sê hoe dit oorgedra word?

All 18 participants answered yes to this question and could give some or all the basic ways that HIV are transmitted. They mentioned the following *modes of transmission*:

- unsafe sex;
- that it is sexually transmitted;
- due to sharing of contaminated needles;
- getting in contact with contaminated blood (including blood transfusions); and
- from infected mother to baby.

One participant (L7) also mentioned the effect alcohol abuse could have in terms of making a wrong choice by “sleeping around” and not knowing with whom it was the next day.

Theme: Knowledge

Question 3 (*sub theme: sharing of knowledge*)

Could you give a practical example of how you could use your knowledge concerning HIV/AIDS to help another person with the correct information?

Kan jy 'n praktiese voorbeeld gee van hoe jy jou kennis aangaande MIV/VIGS gebruik het om 'n ander persoon te help met die korrekte informasie?

Except for one participant (L14), all the other participants have shared and are willing to share relative HIV/AIDS information or knowledge with:

- family members (5 participants);
- friends (5 participants);
- colleagues (3 participants); or
- acquaintances (4 participants), like one participant who made people aware at an accident scene not to touch blood (without having the necessary protection, to act as a barrier between you and the other persons blood).

Only one participant (L14) said that she has not yet met a person who does not know about AIDS.

Theme: Accessibility

Question 4

If you had a choice would you prefer the HIV/AIDS training to be part of the curriculum or should it be offered as a course on it own for any person (even if the person is not part of the ALC)? Please motivate your answer?

As jy 'n keuse gehad het sou jy verkies om die MIV/VIGS opleiding as deel van die kurrikulum te hê of as 'n aparte kursus vir enige persoon (selfs as die persoon nie deel is van die VOS nie)? Motiveer asseblief jou antwoord?

Only one participant (L10) indicated that the HIV/AIDS training should be part of the curriculum and at the same time also offered as a separate course. Another participant (L14) preferred it to be part of the curriculum, whilst the rest chose the HIV/AIDS

training to be offered as a separate course so that more people from the community could be educated about the disease. Reasons for the latter ranged from:

- the fact that if it is part of the curriculum all learners might not complete the course due to the high drop-out rate; and
- that not all people are interested in studying, but might be interested in completing a short course like HIV/AIDS.

Theme: Follow-up

Question 5

Do you think a follow-up course should be offered? Motivate?

Dink jy 'n opvolg kursus moet aangebied word? Motiveer?

All the participants felt that a follow-up course was necessary, except one participant (L11) who felt that the information she received during the initial training programme was adequate. The reasons why they felt they needed a follow-up course were:

- some needed to know more about emotional support;
- how to handle and communicate with people who are HIV+; and
- that there are always new developments that a person needs to be aware of.

Theme: Impact on economy

Question 6

What impact will HIV/AIDS have on our country's economy?

Watter impak sal MIV/VIGS op ons land se ekonomie hê?

All participants said that it would affect the economy negatively. The participants mentioned some of the following as reasons for the answers:

- that the disease will put pressure on the medical fraternity;
- the latter will also have negative influence on the medical aids and ultimately become more expensive;
- lower production due to ill workers and increased training costs of new workers due to death of trained workers;
- orphans due to parents dying of HIV/AIDS will lead to higher taxes; and

- even to an increase in crime, because orphans might not find jobs and may have to take care of themselves and siblings via criminal means.

Theme: Initial interest in HIV/AIDS

Question 7

Why did you attend the HIV/AIDS training?

Hoekom het jy die MIV/VIGS opleiding bygewoon?

They had heard about HIV/AIDS, but wanted to know more about the disease. The information they gained they felt they could use not only to protect themselves, but also their families and friends.

Theme: Parental and community involvement

Question 8

Do you think parents should become involved in educating the children about HIV/AIDS issues? Please motivate your answer?

Dink jy dat ouers betrokke moet raak met die opvoeding van hulle kinders rakende MIV/VIGS verwante sake? Hoekom?

All the participants felt that parents should be empowered about HIV/AIDS in order to inform their children about the disease and possible consequences of the disease. They mentioned that the parents involvement can range from:

- informing their children about how HIV/AIDS might impact on the economy;
- how to respond to a person who is HIV+;
- ensuring their children do not get the wrong information from the street; to
- the possibility that it can strengthen the bond between parents and child.

Theme: Parental and community involvement

Question 9

Would you recommend such a HIV/AIDS programme to fellow adult learners at the ALC? Why?

Sal jy so 'n MIV/VIGS program aan mede volwasse leerders aanraai? Hoekom?

All the participants said they would recommend such a HIV/AIDS programme to fellow adult learners in order to make them aware that there is no medical or health cure, except educating each other about the disease.

Theme: Parental and community involvement

Question 10

Would you recommend such a HIV/AIDS programme to community members who are not learners at the ALC? Why?

Sal jy so 'n MIV/VIGS program aan gemeenskapslede aanraai wie nie deel is van die VOS nie? Hoekom?

All 18 participants said yes they would recommend such a HIV/AIDS programme to community members who are not learners at the ALC, because it is information every member of the community should have. They mention:

- that people in the community know very little about the disease, e.g. how it is transmitted; and
- if they are educated better they would support and help each other.

Theme: Peer education

Question 11

Would you be willing to train others about HIV/AIDS at an ALC? Why?

Sal jy bereid wees om ander op te lei aangaande MIV/VIGS by die VOS? Hoekom?

One (L3) of the 18 participants was adamant that she would not at all be willing to educate others about the disease, while the other 17 felt they would be able to do it, with a few (L2 & L9) requesting more information and training in order to educate or train others.

Theme: Accessibility

Question 12

Should people pay if they wanted to attend such training courses? Why?

Moet mense betaal as hulle sulke opleidingskursusse wil bywoon? Motiveer?

The 18 participants all felt that people should not pay for such HIV/AIDS training courses. Some felt it is the government's responsibility to educate people for free, because it does not only affect the individual but the whole country.

Theme: Anti-discrimination and support

Question 13

Why do some people discriminate against people who are HIV+?

Waarom diskrimineer sommige mense teen ander wat MIV+ is?

The participants felt that people discriminate against people who are HIV+ because:

- they are ignorant and not informed about the disease; and
- suggested that these people should be educated about HIV/AIDS.

Theme: Anti-discrimination and support

Question 14

How can people support a HIV+ person?

Hoe kan mense 'n MIV+ persoon ondersteun?

Their answers range from:

- treating them like any normal human being;
- that they (HIV+) need to follow a healthy diet; to
- caring and loving them and show them that they are still part of the community.

4.8.2 Interview findings interpreted according to the themes and sub themes

The researcher had specific reasons why he asked these questions, which will become clear in the following section.

Theme 1-Accessibility

This theme consisted of three questions, namely questions 1, 4 and 12. The researcher wanted to know what factors would make HIV/AIDS education learner friendly for people seeking such education. The participants had no objection to the use of ALC's for HIV/AIDS education. They also felt that *HIV/AIDS education should not be part of the curriculum, but should be offered as a short course*. This is a valid point, especially if we look at the high drop out rate at ALC's. The high drop out rate highlights the need for short courses, rather than having it as part of the curriculum. The interviewees thus also identified the high drop out rate as a reason why the majority of them felt that HIV/AIDS education should be offered as a short course.

The other factor that would have an impact in terms of the number of people that needs to be educated about HIV/AIDS, is the question about *whether people should pay for such a course*. The participants felt people should not pay, because they are too poor. The researcher agrees with the latter, and because he understands the importance of making HIV/AIDS education available to more people it is especially important for role-players like government departments, the private sector and NGO's to discuss and ultimately supply financial, human and material resources to these working class communities. This will be one way of educating the unemployed about HIV/AIDS and it might be a motivational experience for them to further their formal education.

Theme 2-Knowledge

Question 2 deals with the *modes of transmission* and question 3 deals with the *sharing of knowledge*. These questions give the researcher an idea of whether participants can remember the modes of transmission and secondly whether they were or could play valuable roles in spreading HIV/AIDS information to other people, especially uninformed people. Most of the intervention participants consequently shared HIV/AIDS information with other people and in the process supplied them with the correct information. The participants could also mention some or all of the ways that HIV can be transmitted.

Theme 3: Follow-up

Question 5 referred to *whether follow-up courses should be offered*. The researcher is of the opinion that follow-up courses are important. It is important for the reasons the participants mentioned, such as for the provision of new information they might need and the number of different issues related to HIV/AIDS that cannot be covered in one session. Looking at the pretest results of participants who were previously educated about HIV/AIDS it makes it clear that people should be offered follow-up courses. The content and time intervals of follow-up courses should depend on peoples' literacy levels, as well as their knowledge about HIV/AIDS.

Theme 4: Impact on economy

The researcher asked this question (question 6) to see if participants understood what *impact the disease would have on the economy*. The researcher was also involved with the training of the primary school educators in the Gugulethu, Nyanga and Philippi area. A few of these educators argued that HIV/AIDS would have a positive impact on the economy, because hospitals, doctors and pharmacies will make more money, and there would be jobs for others who would have to take the place of sick and dead workers. The above-mentioned viewpoints of some of these teachers are not going to have a positive impact on our economy if that is what they are thinking. The latter scenario thus prompted this question. All the participants could however mention reasons why it will have a negative impact on our economy. The fact that the participants could give reasons why HIV/AIDS will have a negative impact on our economy also emphasized the reason why HIV/AIDS education is important. The literature review section made us aware of how myths and wrong information is spread and this point about the impact on our economy is no exception, and that is why we need to educate people about HIV/AIDS related issues. The interviewees showed with their responses that they understood the negative impact HIV/AIDS can have on our economy if it is not brought under control.

Theme 5: Initial interest in HIV/AIDS

Question 7 refers to this theme and asks the question *why participants attended the HIV/AIDS training*. The majority of participants have heard about HIV/AIDS, but wanted to know more about the disease. With the information they gained from the programme

they felt they could use it not only to protect themselves, but also their families and friends.

Theme 6: Parental and community involvement

This theme consisted of three questions, namely questions 8, 9 and 10. Question 8 refers to *whether parents should be involved in educating the children about HIV/AIDS*. The participants felt that parents can play an important role in educating the children about the disease and at the same time also strengthen the bond between parent and child.

Questions 8 and 9 refer to *whether participants would recommend such an HIV/AIDS programme that they have attended to fellow adult learners and to community members who are not part of the ALC respectively*. The interviewees responses highlighted the importance for fellow learners and other community members to be educated because it would not only play an important preventative role, but would hopefully also decrease the discrimination and stigma levied against people infected with HIV/AIDS, (and their families).

Theme 7: Peer education

This theme is covered by question 7. The question refers to *whether participants will be willing to train others about HIV/AIDS*. All the participants were positive about training others about HIV/AIDS, except one. The researcher however feels that although 17 out of the 18 participants were willing to educate others, that peer educators should follow a special programme, which focuses on content and facilitation skills. In conjunction with the latter point, peer educators should initially be mentored and coached the first few courses that they run in order to give them feedback and to make sure they stick to the facts.

Theme 8: Anti-discrimination and support

This theme consisted of two questions, namely questions 13 & 14. Question 13 refers to *why some people discriminate against HIV+ people*. Participants saw HIV/AIDS education as the strongest weapon to decrease the discrimination and stigma levied against people infected with HIV/AIDS, and their families. According to them, the

majority of people who discriminate against an infected person do so because they are ignorant and not informed about the disease.

Question 14 refers to *how HIV+ people can be supported*. The education of communities might lead to increased support and understanding for people living with the virus and will allow the following responses from the interviewees to become a reality in our communities:

- that they treat them (HIV+ people) like any normal human being;
- that they (HIV+ people) are educated about their dietary requirements; and
- to care and love them and show them that they are still part of the community.

All the above can only be achieved and enhanced through education and making sure the correct information about HIV/AIDS reaches as many communities as possible.

4.9 CONCLUSION

In this chapter, the findings of the pretest, posttest and post-posttest questionnaires have been reported. The results showed there was a difference between those who received the intervention (experimental group) and those who were part of the control group. A bigger test might be to study the experimental group participants every two years to see if the programme information has been retained or whether follow-up courses should have been introduced on an annual basis or not. The latter question is however beyond the scope of this study.

In conjunction with the questionnaire findings, the interviews that were held with the 18 remaining participants of the experimental group were also interpreted, which lead to the conclusions and the recommendations of this study.

In the following chapter, the conclusions and the recommendations arising from the study will be discussed.

CHAPTER 5

FINDINGS, SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In the previous chapter the results of the questionnaires and interviews were presented, analysed and interpreted. In this chapter the findings are summarized and conclusions and recommendations are discussed.

5.2 FINDINGS FROM THE QUESTIONNAIRES

The following findings were gathered from the information supplied by the NQF-level 4 learners of the FHALC by means of a questionnaire.

- 5.2.1 It was evident from this study that the FHALC caters for adults of all ages to further their studies, as can be seen from the gender and age distributions show in items 4.2.2 and 4.2.3 respectively.
- 5.2.2 At the pretest stage there were no statistical significant differences between the experimental and control groups as regards their knowledge levels, as indicated on page 91 (the last paragraph of item 4.3.1.1).

- 5.2.3 At the pretest stage the gender ratio was 60: 40 in favour of the females, as highlighted in the second paragraph of 4.2.2.
- 5.2.4 The 18-24 age group had the highest number of participants at the pretest stage, with a 37 % (29 participants) representation out of 78 participants as can be seen in Figure 4.3. At the post-posttest the 18-24 age group still had the highest number of participants with 48% representation out of 48 participants as highlighted in Figure 4.5.
- 5.2.5 There was no statistically significant difference between the participants who had previous HIV/AIDS education and those who did not at the pretest stage, as indicated in the fourth paragraph of 4.2.4.
- 5.2.6 The number of participants who were employed and who have had HIV/AIDS training only comprised 10 out of 45 participants (22%). The number of participants who were unemployed and had HIV/AIDS training only consisted of 5 out of 33 participants (15%) as illustrated in Table 4.2. In total only 19% (15 of the 78 participants) were exposed to HIV/AIDS training as indicated the third paragraph of 4.2.4. One reason for the low exposure to HIV/AIDS education is the fact that employers are not bound by law to develop a workplace AIDS policy and programme, as highlighted in the sixth paragraph of section 1.1.
- 5.2.7 With regards to the parental and marital status of the participants 56 of the 78 indicated they had children (Table 4.4). Sixteen of the 56 parents were single, which is an indication that they had unprotected sex as indicated in 4.2.5. Table 4.4 also highlights the fact that the 18-24 age group represents the highest single parent group in this study, namely 10 (63%) out of 16 single parents in this study.
- 5.2.8 During the knowledge gained stage (comparing the pretest to posttest results) the experimental group showed statistically significant results in nine of the 22 questions as indicated in item 4.4.1. The nine questions are highlighted in item 4.4.1.1 (page 108 to page 110). The control group however yielded no statistically significant results during this stage.

5.2.9 During the knowledge gained stage both the male and female groups in the experimental group showed statistically significant results in the same five of the 22 questions, as indicated in item 4.4.2. The control group however yielded no statistically significant result during this stage as indicated in item 4.4.3.

5.2.10 During the knowledge gained stage the following age groups in the experimental group showed statistically significant results in questions 1; 6; 17; 19; 21 and 22, as indicated in item 4.4.4:

- in question 1 the 18-24 age group was the only group that yielded a statistically significant result;
- in question 6 the 30-34 age group was the only group that yielded a statistically significant result;
- in question 17 the 18-24 age group was the only group that yielded a statistically significant result;
- in question 19 the 18-24 age group was the only group, which yielded a statistically significant result;
- in question 21 the following age groups, namely 18-24; 30-34 and 35-39 yielded statistically significant results; and
- in question 22 the following age groups, namely 18-24 and 30-34 yielded statistically significant results.

The control group however yielded no statistically significant result during this stage as indicated in item 4.4.5.

5.2.11 During the retention of knowledge stage (comparing the posttest to post-posttest results) the experimental group yielded no significant results, whilst the control group yielded one statistically significant result during this stage, namely for question 16 as indicated in item 4.5.1.

5.2.12 During the retention of knowledge stage both the male and female groups in the experimental group showed no statistically significant results in any of the 22 questions as indicated in item 4.5.2. The control group however yielded a statistically significant result during this stage as indicated in item 4.5.3, namely question three.

- 5.2.13 During the retention of knowledge stage none of the age groups in the experimental group showed any statistically significant results in any of the 22 questions as indicated in item 4.5.4. The control group also yielded no statistically significant result during this stage as indicated in 4.5.5.
- 5.2.14 The number of unsure responses were higher at the pretest stage in the experimental group, but after the intervention the unsure responses of the experimental group was much lower than the control group during the posttest and the post-posttest as can be seen in Table 4.9.
- 5.2.15 According to the results from the pretest stage there were no statistical differences between the control group and the experimental group regarding their knowledge about HIV/AIDS and related issues, but after the intervention the experimental group scored significantly higher on both the posttest and post-posttest as illustrated in Figure 4.9 and Figure 4.11 respectively.
- 5.2.16 The responses by the participants on question one of the questionnaires indicated their perceptions of what they thought they knew about HIV/AIDS. The participants who were exposed to the intervention did not only score higher than the control group during the post and post-post test, but their perceptions (question one) about what they thought they knew about HIV/AIDS also increased as illustrated in Figure 4.8 and Figure 4.10 respectively.
- 5.2.17 The high dropout rate of adult learners needs to be taken into account when thinking of implementing HIV/AIDS education in ALCs as indicated in the second paragraph of item 4.2.

5.3 FINDINGS FROM THE INTERVIEWS

The findings are based on the interviews with the 18 participants from the experimental group. The interviews were only conducted with the remaining experimental group members and not with the participants from the control group.

- 5.3.1 From the participants' responses as highlighted on page 135 (under the theme: peer education) there is a willingness from their side to be peer educators, but at the same time they requested more training and information to empower them as peer educators.
- 5.3.2 According to the responses of the interviewees on page 132 (question 3, under the theme: knowledge) they have already started spreading helpful information to family members, friends, colleagues and significant others.
- 5.3.3 The participants were aware of how valuable the HIV/AIDS information was, especially in terms of saving lives and not getting the wrong information from the street, as can be seen on page 131 (question 1, under the theme: accessibility).
- 5.3.4 According to the responses of the interviewees on page 135 (question 12, under the theme: accessibility) they felt that in order to reach more people the HIV/AIDS training should be free of charge.
- 5.3.5 The interviewees understood that the disease would have a negative impact on the economy if people are not educated about the disease as can be seen on page 133 (question 6, under the theme: impact on economy). Hopefully the HIV/AIDS educated people will model responsible behaviour and prevent further infections, which should have a positive impact on the economy as a whole. This is however a long term goal and needs to be monitored in order to see if education has an impact in reducing further infections.
- 5.3.6 According to the responses of the interviewees on page 136 (question 13, under the theme: anti-discrimination and support) they highlighted the importance of HIV/AIDS education and realized that people discriminate against HIV+ members of society, due to ignorance. This also highlights the need for all people to be educated about the disease in order to minimize discrimination against infected people and the fear and myths surrounding the disease.

- 5.3.7 The interviewees understood that they have a role to play in supporting infected people and treating them with the same dignity and respect as other members of society, as can be seen on page 136 (question 14, under the theme: anti- discrimination and support).
- 5.3.8 According to the responses of the interviewees on page 132 (question 4, under the theme: accessibility) the majority of participants felt that the HIV/AIDS education programme should be offered as a short course and not as part of the curriculum. Two of the main reasons why interviewees favoured the latter were that if it is part of the curriculum all learners might not complete the HIV/AIDS course due to the high drop-out rate; and that not all people are interested in studying, but might be interested in completing a short course on HIV/AIDS.
- 5.3.9 The latter is further supported by the interviewees' responses on page 135 (question 10, under the theme: parental and community involvement). The interviewees' motivations were that people in the community know very little about the disease, e.g. how it is transmitted; and if they are educated they would be better equipped to support and help each other. Only one participant felt that the HIV/AIDS-course should be part of the curriculum and another felt it should cover both options, namely the short course, and as part of the curriculum as indicated on page 132 (question 4, under the theme: accessibility).
- 5.3.10 According to the responses of the interviewees on page 134 (question 8, under the theme: parental and community involvement) participants felt that educating parents about the disease would have a positive derivative, namely that their children would get correct information from their parents and at the same time it could also enhance relationships between parents and their children.
- 5.3.11 The interviewees initial interest in HIV/AIDS training (question 7), as can be seen on page 134, was that they wanted to know more about the disease and in the process of gaining knowledge they could protect themselves, as well as their families and friends.

- 5.3.12 According to the responses of the interviewees on page 133 (question 5, under the theme: follow-up) the majority felt that they needed a follow-up course which would address issues like emotional support; how to handle and communicate with people who are HIV+; and the fact that there are always new developments that a person needs to be aware of.

5.4 CONCLUSIONS BASED ON THE FINDINGS

- 5.4.1 Item 5.2.2 indicated that the participants of the experimental group and the control group were on par in terms of their pretest knowledge levels of HIV/AIDS related issues. The latter can be attributed to the random sampling method that was used to divide participants into the two groups, as highlighted in section 3.2.
- 5.4.2 Item 5.2.4 indicated that the 18-24 age group had the highest number of participants at the pretest stage. The latter might be due to the high dropout rate in the mainstream schools as highlighted in section 2.1 (second paragraph) and the learners realizing that they would have to improve their academic qualifications in order to make themselves more marketable when applying for jobs.
- 5.4.3 Item 5.2.5 highlighted the fact that there was no statistically significant difference between participants who have had exposure to previous HIV/AIDS education (15 out of 78) and those participants who had no exposure. The latter is an indication of how important follow-up courses are and by following the route of follow-up courses we might not fall in the trap of become complacent as Aggleton (1997) warns us in section 2.12.
- 5.4.4 The responses from the participants of the experimental group regarding follow-up courses also highlighted the need for further training, as indicated in item 5.3.12.
- 5.4.5 Item 5.2.6 indicated that only 15 out of the 78 participants (19%) were exposed to previous HIV/AIDS education. The provision of in-house HIV/AIDS education programmes should be encouraged in the workplace, because the majority of employers

are not offering HIV/AIDS education yet. The latter is not only supported by this research findings, but also by Smart and Strode (1999) in section 1.1 (sixth paragraph), however not all employers might have the capacity in terms of resources to go the route of in-house HIV/AIDS education. The latter concern should not be seen as an obstacle, but rather as an opportunity for employers to give something back to their workers and families by sponsoring HIV/AIDS education programmes at ALCs.

- 5.4.6 The number of single parents (16 out of 56 parents) in this study, as highlighted in item 5.2.7, indicated that they have had unprotected sex and the possibility is that some of them are still having unprotected sex. The latter is one of the main modes of HIV transmission, especially if one or both partners are not faithful in their relationship. The 18-24 age group is the group that represents 63% of the single parents in this study according to item 5.2.7 and if they continue to have unprotected sex their children might be part of the AIDS orphans as highlighted in section 2.9. The latter will not only put a burden on the country's economy but might also lead to an increase in the crime rate.
- 5.4.7 The experimental group who received the training showed a significant increase in knowledge compared to the control group during the knowledge gained stage as highlighted in item 5.2.8. Looking at the questions that yielded significant results for the experimental group, we can see the importance of HIV/AIDS education, and how it can improve the knowledge of people who are possibly at risk of contracting the disease (for example those practicing unsafe sex and intravenous drug users) if they are not informed about the facts of HIV/AIDS. Some of these above-mentioned nine questions are also some of the myths and information that people get from people who themselves are lacking the necessary knowledge regarding HIV/AIDS and related issues. To latch on to the latter the need for HIV/AIDS education is pointed out by the fact that the pretest showed that:
- nearly 50% out of 78 participants did not know that AIDS cannot be cured (question four), as indicated on page 85; and
 - more than 42% of participants did not know that a mosquito cannot infect a person with HIV (question six) as indicated on page 86.

- 5.4.8 The other two questions that yielded statistically significant results as indicated in item 5.2.8 are, firstly the fact that some of the participants thought that AIDS can be cured if you have sex with a virgin (question 15), and secondly that the pretest results indicated that more than 70% of the 78 participants did not know what the window period is (question 19), as highlighted on pages 88 and 89 respectively. These above-mentioned points are worrying aspects, but this study showed that these misconceptions could be addressed through HIV/AIDS education as indicated in section 4.4.1.
- 5.4.9 Item 5.2.9 indicated that there was no difference in the performance of males and females in the experimental as well as the control group.
- 5.4.10 Item 5.2.10 indicated that in the experimental group:
- the 18-24 age group yielded statistically significant results in questions 1; 17; 19; 21 and 22;
 - the 30-34 age group yielded statistically significant results in questions 6; 21 and 22; and
 - the 35-39 age group yielded a statistically significant result in question 21.
- The age groups in the control group on the other hand yielded no statistically significant results.
- 5.4.11 Item 5.2.11 indicated that during the retention of knowledge stage the experimental group yielded no statistically significant results (including question 16, because they cannot do better than the 100% result they obtained as indicated in section 4.5.1), whilst the control group yielded a statistically significant result, namely for question 16.
- 5.4.12 Although the experimental group showed a slight drop in terms of retention of knowledge it was still higher than the control group, as indicated in Figure 4.10 (page 124).
- 5.4.13 Although people are aware of AIDS, they lack basic knowledge about the disease. The lack of basic knowledge can influence their decision-making processes and also their ability to give correct information about the disease to others. One example from this

study is their poor understanding of the *window period*. It is evident from section 4.4.1 (question 19, on page 106) in this study that many people did not know what the *window period* is. It does not mean if person X and person Y's test results are negative that they can have sex without a condom, especially if one or both of them had unprotected sex within the three months before the test. A negative result should therefore be interpreted with caution. The only way to make this point clear to people is through education and role-playing it in order to make it more visual and realistic for learners.

- 5.4.14 It is evident from the performance of the experimental group that basic HIV/AIDS education is not only important, but during the interviews the participants from the experimental group also motivated why it is important that follow-up courses should be offered, as indicated in item 5.3.12.
- 5.4.15 ALCs are under-utilized in fighting the HIV/AIDS pandemic, as they are not currently (2003) used to promote HIV/AIDS education. In poor communities ALC's should be seen (and marketed) as centres to educate people in formal education as well as short courses (including health education and Lifeskills' courses). Making the latter a reality depends on the main role players (relevant government departments, private sector, CBO's and NGO's) sitting down and discussing what each group is prepared to contribute in order to make HIV/AIDS education accessible to everyone.

5.5 RECOMMENDATIONS

After presentation, analysis and interpretation of the results, conclusions have been drawn in this chapter. Finally, the researcher makes the following recommendations.

Although the sample size is too small to make generalizations about the broader population, the study gives us an indication of how many people were actually exposed to HIV/AIDS education prior to the intervention programme of 2 March 2002 at the FHALC, as indicated in Figure 4.6. In order to reach more people regarding HIV/AIDS education it is thus recommended that

ALCs and the private sector should start negotiations about how they can complement each other in terms of educating not only their workers, but also their workers' family members.

Participants indicated that they would be willing to be trained as peer educators, but coaching is recommended to assist and guide them with the initial facilitation process. The coaching process should thus complement their training. This would lead to uniformity, especially in terms of the facts that peer educators would have to share with their peers (adult learners).

It is recommended that the training should not only be knowledge based, but rather be coupled with skills training and development. The latter combination will allow learners to be even more effective and better equipped to share important and relevant HIV/AIDS information with significant others. Parents who will be able to talk to their children about HIV/AIDS issues will create an environment of trust between them and at the same time their children can also verify information they had gotten from the 'street'.

Seeing that employers are not bound by law to implement a HIV/AIDS policy and programmes, as highlighted in section 1.1 (paragraph five), it is recommended that employers should be encouraged to do so. A further recommendation is that best practice models from employers who are implementing policies and programmes in their businesses should be published or made available to other employers, which could use it as guidelines. The role of ALCs in terms of offering a service to employers, who want their workers to be educated about HIV/AIDS should not be underestimated. Logistical issues need to be discussed and researched, because it can be done with proper planning between all role players as indicated in section 2.2.

The low number of previously HIV/AIDS educated participants, plus the added concern about the quality and the number of hours they were exposed to in the education programme or course is an unknown factor. The less than twenty percent of participants who have previously been exposed to HIV/AIDS education and the fact that they did not score significantly higher than those participants who had not been previously exposed to HIV/AIDS education highlights the need for establishing a committee that consists of at least government departments and the private sector involved with HIV/AIDS education to give guidelines about what a basic HIV/AIDS programme should consist of.

It is recommended that HIV/AIDS education should not be promoted by one session or via an 'Aids awareness week', but that it accommodates for concerns that people forget, as indicated in items 5.4.3 and 5.4.14.

It is recommended that the need for follow-up courses as indicated in item 5.3.12 and the identification of such courses should flow from the suggested basic programme, depending on the needs of that specific group who has been trained. The focus of the follow-up courses might thus be different from group to group. Things that might influence courses are participants':

- education levels;
- literacy levels;
- need to focus on prevention and or support of people who are infected or affected by the disease;
- who might be people who are HIV+ and need to know how to improve and maintain a healthy lifestyle;
- parental skills; and
- willingness to be trained as peer educators.

It is also recommended that the business sector should support HIV/AIDS education in their local area of operation and in so doing ensure a healthier customer base. The researcher supports Naidu's (2002) plea in section 2.6, that the business sector should be encouraged to partner with, CBOs (NGOs and ALCs) in their local areas of operation to strengthen community responses regarding HIV/AIDS.

The involvement of the business sector to support and to help with the funding of HIV/AIDS education programmes should be encouraged. Although participants from the experimental group stressed the importance of the programme, they were all against the idea that people should pay for such courses, as indicated in item 4.8.1 (question 12). It is thus recommended that the private sector could play a major role in subsidizing or sponsoring HIV/AIDS education programmes. The benefits will ultimately directly or indirectly come the private sectors way, with healthy, productive workers and a healthy society buying their products. The business sector should not only focus on educating their workers, but also the workers' families. The

latter is important, because the worker might be healthy, but if one or more of his/her family members are infected it will also have an impact on his/her productivity and absenteeism.

HIV/AIDS training is especially important for those adults who are illiterate and still sexually active. They cannot read books, pamphlets, billboards or rosters and overviews of television programmes in magazines and newspapers to make them aware about HIV/AIDS issues. It is thus recommended that HIV/AIDS education could be structured in such a way that learning can still take place, for example via role playing, making use of video's, participants discussing their own experiences about HIV, question and answer sessions, and all this can be done without them having to read. A further recommendation is regarding this point is that it is important that HIV/AIDS educators/trainers should be aware of the literacy levels of participants so that the training and material presented would be appropriate.

It is also recommended that a long term research study should be done to specify any expected gains flowing out of community based or ALC's HIV/AIDS education programmes. Expected gains should be seen in the decline of HIV/AIDS infections, a drop in absenteeism from the workplace, stability in the labour force and in productivity, which in turn will or should have a positive influence on our country's economy. This once again highlights the point that not only the workers should be educated, but also their families, as well as the unemployed.

The study highlighted the need for parents to be educated about HIV/AIDS. It is thus recommended that HIV/AIDS education for parents implies that parental skills have to be taught, where parents can role-play how to use their HIV/AIDS knowledge in order to talk or answer their children about HIV/AIDS related issues.

HIV/AIDS education is the main means of convincing individuals to modify their risk behaviour, minimize their fear and prejudice based on ignorance, and build a rational and sensitive attitude towards HIV-infected persons. It is recommended that HIV/AIDS issues should be tackled by using existing structures, like ALCs and CLCs, which could be used to become a hub of community development and upliftment, especially in previously disadvantaged communities.

The next recommendation stems from the high dropout rate at ALCs (as well as in the mainstream), which indicates that it might be better to offer HIV/AIDS education as a short course and not necessarily as part of the curriculum.

Providing HIV/AIDS education should not be about making money at community members' expense, so it should be offered free of charge where possible. The latter is supported by the researchers findings as indicated in item 5.3.4. The HIV/AIDS education programme however has the potential to create jobs for community members, especially the unemployed. They could be trained as HIV/AIDS peer educators. It is recommended that the latter would work well if a good mentoring or coaching programme is in place, that is where newly trained peer educators are guided and given feedback in order to improve their facilitation skills as well as to make sure they teach the correct facts about HIV/AIDS.

The completion or attendance of a HIV/AIDS programme should allow participants to receive a certificate in order to boost their self-esteem and at the same time act as an advert for other members of society to improve their knowledge of HIV/AIDS.

ALCs are traditionally found in predominantly black and coloured communities, but this should not create the impression that only certain communities or race groups need HIV/AIDS education. Irrespective of their risk (or race), all people must be provided with basic information and the means to protect themselves against the virus.

The interviews have shown that the adults who are educated about AIDS cannot only play a major role as peer educators, but also as parents informing their children about HIV/AIDS related issues. As previously mentioned the age group 15-24 has the highest HIV infection rate, thus it stands to reason that the parents or even older brothers or sisters can play a role in spreading the information about HIV/AIDS rather than the virus. The 15-24 age group might consist of dropouts from the mainstream schooling system. The latter might be beyond the scope of this study, i.e. to find out how many mainstream dropouts are in this specific age group, but it may imply that those dropouts would not get the full benefit of HIV/AIDS education in the mainstream. The ALC might be one option for dropouts from the mainstream to be educated about HIV/AIDS.

The researcher wants to raise awareness about the pandemic proportions AIDS has taken on and that HIV/AIDS education should not only be focusing on empowering learners and educators at public school level and on some workers in the private sector. We have to look at educating our adult learners through Adult Learning Centres and Community Education Centres in communities that would otherwise not be exposed to HIV/AIDS education. It is recommended that partnerships with the Education Department and/or private sector need to be explored in order to make HIV/AIDS education a reality in the above-mentioned institutions.

It is also recommended that the information in this study should be published as widely as possible. This would ensure that as many role-players as possible, like the education department, health department, private sector, trade unions, NGOs and CBOs, would be informed of the results of the study.

5.6 CONCLUSION

The main problem addressed by this study is that not all adults are being educated about HIV/AIDS and related issues. The researcher is concerned about those people who are unemployed, those who are working at companies where no AIDS policies and programmes exist, and those in the informal sector. To accommodate these groups the ALC can be utilized to play a meaningful role in their education.

The aim of this study was to see if the HIV/AIDS training programme leads to a greater awareness about HIV/AIDS and related issues. The results of the study indicated that the knowledge levels of those learners exposed to the HIV/AIDS education programme increased significantly compared to those who were not part of the experimental group, as indicated in 5.4.7. Thus the answer to the first research question, as stated in section 1.6 (page 9), is positive. The answer to the second research question (which refers to the reliability of the information that the experimental group will be sharing with others) is positive, as indicated in 5.3.2 and 5.3.10. The answers to the third (whether HIV/AIDS education would lead to better understanding and support of PWAs) and the fourth research questions (were they aware of the impact HIV/AIDS would have on the economy) are both positive, as indicated in 5.3.6 and 5.3.5 respectively. The answer to the fifth research question (whether there was a difference between the HIV/AIDS knowledge levels of males and females) is negative, as indicated in

5.4.9. The answer to the sixth research question (was there a difference in terms of the knowledge levels of the different age groups) was positive in the experimental group during the knowledge gained stage, as indicated in 5.4.10. The age groups in the control group however yield no statistically significant results, as indicated in 5.4.10. The answer to the seventh research question was that 15 out of 78 participants were exposed to HIV/AIDS education prior to this study, as indicated in 5.4.5. The answer to the last research question (is there a need for follow-up programmes) was positive, as indicated in 5.3.12 and 5.4.3. The study also concludes that HIV/AIDS education should be offered as a short course and not as part of the ALC's formal subjects or learning area's, as indicated in 5.3.8.

The researcher believes that this study could make a contribution to the government sector, private sector, trade unions, NGOs and CBOs to work together and use existing education structures, like ALCs to create healthier and more knowledgeable communities in preventing HIV infections. The latter should minimize the fear and anxiety about HIV/AIDS as well as change the negative attitudes towards HIV-infected persons due to ignorance about HIV/AIDS. Hoping for a vaccine or cure for HIV/AIDS at this stage is an unsound strategy. We might not have a medical vaccine, so our only vaccine against HIV is education. HIV/AIDS education however should not only be seen as one training session, but rather as a sustainable and ongoing programme. The latter should be seen as the backdrop to the fact that right now (2003) prevention is our only line of defence against HIV/AIDS.

The focus should not only be on high-risk groups, but on every one and making them aware of the dangers when participating in high-risk activities. People who might not be classified as part of a high-risk group can also be infected if they do not know how the disease is transmitted. "This epidemic is only going to be conquered when the population as a whole is mobilized against it" (Whiteside and Sunter, 2000:135). I hope that people, by utilizing ALCs as HIV/AIDS education centres, will spread the word rather than the virus. The modes of transmission is know to us, so we need to stick to the rules in order not to become part of the HIV/AIDS statistics. *The bottom line is that HIV/AIDS can be beaten!*

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CONFIDENTIAL/ VERTROULIK

Please complete the following information required:
Voltooi asseblief die volgende inligting verlang:

GENDER/ **GESLAG**:

M	
---	--

AGE/ **OUDERDOM**:

18 – 24
25 – 29
30 – 34
35 – 39
40 – 44
45 – 49
50 +

EMPLOYED/ **WERK**
 UNEMPLOYED/ **WERKLOOS**

--

MARRIED/ **GETROUD**

DIVORCE/ **GESKEI**

SINGLE/ **ENKEL**

Parent or guardian of children:
Ouer of voog van kinders:

0 - 10 years/ jaar
11 – 21 years/ jaar
22+

← Indicate how many e.g. 1
 ← Toon getal hier aan, bv 1
 ←




Have you been exposed to HIV/AIDS education?
Was u al blootgestel aan MIV/VIGS opleiding?

Y	N
---	---

APPENDIX A

Answer the following questions by making a tick in the appropriate block.

Beantwoord die volgende vrae deur die gepaste blok te merk met 'n kruisie.
(DON'T GUESS.....MOENIE RAAI NIE.....)

	Yes 	Don't know 	No 
1. Do you think your knowledge about HIV/AIDS is adequate to make informed decisions regarding the disease? <i>Dink jy dat jou kennis rakende MIV/VIGS genoegsaam is om ingeligte besluite te kan neem aangaande die siekte?</i>			
2. Is there a difference between HIV and AIDS? <i>Is daar 'n verskil tussen MIV en VIGS?</i>			
3. If a person becomes infected with HIV, does this mean he or she has AIDS? <i>As 'n persoon besmet word met MIV, beteken dit dat hy of sy VIGS het?</i>			
4. Can AIDS be cured if it is treated within the first month? <i>Kan VIGS genees word as dit binne die eerste maand behandel word?</i>			
5. Can a person become infected with HIV by having unprotected sex (without a condom) with someone who is infected by HIV? <i>Kan 'n persoon besmet word met MIV deur onbeskermde seks (sonder 'n kondoom) te hê met iemand wie besmet is met MIV?</i>			
6. Can mosquitoes pass on HIV just like they pass on malaria? <i>Kan muskiete MIV versprei, net soos hulle malaria versprei?</i>			
7. Can a person who has sex only with healthy looking partners become infected with HIV? <i>Kan 'n persoon wie slegs seks het met persone wat gesond lyk, besmet word met MIV?</i>			
8. Is HIV a disease that mainly affects homosexuals? <i>Is MIV 'n siekte wat hoofsaaklik homoseksuele mense raak?</i>			
9. Can you get HIV from hugging someone who is HIV positive (HIV+)? <i>Kan jy met MIV besmet word as jy iemand omhels wat MIV positief (MIV+) is?</i>			
10. People who are sharing the same house with someone who is HIV+ are also infectious and can also pass on the virus to other people. <i>Mense wie dieselfde huis deel met iemand wat MIV+ is, kan ook ander mense aansteek met die virus.</i>			
11. Is it safe to only have unprotected sex with a person you know? <i>Is dit veilig om slegs onbeskermde seks te hê met 'n persoon wie jy ken?</i>			

APPENDIX A

12.	Can you become infected with HIV the first time you have sex? <i>Kan jy besmet word met MIV die eerste keer as jy seks het?</i>			
13.	People who are HIV+ should not be allowed to socialise with healthy people. <i>Mense wie MIV+ is moet nie toegelaat word om met gesonde mense te sosialiseer nie.</i>			
14.	Is it a shame to be friends with a person who is HIV+ ? <i>Is dit 'n skande om bevriend te wees met 'n persoon wat MIV+ is?</i>			
15.	Is it true that a person who is HIV+ can be cured if he has sex with someone who is a virgin? <i>Is dit waar dat 'n persoon wie MIV+ is, genees kan word deur seks te hê met 'n persoon wat nog 'n maagd is?</i>			
16.	Can you see if somebody is HIV+? <i>Kan jy sien of 'n persoon MIV+ is?</i>			
17.	Are men at greater risk to HIV infection than women in South Africa? <i>Is mans se kanse groter om besmet te word met MIV as vroue in SA?</i>			
18.	Is it safe to share the same razorblade with someone else? <i>Is dit veilig om dieselfde skeerlem met iemand anders te deel?</i>			
19.	Is the 'window period' the stage where you can see the person is physically ill? <i>Is die 'venster periode' (window period) die stadium waar jy kan sien die persoon is fisies siek?</i>			
20.	Is it true that it is good for the country's economy if more people are HIV+? <i>Is dit waar dat dit goed vir ons land se ekonomie is as meer mense MIV+ is?</i>			
21.	Please provide us with the telephone number <i>of the AIDS HELPLINE</i> <i>Kan u ons asseblief voorsien van die VIGS HULPLYN (AIDS HELPLINE) telefoonnommer.....</i>			
22.	What does the acronym AIDS stand for? <i>Waarvoor staan die afkorting VIGS?</i>			

APPENDIX B

TRANSKRIPSIE

1. Do you think similar HIV/AIDS programmes should be offered at all ALC's? Why?

Dink jy soortgelyke MIV/VIGS programme moet aangebied word by alle Volwasse Onderwys Sentra (VOS)? Hoekom?

L1 Ja, want...Omdat ek dink dis 'n opvoedkundige program en 'n mens kan baie daardeur leer en jy kan dit oordra aan jou medemens die inligting wat jy opdoen.

L2 Ja ek dink so. Dit is baie interessant om te leer oor hierdie dinge. Op die straat hoor jy van VIGS, maar nie soos jy dit by 'n sentrum sal kry nie. Dit is meer... dit is baie meer ingewikkeld as jy sit en luister na wat die mens te sê het oor VIGS en ...ek dink dis 'n goeie idêe dat VIGS as 'n program aangebied word aan sentrums, veral so by die leerdersentrums baie mense weet min van VIGS af en wanneer hulle in sit in 'n program, hulle leer baie daar uit.

L3 Ja, (stilte)...ek dink dis beter as dit so gedoen word want daar is baie volwasse mense wat nou nie eintlik die 'dingesse' ken nie van VIGS nie...dat hulle eers weet daarvan en oordra aan mense wat nie weet daarvan nie.

L4 Ja, omdat mense meer kan weet oor VIGS en dit nie op straat moet hoor nie, maar van professionele mense.

L5 Ja meneer, want ek dink dit is noodsaaklik vir almal onderrig kan kry en weet waaroor MIV/VIGS gaan want dit lyk asof baie mense nie 'n idêe het waaroor VIGS gaan nie.

L6 Ja, dit sal vir ons baie van hulp wees om inligting oor te dra aan die oningeligtes.

L7 Ja. Om die mense meer kennis te laat opdoen, mense meer wysheid gee sodat hulle weet wat die oorsaak is van MIV/VIGS.

L8 Ja, want baie van die mense is hulle miskien onder die indruk dat hulle weet wat aangaan, maar in die 'real life' het hulle nog baie kennis wat hulle moet opdoen.

L9 Ja... sodat hulle meer kan uitvind oor VIGS, want daar is baie van hulle wat nie weet hoe gevaarlik VIGS is nie en hoe dit oorgedra word nie.

L10 Ja. Om rede dit is goeie inligting en ons kan dit deel maak van ons lewens, veral met ons familie en vriende te deel. Hierdie inligting hang van lewe en dood af.

L11 Ja, want baie van die grootmense wat die aandskole bywoon weet hulle se self nie hoe VIGS rond versprei kan word nie.

L12 Ja ek dink so, dit is baie belangrik dat ons weet en meer ingelig word omtrent MIV en VIGS.

L13 Ja, sodat meer en meer mense opgelei kan word en tot die kennis kan kom van VIGS.

L14 Ja ek dink dit moet, want daar is baie mens wat ek weet wat niks van MIV/VIGS af weet nie. Ek dink dit sal 'n goeie idee wees om dit te hou by 'n Volwasse onderwys sentrum.

L15 Ek dink dit moet aangebied raak, want baie mense verstaan nie regtig waar wat die woord of wat VIGS eintlik is nie. So dit moet definitief aangebied raak, laat baie meer mense kan verstaan wat gaan aan.

L16 Ja. Volwasse mense wat by die VOS is is ook nie baie ingelig nie, so ek dink dit sal baie goed wees.

L17 Ja dit sal 'n goeie idee wees vir volwasse onderwys, want so sal volwassenes leer oor VIGS.

L18 Ja, want daar is baie volwassenes wat nog nie baie ingelig is oor 'HIV/AIDS' nie, daar is nog baie mense wat graag kursusse wil loop...so ek dink dit is ja.

2. After receiving the HIV/AIDS training do you think you can educate others (friends, family members and colleagues) about how HIV is transmitted? Could you tell me how it is transmitted?

Nadat jy die MIV/VIGS opleiding ontvang het, dink jy dat jy ander (jou vriende, familie en kollega's) kan leer oor hoe MIV oorgedra word? Kan jy vir my sê hoe dit oorgedra word?

L1 Ja ek is positief dat ek ander mense sal kan positief beïnvloed met inligting ek het nog nie op die stadium spesifiek te doen gehad met iemand wat VIGS het nie. Maar ek is seker ek kan want ek het al vir familie en vriende vertel van die kursus wat ek gedoen het.

Dit is seksueel oordragbaar en natuurlik met bloedoortappings is die risiko ook groot.

L2 Ek sal sê ja, positief. Daar is verskillende maniere, byvoorbeeld seksueel, van moeder na baba en dan wanneer jy met bloed...bloed in kontak kom wat MIV/VIGS is...VIGS in het, dan kan jy ook VIGS opdoen.

L3 Ja. Deur naalde... en so aan. 'Dieselde dinges' naalde en skeerlemme te gebruik wat ander mense gebruik is dit moontlik om oor te dra.

L4 Ja. Deur besmette naalde, deur seks, van ma na ongebore baba en....(Is dit al?) L4 skudde kop bevestigend, ja.

L5 Ja, deur seksuele omgang, bloedoortapping, as gevolg van spuitnaalde en as gevolg van in aanraking te kom met iemand anders se bloed wat 'VIGS-positief' is.

L6 Ja, dit word oorgedra van moeder na kind, deur bloedoortappings, bv as jy jou hare sny by 'n... by 'n haarkapper en die lemmetjie is miskien besmet, naalde, besmette naalde gebruik.

L7 Ja. Die kennis wat ek het kan ek weer oordra aan my broers en susters en aan ander kennisse wat ek ken. Dit word oorgedra van besmette moeder na die ongebore baba en deur besmette bloed van persoon wat miskien gebruik word in bloed oortappings,...dit word oorgedra by veral die 'ouense' wat 'drugs, gebruik dieselfde spuitnaalde deel vir dwelm gebruik, deur rond te slaap sonder beskerming...en drankmisbruik kan ook 'n oorsaak wees want die volgende dag weet jy nie eens met wie het jy geslaap nie.

L8 Ja die kennis wat ek nou opgedoen het kan ek nou gaan oordra. Dis wanneer jy met besmette bloed in aanraking kom of met verskillende bedmaat omgang het, jy kan ook bloedoortappings of met naalde of tattooering dit opdoen...ook deur onbeskermd seks, swangerskappe...van moeder na kind kan dit oorgedra word.

L9 Ja, want die klein bietjie kennis wat jy het kan jy met hulle deel, maar hulle moet ook na so kursus toe gaan sodat hulle ook ander kan help. Deur bloed, deur ma tot kind by geboorte en borsmelk. Ek ken nie die ander nie.

L10 Ja. Dit word oorgedra vanaf die ma na kind waar 'pregnancy concern' is, deur borsvoeding, vuil naalde wat herhaaldelik gebruik word ook deur onbeskernde seks en in 'ope' wonde van een persoon na 'n ander waar bloed in kontak kom met mekaar.

L11 Ja, dit word op drie maniere oorgedra. Dit word oorgedra deur 'unprotected sex', deur ouers, deur ma's wat 'pregnant' is wat seks het, meer as een seksmaat het en bloed deur naalde, deur dieselfde naalde kan gebruik en sonder kondome, en ma na baba in die, in die baarmoeder.

L12 Ja, ek dink ek kan...dit word oorgedra van mens na mens, dit is gewoonlik in die bloedstelsel, van ma na 'n babaen dit sal wees in die baarmoeder, en dan gewoonlik is dit in die borsmelk, en dan ook seksueel sonder 'n 'condom'.

L13 Ja, as jy seksueel aktief is, sonder 'n kondoom, van ma na baba, borsmelk en gedurende geboorte en in die baarmoeder, vermenging van bloed.

L14 Ja, ek kan. Dit kan oorgedra word deur 'n besmette naald of met iemand seks te het sonder 'n kondoom.

L15 Ek sal definitief iemand kan verduidelik wat dit oor is en sal ek kan verduidelik want ek het bietjie agtergrond oor 'MI/VIGS'. Dit word deur verskillende 'partners' sonder kondoom, dit word oorgedra deur seksueel te verkeer met verskillende mense sonder 'n kondoom, deur byvoorbeeld dieselfde naalde te gebruik en van ma na baba, as die ma miskien MIV is kan sy dit oordra na baba.

L16 Ja, ek dink so. Dit word oorgedra van rondslapery sonder 'n kondoom....net die man of vrou hoef rond te slaap om sy maat te 'infect'...VIGS te gee; deur moeder na baba by geboorte of borsvoeding en deur spuitnaalde of skeerlemme te deel.

L17 Ek sal sê ja. MIV word oorgedra deur middel van losbandigheid van seks, besmette naalde wat gebruik word ...oor en oor by persone en van 'n swanger vrou na baba of van ma na kind.

L18 Ja. Seksueel, wanneer jy seks het sonder 'n kondoom, ma na die baba gedurende geboorte...borsmelk, vermenging van bloed en dieselfde spuitnaalde te deel.

3. Could you give a practical example of how you could use your knowledge concerning HIV/AIDS to help another person with the correct information?

Kan jy 'n praktiese voorbeeld gee van hoe jy jou kennis aangaande MIV/VIGS gebruik het om 'n ander persoon te help met die korrekte informasie?

L1 My kind het onlang sy is agt jaar oud, sy is in graad twee. Hulle het so twee weke gelede MI (AIDS)-week gehad en haar juffrou het gevra dat die ouer hulle moet help om inligting te gee oor hoe MIV kan oorgedra word en ek kon vir haar inlig.

L2 Daar was 'n geval by ons werk waar een van die...die mense gedink het hulle het VIGS en daar was toe die ...die oproering dat hulle weg van die persoon af wil bly omdat hulle bang is hulle gaan besmet word met die 'HIV'-positief met VIGS virus en ek het toe net vir hulle benader en vir hulle gesê VIGS word nie opgedoen deur aanraking nie of dieselfde 'liepil' te gebruik nie. VIGS word net opgedoen deur middel van bloed, seksueel en van moeder na baba en dit het nogal baie mense aangeraak en ek het vir hulle ook bewys dat u kan vat aan iemand wat

VIGS het en jy sal dit nie kry nie, alhoewel jy net versigtig is as daar bloed betrokke is.

L3 Ek het die klas bygewoon waar ek meer inligting kon gekry het om ander mense inlig oor dit wat ek geleer het by die klas.

(soos wie het jy al gehelp?)...Kan jy die vraag herhaal asseblief. (Vraag herhaal)...die wat ek geleer het by die skool het ek 'basically' oorgedra aan hulle wat ek weet van, ek het dit mondelings gedoen deur te praat met hulle (Wie is hulle waarna jy verwys?)... Van my 'vrinne', die wat nou 'unprotected sex' of dinge doen het ek nou... my 'vrinne' gesê wat ek geleer het wat hulle ouers hulle moes geleer het of iemand anders hulle 'wysgemaak' het van.

L4 Deurdat ek familieleden bewus gemaak het hoe VIGS oorgedra word ennet dat dit nie op enige manier oorgedra kan word nie, soos 'liepels' en al daai goed wat die mense op straat praat nie. Ek vertel vir hulle wat ek by die kursus geleer het en hoe word dit oorgedra.

L5 Ja ek het byvoorbeeld 'n persoon (vriend) verduidelik rondom MIV/VIGS want die ou was onder 'n wanindruk van hoe dit ontstaan en hoe dit veroorsaak word en hoe dat dit oorgedra word.

L6 Ek kan byvoorbeeld by die huis my kinders meer ingelig het aangaande hoe VIGS oorgedra word en vir my man kan ek ook ingelig het en my vriende. by die kerk kon ek ook gepraat het met die ouers om hulle kinders te waarsku oor die gevare VIGS.

L7 Ja definitief. Kyk soos eenkeer wat ek by 'n motorongeluk was het ek die mense gesê hulle moet versigtig te werke gaan want jy weet nooit watter van die mense dra die virus nie...as jy dus 'n seer plek op jou het kan daardie bloed van die ander persoon in aanraking met jou kom en op die ou einde word jy ook aangesteek.

L8 Ja deur die feit dat ek die jongspanne afgewys het van die tattooermerke waarmee hulle hul wou laat tattooer, want jy kan VIGS so opdoen.

L9 My suster het vir my baie vrae gevra toe ek klaar is met die kursus en sy het vir haar vriende gesê by die skool dat hulle moet kondome gebruik as hulle seksueel aktief is en so sorg hulle dat hulle nie VIGS kry nie en swanger raak nie.

L10 Daar gaan soos hulle sê tussen hakes baie ‘rumours’ rond en baie mense dink hulle weet als wat aangaan, maar vandat ek hierdie kursus geloop het kan ek wel mense korrekte informasie gee oor VIGS as hulle met verkeerde stories rond loop.

L11 Ja ek het wel my suster se vriendin help, wel gehelp, sy het gedog dat VIGS deur drukkies en hand, hant, ‘handvatte’ en soen kan gegee word en ek het vir haar gese dit kan alleen oorgedra word op drie maniere.

L12 Kan ek net weer daai vraag kry.(Vraag herhaal)Ja ek kan meer ingaan omtrent MIV en VIGS om daardie een te vertel en hoe en waar.... en waar om help te kry.

L13 Herhaal net gou daai (Vraag herhaal)ek kan byvoorbeeld ‘n vriend of vriendin waarsku as hy seksueel aktief is om ‘n kondoom te gebruik.

L14 Ek het nog nie iemand tegekom wat nog nie weet van VIGS nie.

L15 Ek werk vir ‘n tandarts en ‘n pasient wou weet is die tandarts of sy assistente nie bang hulle kan VIGS kry nie met al die bloed van die mense. Ek het vir haar gesê ons gebruik ‘gloves’ en kan dit slegs kry as daar ‘n stukkend plek in die ‘glove’ en jou vel is, andersins sal jy dit nie kry nie.

L16 Ja, my vriend sê dat dis meestal net die mofies wat VIGS kry, maar ek het vir hom verduidelik dit is nie so nie en dat ons almal dit kan kry as ons nie verstaan hoe dit oorgedra word nie...en onbeskermd seks is die domste ding om te doen. My vriend was 'geworried', want hy het al 'n paar keer sonder 'n kondoom seks gehad. Ek het hom gesê hy moet gaan vir 'n toets...ja.

L17 Ek sou sê ja. 'n Kollega by die werk het my gevra hoe jy VIGS kan kry en ek het vir hom gesê jy kan nie VIGS kry deur middel van of uit dieselfde beker te drink of dieselfde pot of toilet te gebruik nie.

L18 Ja, soos by die werk het 'n kollega gesê jy kan HIV kry as 'n muskiet jou byt en ek het vir hom informasie gegee om vir hom te sê dat 'n muskiet nie HIV oordra nie, maar deur rond te slaap sonder 'n kondoom, van ma na baba, en so aan.

4. If you had a choice would you prefer the HIV/AIDS training to be part of the curriculum or should it be offered as a course on it own for any person (even if the person is not part of the ALC)? Please motivate your answer?

As jy 'n keuse gehad het sou jy verkies om die MIV/VIGS opleiding as deel van die kurrikulum te hê of as 'n aparte kursus vir enige persoon (selfs as die persoon nie deel is van die VOS nie)? Motiveer asseblief jou antwoord?

L1 Ek sal dit nogal grootliks wil aanbeveel vir as 'n mens ander mense kan aanstel as hulle nie deel is van die sentrum nie en dis 'n goeie ding vir vir ekstra kursus.

L2 Ek sal sê deel van die kurrikulum by baie skole, baie kinders weet nie waaroor VIGS gaan nie en as dit in die kurrikulum ingesit word weet ek en ek glo sal die dode syfer.... sal verminder en kinders sal besef wat VIGs werklik is.

(En by die volwasse onderwys sentrum?)

Hulle sê moes nou groot mense weet alles, maar ek stem nie saam nie. Wanneer dit kom by VIGS is daar baie te leer en ek dink dit sal goed wees om dit aan te bied by sulke sentrums. As deel van 'n kursus.

L3 Die kursus moet oop is vir almal al wil hulle nie skool loop nie.

L4 Al is die persone nie deel van die volwasse sentrum nie, laat hulle ook deel is van die kursus. Ouer mense weet nie altyd hoe word VIGS oorgedra nie en hulle ook met die virus bekend gemaak word...die virus aan hulle bekend gestel word.

L5 Ja...is nie altyd dat mense die geleentheid kry om uit te vind van VIGS nie.so as 'n aparte kursus kan dit aangewend word vir mense wat graag meer wil weet en wat ook betrokke wil wees in die omgewing of in sy samelewing om ander te help.

L6 Ek dink dit sal raadsaam wees om enige mens opleiding te gee al is hulle nie deel van die aandskool (Volwasse onderwys sentrum) nie.

L7 Ja, ek sou verkies het dat dit vir enige persoon moet gewees het want op die manier is daar vir party mense wat nie by volwasse onderwys sentrums kan uitkom nie, ek bedoel mense wat al klaar skool opleiding gekry het en vir hulle is dit miskien....hulle is by ver geleë plekke en kan dit vir hulle aangebied word... vir almal wat nie volwasse onderrigklasse wil of kan bywoon nie.

L8 Ek sou sê dit moet as 'n kursus aangebied word om ander mense ook te help.

L9 Vir enige persoon, nie net vir sekere mense nie, want hoe gaan die ander weet wat nie klasse bywoon nie, dit is mos vir hulle ook belangrik.

L10 My persoonlike opinie dit sou goed gewees het as dit apart en ook as deel van die sillabus aangebied kon word.

L11 Ek sal dit, ek sal dit, ek sal dit aanbeveel dat dit by enige persoon kan aangebied word want daar is mense daar buite wat glad nie weet nie, glad nie weet hoe 'AIDS' oorgedra kan word nie.

L12 Ja ek dink dit sal goed gewees het as dit apart is van kurrikulum want dan sal baie mense, hulle sal van hierdie opleiding weet, hulle sal meer weet en en die inligting ontvang omtrent MIV/VIGS.

L13 Dit kan deel wees van die kurrikulum, maar as dit 'n aparte kursus is kan enigeen deelneem daaraan en sodoende kan meer en meer mense kennis op te doen (Watter een verkies jy, die aparte kursus of die kurrikulum) Ek sou sê die aparte kursus.

L14 Ek dink dit moet deel wees van die kurrikulum, dit moet soos 'n vak op skool aangebied word.

L15 Dit moet deel is van die kurrikulum sodat mense kan leer wat VIGS is en dan op die anderkant... baie mense maak ook soms nie klaar nie en kan dan nie alles uitvind oor VIGS nie, dan is dit eintlik beter om dit as 'n aparte kursus te het.

L16 Vir my dink ek....aparte kursusse is beter. Vigs is 'n groot probleem en as ons almal wil leer oor MIV/VIGS moet ons hulle nie wil 'force ' om 'VOS' toe kom nie, want part is klaar met skool of wil nie verder skool loop nie, maar....maar wil weet van VIGS.

L17 Ek sou verkies die aparte kursus. Baie van my vriende wat by die aandskool was het dit 'gedrop'.

L18 Ja. Daar is nog baie mense wat HIV as 'n aparte kursus wil leer en nie as deel van die kurrikulum nie.

5. Do you think a follow-up course should be offered? Motivate?

Dink jy 'n opvolg kursus moet aangebied word? Motiveer?

L1 Ja ek dink so... sodat as ek... alhoewel ek voel ek is goed ingelig is 'n mens nooit veral wat die emosionele sy betref ...kan ek nie baie seker wees nie, maar ek glo volgens my persoonlikheid sal ek iemand kan beïnvloed.

L2 Positief, ek dink so baie mense het ingekom vir die program en het baie goed geleer...hulle het daar uitgegaan en hulle het vergeet van die goed hulle en het nie die goed gaan toepas op hulle lewens nie en ek dink as ons net nog 'n kursus kry om dit net 'n bietjie uit te bring, dan sal ons meer dit toepas op ons lewens.

L3 Ja ek dink so. Want die inligting wat 'n mens kry is nooit te 'min' om te weet daarvan nie, om nog by te kry sal beter wees om meer mense wys te maak.

L4 Ja. Daar word elke dag nuwe dinge oor 'HIV' uitgevind. Mense hou net op by een kursus en dan weet hulle nie wat is die nuwe verwickelinge nie, so hulle moet bekend gestel word aan die nuwe verwickelinge.

L5 Ja, die kennis wat ons tans het ek glo nie is so breed versprei dat jy iemand beter kan help nie maar as dit verder kan gaan sodat jy meer kan ingaan en meer betrokke kan wees en ook meer mense kan help.

L6 Ja ek dink so, die eerste eerste kursus wat ons gedoen het is meestal net die basiese dinge wat ons geleer het so ek sal meer wil weet oor hoe die mense wat dit het, hoe om met hulle te kommunikeer of hoe om hulle te hanteer.

L7 Ja, definitief. Dit bied vir ons die kans om meer dinge te leer wat vorendag gekom het, nuwe dinge.

L8 Ek sou sê ja. 'n Opvolg kursus is belangrik om meer aandagtig gemaak te word.

L9 Ja, want elke jaar is dinge verskillend.... Nuwe goed kom by, nuwe goed word ontwikkel.

L10 Die program soos dit was, was baie goed, maar daar was nie genoeg tyd om veral na die emosionele kant te kyk nie, so dit kan nog uitgebrei word met opvolg sessies en motivering.

L11 'n Opvolgkursus, ek dink nie so nie, ek het genoeg 'uitgevinne' by die kursus en dit het net vir my 'n positiewe beeld gegee... dat ek meer kan weet van VIGS.

L12 Ja sekerlik, net om meer mense aandagtig te maak en mense meer se kennis uit te brei omtrent MIV en VIGS.

L13 Ja, want een kursus is nie genoeg nie ek bedoel daar is so baie meer informasie en mens kan dit nie alles in een kursus op doen nie.

L14 Ja, want ek as persoon sal baie graag meer wil weet hieroor. Die kursus wat ek gedoen het, ek dink nie dit was genoeg nie, definitief nie.

L15 Ja, ek het verstaan wat ek gedoen het in die kursus en ek het baie geleer, maar daar is nog baie meer wat 'n mens moet leer. Dit is nou regtig waar iets wat interessant is en gevaarlik.

L16 Ja. Ek het baie geleer, maar daar is nog baie dinge wat ek moet leer en nuwe of beter goed wat ek moet ken van VIGS.

L17 Ja. Ek voel daar is nog baie wat ons moet leer oor VIGS, nog baie.

L18 Daar moet 'n opvolg kursus wees, veral as jy miskien a paar feite vergeet het of nuwe feite by kry.

6. What impact will HIV/AIDS have on our country's economy?

Watter impak sal MIV/VIGS op ons land se ekonomie hê?

L1 As daar nie drasties iets aan gedoen word nie soos byvoorbeeld 'n teenmiddel gekry word nie ek glo die arbeidsmark sal daal veral tussen die ouderdomsgroepe 20-40 wat in die arbeidsmark is en baie kinders gaan wees gelaat word en kinders van 10 of 11 moet alreeds dan al ouers speel wat nog nie eers vir hulle self kan werk nie.

L2 Soos ons almal weet is VIGS een van die grootste viruses op.. in die land en baie mense sterf deur middel van VIGS ek dink die land het nogal swak deurgekom deur VIGS omdat baie min mense weet wat VIGS betref... waarom dit gaan en is hulle nie rêrig bekommerd oor dit nie, maar sodra jy VIGS opdoen dan... dis dan wat jy 'kop kry' en ek dink die land het nodig om die mens te laat weet. Baie mense gaan partytjies toe sonder 'protection' en ek dink dis belangrik as dit kom by seks... ons se land kry rêrig swaar deur hierdie virus.

L3 Dit sal definitief 'n groot impak het, dit sal ekonomie laat daal.

L4 Deurdat die ekonomie sal daal as gevolg van die groot aantal MIV-positiewe mense in die land.

L5 Dit sal 'n negatiewe impak het, baie mense sal werkloos wees, kinders wat sal sonder ouers gelaat word, hulle sal wees wees en baie van die mense sal steel om aan die lewe te bly.

L6 Dit sal rêrig 'n 'disaster wies' as die MIV virus soos dit nou aangaan, lewens eis, kinders word sonder ouers gelaat, kinders het nie ander heenkome nie. Hulle sal steel om aan die lewe te bly want die broodwinner is weggeneem. Die werkers word geraak, hulle gaan dood.

L7 Ek dink dit sal byvoorbeeld as baie mense moet aangesteek word hoeveel kennis het hulle nie oorgedra nie, as hulle moet dood gaan van VIGS is dit 'n groot verloor vir 'onse' ekonomie want die mense sterf almal uit en dan is daar nie mense wat kan voort gaan met opvoedkundigheid van ander nie en al daai ding en... kinders word weerloos gelos ...hulle het nie 'n heenkome nie mense sterf net en en land gaan net agter uit.

L8 Ons land se ekonomie sal baie daal, want hoe meer siektes, kom ons sê die siekte MIV/VIGS het 'n hewige impak op die ekonomie...alles sal duurder word en ons mense swakker en swakker as gevolg van VIGS...die ekonomie sal net nie suksesvol wees nie.

L9 Die mense sal begin siek word en as hulle miskien hulle werke verloor, dan sal daai kinders van daai mense as hulle sterf wees word...en dan moet die 'social workers' in komen dan moet on meer 'tax' betaal. Diefstal...die kinders gaan miskien steel as hulle nie kos en geld het nie.

L10 Soos ons weet MIV/VIGS het nie 'n ouderdomsvlak nie, dit tas ons ambagsmense aan en as hulle weg gaan en ons jongmens ook moet uitsterwe as gevolg van VIGS kan ons self dink dat wie gaan die werk aan die einde van die dag doen, wie gaan die kennis oordra na die jong man toe....en spesiaal ook vir die man op die pad/straat, jou 'rates' sal opgaan, ons sal meerder moet betaal en

vir behandeling as ons dink aan ‘medical aid’ sal styg. In alle dele van die lewe sal dit ‘n impak het, nie net op die ekonomie nie.

L11 Ek dink dit sal die land se ekonomie verswak omrede die ouers van die kinders sal doodgaan, en die kinders sal sieklik word later van tyd, en hulle sal uit hulle werke bly of miskien uit skole., dan sal die belasting op gaan en die medie, en die mediese fondse sal wel ook op styg.

L12 Ja dit sal ‘n groot impak het. Die ekonomie sal onsettend daal as ons nou kyk na familie waar die vader miskien besmet is en hy sal dit nou seker oordra na die ma en later sal die kinders lei daar onder. Natuurlik sal hulle dokters moet sien, hospitale en natuurlik hulle mediese fons gelde, en hulle mediese fons sal later nie meer kan by hou nie om hulle te betaal, uit te betaal so dit sal ‘n taamlike groot impak het op die ekonomie.

L13 As ‘n persoon besmet is met VIGS kan hy siek word en dan is hy afwesig van sy werk, die produksie daal en soos die mediese...as jy nie mediese fonds het nie gaan jy na ‘n staathospitaal toe en dan betaal die ander mense meer belasting.

L14 Dit sal die ekonomie swakker maak.

L15 Ons land se ekonomie gaan verskriklik daal, want mense is baie onverskillig en baie mense het dit, want as jy hoor hoeveel persent het VIGS.

L16 Ons se ekonomie gaan sukkel...mense gaan dood of te siek wees om te werk, minder werk sal gedoen word; arme kinders sal moet steel om aan die lewe te bly; mediese geld sal duurder raak....oumas en oupas sal moet kinders grootmaak.

L17 MIV/VIGS het ‘n groot impak op ons land se ekonomie omdat die mense siek raak en produksie daal, mediese onkoste is hoog en iemand anders moet geleer word om sy werk te doen.

L18 Hoe kan ek nou sê, dit (die ekonomie) sal nie verbeter nie dit sal eintlik versleg, byvoorbeeld as kinders se ouers sterf as gevolg van HIV sal die staat die kinders moet 'foster' en (nie) net dit ook nie... as die kind wees is en hy woon nou by ander mense dan sal hy begin steel, want wie sê nou die mense sal agter hom kyk. Hy sal steel en in die tronk beland en ekonomie sal net slegter word.

7. Why did you attend the HIV/AIDS training?

Hoekom het jy die MIV/VIGS opleiding bygewoon?

L1 Omdat dit is 'n siekte wat deel is van ons lewe ek kan nie sê dit sal my nie raak nie of my gesin nie raak nie so ek het gevoel ek behoort dit te doen, want dit kan oor 'n jaar of twee ek of my kind wees.

L2 Om die eerlike waarheid te se ek het niks geweet van MIV?VIGS nie en toe ek daar uitstap na die kursus het ek baie baie geleer. Die informasie was van....van toepaslik op my lewe gewees en ek kan dit nou oordra aan ander mense.

L3 Ek het gevoel dit sou nodig wees vir my om ander mense te help daarmee, selfs my jonger broer, vriende, familie...

L4 Deurdat ek self wil hoor hoe word dit oordra en familie en vriende wat nie die kursusse wil bywoon nie vir hulle te vertel van die virus.

L5 Omdat ek meer wou weet rondom MIV/VIGS.

L6 Dis maar net om meer inligting te kry aangaande die siekte.

L7 Ek het dit bygewoon om my kennis uit te brei en ook om te wet hoe om MIV-persoon te behandel seker te wees hoe om persoon te behandel wat die virus dra.

L8 Ek voel ek kon net daarby baat, om my self te kanbeskerm en ook om ander te help.

L9 Omdat ek 'n gesinsvriend gehad het wat dood is van die virus en ek wou net meer geweet het omtrent VIGS.

L10 Omrede ek as persoon dink dit is baie goed vir 'n enkel persoon, maar ek ook 'n pa is van 'n kind sal ek baie graag die regte inligting wil oordra na hom as hy vir my enigiets wil vra oor VIGS.

L11 Om meer te weet van MIV/VIGS.

L12 Omdat ek baie min geweet het oor die hele proses van MIV/VIGS en ek het gevoel dit is nodig dat ek dit moet weet, al daai nodige informasie sodat ek myself en my familie en kinders dit kan deel en ook met my vriende.

L13 Omdat ek self meer wou geweet het omtrent dit.

L14 Want mense het gepraat van VIGS en jy hoor van VIGS oral. Ek het nie self baie geweet van VIGS nie, ek het net geweet seksuele omgang.... So dis hoekom ek dit bygewoon het, om bietjie meer uit te vind daarvan.

L15 Ek het dit bygewoon, want ek wou meer geweet het van VIGS. Ek het 'geverstaan' wat dit is, maar ek het meer inligting nodig gehad. Ek het baie 'geverstaan' toe ek klaar met die kursus gewees het, toe weet ek eintlik wat dit.

L16 Ek het geweet of gehooer van VIGS ...'AIDS', maar hoe dit oorgedra of vermy kan word was ek nie van seker nie, dus hoekom ek moes kom vir die les.

L17 In ons land is daar baie mense wat min kennis het van die siekte en omdat daar so baie siek mense is. Ons mense dra min kennis daarvan.

L18 Ek wil baie meer weet oor HIV/AIDSelke dag is daar net meer mense wat besmet word, so ons moet meer weet oor AIDS.

8. Do you think parents should become involved in educating the children about HIV/AIDS issues? Please motivate your answer?

Dink jy dat ouers betrokke moet raak met die opvoeding van hulle kinders rakende MIV/VIGS verwante sake? Hoekom?

L1 Ja ek dink so soos ek redes genoem het my dogter is agt jaar en ek het vir haar uitgevra wat haar juffrou... wat het haar juffrou vir hulle geleer omtrent AIDS en sy kon vir my sê dat die juffrou het gesê 'n mens moet kondome gebruik as 'n mens seks het. Dit was vir my verbasend dat sy dit nou spesifiek sal noem, want outomaties moes ek die woord seks beskryf. Ek moes vir haar beskryf wat dit is en wat gebeur as 'n mens seks het.

L2 Absoluut, in baie families is ouers bang om met hulle kinders te gesels oor seks, en dis wa hulle die fout maak hulle moet openlik praat met hulle kinders leer want hulle kinders leer die dinge op die straat en dit kom nie na hulle toe op die regte manier nie. As jy as ouer vir jou kind reg wil opbring of die regte dinge wil leer sal ek sê jy moet met hulle praat oor seks en MIV/VIGS.

L3 Ja ek dink hulle moet, ek dink ouers moet betrokke raak daarby en kan hulle ôk selfs help as jy nie self.... jouself kan help nie met 'n probleem dan kan hulle op 'n beter manier vir jou wys of sê hoe om dit te doen.

L4 Ja, omdat kinders wil altyd van ouers af weet seker 'goete'. Sekere dinge weet ouers ook nie self wat om vir kinders antwoord te gee nie so ouers is 'n hoofrol in die kursusse, opleidingswerk wat gedoen moet word.

L5 Ja, sodat hulle ook hulle kinders beter kan toerus rondom MIV/VIGS.

L6 Ja, ons as ouers het... het nie die... die inligting gehad nie, nou as ons dit nou kry kan ons vir ons kinders weer inlig dat hulle weer weet waar hulle staan met die... die siekte.

L7 Ja, definitief...daar is baie kinders wat nog nie kennis het van VIGS nie en partykeer is dit makliker vir ouers om dit oor te dra aan hulle kinders as wat dit byvoorbeeld vir die opvoeder is.... Dit maak ook daai band sterker tussen ouers en kind.

L8 Ja, ek sal sê hulle moet betrokke raak, want dit is mos waar die verhouding by die huis reeds begin. Ek dink die ouers moet betrokke raak om hulle kinders die regte inligting te wys (verskaf).

L9 Ja, want dan sal daar 'mindere' mense wees wat VIGS kry en ekonomie sal verbeter en sterftes sal verminder as gevolg van VIGS.

L10 Ek dink ouers moet 100% betrokke raak, want hoe vroeër die kind van VIGS kan leer hoe beter is dit vir elkeen.

L11 Ek dink so, want deesdae as een van ons miskien 'n outjie of 'n meisie het en ons hou miskien 'hanne' vas dan weet die ouers nie, as ons saans saam sit dan sal die ouers altyd se: "jy moet oppas vir VIGS", dan dink hulle dat 'hantjies' vashou wel VIGS veroorsaak. So om hulle meer in te lig, ek dink dis goeie, goeie raad dat ouers wel die VIGS program saam met hulle kinders moet bywoon.

L12 Ja, ouers moet soveel as moontlik kennis dra oor MIV/VIGS sodat hulle hul kinders meer kan leer oor die hele 'n 'n 'n proses van MIV en VIGS sodat hulle kinders nie moet gaan en in daardie 'selle' gevaar in gaan nie, sodat hulle besmet kan word met daardie virus nie. Dit is hoekom dit noodsaaklik is vir die ouers, sodat hulle moet weet van hierdie dinge.

L13 Ja, alhoewel kinders by die skool ook leer van dit kan die ouers 'actually' stadig stap vir stap vir hulle verduidelik en so aan.

L14 Ek dink ouers moet definitief betrokke raak. ek glo nie daar is van hulle wat self ook genoeg weet nie.

L15 Ouers sal definitief betrokke moet raak, sodat hulle ook hul kinders kan verduidelik en laat verstaan dat dit 'n gevaarlike virus..en die ouer sal miskien beter verstaan as wat die kind verstaan en dan kan die ouer maar net die kind meer inlig oor VIGS.

L16 Ja, hulle is jou eerste onderwyser en moet die inligting kry, my ouers wil ook so kursus bywoon en van die kerk broers en susters saam vat...wat ouers is van kinders.

L17 Ja ouers moet betrokke raak want kinders sal natuurlik wil luister na wat hulle ouers te sê het oor die siekte.

L18 Ja, ons ouers moet vir ons inlig omtrent die MIV virus want ons kinders kom ook in aanraking met mense wat MIV (positief) is, en as ons as kinders in aanraking kom met mense wat MIV+ is dan moet ons nie skrik nie, maar weet hoe om sulke mense te hanteer.

9. Would you recommend such a HIV/AIDS programme to fellow adult learners at the ALC? Why?

Sal jy so 'n MIV/VIGS program aan mede volwasse leerders aanraai?

Hoekom?

L1 Ek sal definitief mede leerders aanraai ek het al reeds van hulle aangeraai. Ongelukkig was daar van die mense wat nie die kursus kon bywoon nie as gevolg van hulle werksituasie, maar ek is seker as daar weer 'n kursus moet afkom sal hulle definitief belang stel.

L2 Absoluut, soos ek gesê dit baie mense weet nie waarom VIGS gaan nie en as elkeen die geleentheid moet kry om te leer van MIV/VIGS of informasie te kry dink ek die land sal 'n 'betere' kans het om verder te begin groei.

L3 Ja, ek sal sê elkeen moet dit self bywoon....(dan) sal hulle dit beter verstaan.

L4 Ja,... mense is geneig om (om)dinge vanselfsprekend te vat, so ek dink om kursusse aan te bied is die beste 'solution' vir leerders.

L5 Ja, dit is noodsaaklik dat hulle ook kan weet waarom MIV/VIGS gaan.

L6 Ja ek sal, die, die ...ek sal, ek sal aanraai vir my mede volwassenes om dit op te doen want ek het baie gebaat, baat gevind daarby, geleer baie daarby, byvoorbeeld ek het nie geweet presies hoe word dit oorgedra nie en nou weet ek dit.

L7 Ja, want jy sien die feit is die om dit vir die volwassene oor te dra is makliker, want hulle is meer volwasse as kinders....en hulle is die mense wat dit moet oordra aan die jeug, sodat hulle verstaan waarom dit gaan.

L8 Met graagte ja, want dit kan net die beste uit die persoon haal en voorberei vir die toekoms vorentoe.

L9 Ja, want sodoende kan hulle hul vriende help, miskien as een van hulle vriende die virus het kan hulle hom bystaan en help, so dit is goed as jy weet van VIGS voor jy iets doen wat jy nie moet doen nie.

L10 Ja, omrede soos ek ook gesê het...jy kan nooit genoeg inligting hê oor VIGS nie en ek dink die 'way' ons vir VIGS sien... daar nie 'n gesondheidsmiddel is om dit te genees nie of te keer nie, behalwe mond tot mond kennis om mense bewus te maak en aan te spreek oor die gevare van VIGS.

L11 Ja, dit sal 'n goeie... goeie, goeie raad ook wees vir hulle. Want baie volwasse leerders weet ook nie wat die reeds is hoe VIGS veroorsaak kan word nie.

L12 Ja, ek sal want vir my was dit baie interessant gewies om in so 'n seminaar te kan wees en nadat ek daardie seminaar voltooi het toe voel ek ek het die nodige kennis met my om met ander te kan deel.

L13 Ja, wel sodat hulle ook die kennis kan opdoen.

L14 Ja. Dit gee jou eintlik meer om oor te dink en vir die toekoms ook, jy het kinders wat moet groot word.

L15 Ja ek sal dit aanraai aan mede volwasse leerders..., want baie 'volwassenes' weet nie wat VIGS is nie.

L16 Ja, baie het gehoor van die kursus en wil dit bywoon...hulle sal net baat by die kursus.

L17 Ek sou sê ja, want baie van ons leerders dink hulle het te veel kennis of hulle dink hulle weet, maar as jy hulle daaroor vra dan weet hulle in elk geval niks nie.

L18 Ja ek sal want daar is baie kennis in die program en as jy nou die program klaar gedoen het kan jy ook vir jou medemense kan sê wat jy geleer het en jy sal vir ander volwassenes kan aanraai om te gaan na so 'n program toe, want jy weet daar is baie kennis in so program.

10. Would you recommend such a HIV/AIDS programme to community members who are not learners at the ALC? Why?

Sal jy so 'n MIV/VIGS program aan gemeenskapslede aanraai wie nie deel is van die VOS nie? Hoekom?

L1 Absolute want ek... elke mens het dit nodig het die inligting nodig want 'n mens weet nooit wanneer dit jou familie, jou naaste of beste vriend kan wees nie en die inligting kan net tot jou voordeel strek.

L2 Ek sal dit kan probeer, maar soos ek sê ek het nog nie die volle verstand van MIV/VIGS nie....ek sal 'like' nog meer informasie te kan kry sodat ek dit kan oordra vir mense op die regte wyse(herhaling van vraag) Ja ek sal.... mense weet baie min van VIGS as jy kyk na ons land en die mense wat.... 2 uit 10 mense het VIGS en hulle weet dit nie, so as hulle so kursus moet bywoon sal hulle weet waaroor VIGS gaan en wat die simptome is van VIGS.

L3 Ja ek sal want ek dink ...'ding is'...die gemeenskap met hierdie klomp dinge wat veral...wat buite aangaan kyk hulle sal dit meer nodig het as enigiemand ander want hulle is nie bewus wat aangaan in die gemeenskap nie. Ja hulle sal dit nodig het.

L4 Ja, sodat, sodat daar meer in die gemeenskap gepraat moet word en MIV ook kan verhoed word tussen mense.

L5 Ja, sodat hulle ook kan weet en ook om hulle kinders en wel mense in hul omgewing aangaande MIV/VIGS te kan meedeel.

L6 Ja ek sal. Soos ek reeds gesê (het) is dit... dit sal raadsaam wees as almal kan inligting kry van die siekte want baie van ons se mense is oningelig, hulle is onkundig, hulle weet nie hoe om mekaar te help nie, hulle kan net verkeerd inligting rond strooi maar as hulle as hulle die opleiding kry kan hulle help.

L7 Ja, definitief, want hoekom ek soos sê dit raak ons almal in die land en hulle moet ook weet waarom MIV/VIGS gaan.

L8 Ja, ek sal dit aan raai, want ons mense daar buite het dit ook nodig sou ek sê.

L9 Ja, ons kan miskien vir hulle gaan vertel, maar ons is te min om almal te vertel, maar hulle moet weet van VIGS.

L10 Ja. Die rede is toe ons die kursus bygewoon het het ons ook belowe dat ons sal ander vertel van VIGS en aanraai om so kursus by te woon.

L11 Ek dink elke een wat nie die finansies het nie, nie ouers het of niks het nie, dis belangrik vir elke een om te weet hoe VIGS kan ontstaan.

L12 Ja, ek voel nog steeds min mense weet en het die nodige kennis, besit die nodige kennis omtrent MIV en VIGS en baie min mense weet hoe mense besmet word, waar die siekte vandaan kom en oorgedra word. So ek dink dis baie nodig en ek sal dit graag aan ander volwasse mense ook dit wil oordra.

L13 Ja, want baie van ons gemeenskapslede is nog baie onkundigen hulle weet nie rêrig hoe die siekte op gedoen word en so aan nie. As hulle dus so kursus kan loop, kan hulle kennis opdoen.

L14 Ja, hulle moet, kyk soos hier by ons né, hier is niks vir die mense om te doen nie. Die jong span, hulle is op die pad, hulle drink, hulle rook dagga, selfs die grootmense ook. So hulle sal, hoe kan ek sê om hulle ook meer in te lig want ek dink definitief baie van hulle weet nie eintlik wat om hulle aan gaan nie.

L15 Ja ek sal, want baie mense in ons gemeenskap verstaan nie wat VIGS is nie en oor wat dit gaan nie...en die plekkie wat ek in bly, die mense in die plekkie is baie onverskillig, soos byvoorbeeld ek praat net spesifiek van die dagga rokers, hier is baie dagga rokers in die plek ek dink hulle is ook die mense wat ...wat die virus aandra, want hulle rook en dan rand die meisie aan en verkrag hulle miskien en so kan hulle die virus oordra.

L16 Ja, hulle moet ook geleer word, want VIGS is oral... nie net by ons in die 'VOS' nie.

L17 Veral in die gemeenskap is daar so baie mense wat min kennis het oor die siekte hoe meer kennis het kry hoe beter sal dit wees in ons gemeenskap om mekaar te help en by te staan.

L18 Ja. Dit is nie net die sentrum wat moet kennis dra oor AIDS nie, dit is die hele Suid- Afrika, die hele land... so hoe meer mense weet daarvan hoe beter is dit vir ons se ekonomie.

11. Would you be willing to train others about HIV/AIDS at an ALC?
Why?

***Sal jy bereid wees om ander op te lei aangaande MIV/VIGS by die VOS?
Hoekom?***

L1 Ek dink ek sal dit kan doen, maar emmm ek is geneig om vinnig te praat nie gewoon om voor gehoor te praat nie of groot skare mense nie praat ek gewoonlik vinnig en ek begin te 'stumble' ek werk daaraan. (IS jy bereid om dit te doen?) As ek die geleentheid moet kry ja.

L2 Ja, ek sal bereid wees as ek as ek die regte informasie en opgelei is daarvoor.

L3 Nee ek is nie bereid nie, iemand wat 'experiment' of 'experience' het in die ding sal beter wees, want ek sal nie bereid wees nie. Nee glad nie.

L4 Ja, omdat ek wil dat die land sal regkom en verlosword van die MIV virus wat sversprei word en dat meer mense nie so sal dood gaan nie, 'laat' mense wat nog nie die virus het nie sal lewe sonder die virus.

L5 Ja, omdat ek ook graag hulle sou wou leer rondom MIV/VIGS.

L6 Ja ek sal. Ek, ek sal ander mense kan as, as ek genoegsame inligting het of 'lekke' ingelig is of meer kan weet omtrent die siekte sal ek ander mense kan inlig.

L7 Ja ek sal definitief ander aanraai om deel te wees van so opleiding en om hulle op te lei want dit is 'n gemeenskaps ding die... hoe meer mense weet hoe beter is dit.

L8 Ja, ek sal, want, hulle kan net baat daarby vind om opgelei te word.

L9 Ja, maar dan moet ek eers self baie weet voor ek vir hulle kan oplei.

L10 Ja. Weereens soos vraag tien ook voel ek ons almal kan... hoe ons die stryd kan oorkom is om elkeen 'n 'difference' te maak en dit is om 'input' te gee as 'n mens ook inligting oor kan dra aan ander aan 'n 'next' persoon.

L11 Ja ek sal want dit sal my beter laat voel as mens wat sonder VIGS lewe ander te... meer in kennis te stel van die siek.

L12 Ja met die kennis wat ek nou al sover opgedoen het dink ek ek sal dit kan doen.

L13 Met die nodige kennis sal ek ja.

L14 Bereid te wees? Ja ek sal seker, maar ook aan die anderkant ek is nie 'n mens wat voor mense praat of so.

L15 Ja ek sal bereid wees, want ek vind dit interessant en ek sal daarvan hou om ander mense te help om nie die virus te kry nie.. ek sal.

L16 Ja, dit gaan om lewens te red ..om,om mense 'aware' te maak van die gevaar soos ek alreeds gesê het.

L17 Hoe meer kennis jy het oor MIV/VIGS hoe beter is dit om ander op te lei, so ek sou bereid wees om ander op te lei.

L18 Definitief sal ek bereid wees om ander op te lei. Ek sal die kennis wat ek op 'geneem' het graag wil oordra aan ander mense.... Om kennis te het is om te leef.

12. Should people pay if they wanted to attend such training courses? Why?

Moet mense betaal as hulle sulke opleidingskursusse wil bywoon? Motiveer?

L1 Dit hang seker af ... 'n... die kursus was nou vir ons verniet aangebied gewees en ek glo as meer sulke kursusse verniet aangebied word sal definitief meer mense getrek word aangesien Eersterivier spesifiek 'n groot werkloosheid syfer het.

L2 Nee ek dink nie so nie. Baie mense het nie werk nie en kan dit nie bekostig om (vir) so 'n program te betaal nie. Ek dink dis iets wat die 'gowerment' ons mense moet aanbied... gratis, dit is vir hulle eie gesondheid en ook vir die land se gesondheid.

L3 Nee, waarvoor moet jy betaal vir 'n kursus wat jy verniet kan bywoon, dis nie almal wat geld het om dit by te woon nie, so verkieslik nee, hulle hoef nie te betaal nie.

L4 Nee, omdat dit 'n siekte is en die hele land raak dink ek dit behoort verniet aan mense te gegee word.

L5 Nee, immo aangesien dit deel van die regering se projek is dink ek dis noodsaaklik dat hulle dit gratis kry.

L6 Nee, ek dink nie mense moet betaal nie, maar die, die 'werkeloosheidsyfer' is so hoog, die mense het nie geld om te betaal vir die kursusse nie, so as ondernemings of die regering kan bydra en vir die mense die opleiding kan gee gratis, sal dit help.

L7 Nee, u moet verstaan nê, daar is mense wat finansieel sukkel, maar hulle het die kennis nodig om hulle lewens te red en die van ander.

L8 Ek sal sê indien dit gratis aangebied kan word sal dit 'n pluspunt wees, maar ek sou ook graag betaal word om ander op te lei.

L9 Nee, want daar is sekere mense wat baie graag die kursus wil bywoon, maar nie kan betaal nie en daar is die wat die verkeerde goed doen wat dit makliker maak om die virus te kry en so kursus nodig het.

L10 Ek dink nee, anders gaan ons baie mense uit mis wat dit nie kan bekostig nie en hierdie mense dink ek ook benodig hierdie kursus, arme mense wat dit ook nodig het.

L11 Ek dink nie mense moet betaal nie want omrede as jy betaal dan sal minder mense kom, want mense wat nie finansies het nie sal nie die program bywoon nie en sal dan nie weet nie.

L12 Nee, dit moet gratis wees want dit is 'n saak wat die hele gemeenskap raak en ek voel dit moet gratis wees, elke huis moet almal kennis het omtrent MIV en VIGS

L13 Ek dink dit moet gratis wees, baie van ons mense is werkloos, so as hulle nie werk nie, waar gaan die geld vandaan kom vir so 'n kursus.

L14 Ek dink nie mense moet betaal daarvoor nie, want dit is iets wat mense moet weet, hulle moet weet daarvan. Daar is te veel mense wat afsterf daarvan.

L15 Nee, ek dink dit moet gratis wees, want baie mense sal nie kom as hulle moet betaal nie.

L16 Mense het die inligting baie nodig, maar ek dink nie hulle het geld om te betaal nie, verniet sal dit goed werk om meer mense te leer van 'VIGS'.

L17 Nee, want dit is vir ons as gemeenskap so belangrik om te weet van MIV/VIGS en hoe dit ons land raak.

L18 Nee, ek dink nie so nie. As mens gaan moet betaal gaan hulle nie die kursusse bywoon nie en net redeneer hoekom moet hulle betaal want hulle het dit nie nodig nie of hulle is nie HIV+ nie.

13. Why do some people discriminate against people who are HIV+?

Waarom diskrimineer sommige mense teen ander wat MIV+ is?

L1 Ek sou sê dis onkunde omdat mense nog nie...weet hoe die siekte presies oorgedra word. Jy kan langs iemand sit, en jy kan dieselfde 'toilet' deel, en jy kan uit dieselfde borde en breekgoed uit eet en drink en daar is nog baie onkunde daar omtrent. Die mense weet nie spesifiek wat die regte redes hoekom dit oorgedra word nie.

L2 Ek sal sê omdat hulle nie weet waarom VIGS rêrig gaan nie. As jy in 'n program sit en jy kry informasie dan sal jy weet om met sulke mense te werk soos ek, toe ek in die program deurgesit het ek baie dinge geleer en self tot vandag toe kan ek as ek in kontak kom as iemand wat VIGS het sal ek daai persoon 'n drukkie gee of 'n soentjie gee. Dit bedoel nie ek gaan VIGS kry nie.

L3 Omdat hulle nie opleiding gekry het vir dit nie, omdat hulle 'hoe kan ek sê' nie 'stupid' is nie, 'but' omdat hulle nie bewus is wat aangaan om hulle nie. Ek dink hulle moet gaan vir hierdie kursusse.

L4 Hulle weet nie hoe die mense die goed gekry (het) nie, hulle neem net aan dat dit seksueel oorgedra word, dis hoekom hulle nou so diskrimineer teen ander mense. Hulle het nie kennis van VIGS dis hoekom hulle so aangaan met mense wat MIV-positief is.

L5 Omdat hulle bang is dat hulle kan VIGS opdoen as hulle met iemand kommunikeer en omdat hulle 'n wanbegrip het wa wa ... waaroor MIV/VIGS gaan.

L6 Omdat hulle onkundig is, hulle weet nie hoe hulle geraak kan word deur die mense wat dit het nie. Kan hulle dit kry om te vat aan die mense, of kan hulle dit miskien kry om dieselfde eetgerei te gebruik as hulle, dis waarom dit gebeur.

L7 Ek sou sê die mense wat diskrimineer is die mense wat nie kennis dra van MIV/VIGS nie, want hulle weet absolute niks van hoe word dit oorgedra nie en hoe om die mense te hanteer niedis hoekom hulle diskrimineer.

L8 Ek dink hulle het 'n wanbegrip wat MIV/VIGS is. Hulle het nie die nodige kennis nie, dit is 'n gevalle van onkunde.

L9 Hulle is miskien bang hulle dit ook sal kry en hulle is bang om dood te gaan.

L10 Ek dink die grootste rede vir dit is omdat hulle verstaan nie die MIV nie, omrede hulle het nie so kursus deurgeloop nie, hulle weet nie en hulle is bang vir VIGS....dis die rede.

L11 Omdat hulle, omdat hulle swak ingelig is oor die siekte.

L12 Baie mense dink dat dis amper soos as hulle aan sulke mense raak dan sal hulle ook besmet word, maar dis ver van die waarheid af Jy kan sulke mense omhels, met hulle gesels, dieselde eetgoed, borde jy kan dit saam met hulle deel.

L13 Omdat hulle onkundig is.

L14 Hulle diskrimineer want hulle gaan miskien net dink o jy is MIV-positief of jy het VIGS, of jy het miskien rond geslaap, jy is sleg of so.

L15 Mense diskrimineer VIGS is 'n virus wat dood maak en baie mense dink, waar het jy... soos byvoorbeeld ek... ek diskrimineer nie (teen) mense nie, maar as jy mense aankyk, dan dink jy mar waar het jy miskien die virus gekry en dan dink jy aan al wat slegte dinge is, so daai is seker hoekom mense (teen) ander mense diskrimineer.

L16 Hulle weet nie regtig wat VIGS is nie, hulle is bang soos ek was, omdat ek nie verstaan het nie....nou kan ek dit 'handle'.

L17 Hulle diskrimineer teen ander mense omdat hulle nie weet waardeur die mense gaan nie, hulle ken nie die mense nie, amper so te sê hulle maak hulle eie 'goeters' op en kraak mense af wat VIGS het, omdat hulle min kennis het van MIV/VIGS.

L18 Dit is omdat hulle nie baie ingelig is oor die virus nie ... as hulle meer ingelig is oor die virus sal hulle nie diskrimineer nie en sal hulle die virus aanvaar en net meer veiliger begin lewe.

14. How can people support a HIV+ person?

Hoe kan mense 'n MIV+ persoon ondersteun?

L1 Emosioneel en sielkundig behoort 'n vriend of familielid daar te wees vir so 'n persoon. Al het hy nie voldoende kennis nie, maar emosioneel gaan sulke mense vinniger agter uit of hulle gaan in 'n staat van depressie as niemand.... as dit lyk of niemand vir hulle omgee nie. So dis baie belangrik dat mens die emosionele sy aanraak en ook godsdienstig... op 'n godsdienstige manier.

L2 Om vir hom die regte pad te wys, om vir hom by te staan wanneer hy dit nodig het...om vir hom lief te het en net daar te wees vir hom as hom hy jou nodig het.

L3 Deur vir die persoon te sê om te glo in homself nie en moenie negatief wees teenoor dit nie en te praat daaroor.

L4 Deur daar te wees as hy met iemand wil praat of saam met hom kliniek toe te gaan as hy sy pille moet drink, altyd hom te motiveer om te doen wat die dokters en 'nurse' sê, miskien kan hy nog so lank lewe ook.

L5 Deur vir hom by te staan, hom te help, en vir hom tuis te laat voel in sy gemeenskap in sy omgewing en ook as 'n vriend te aanvaar.

L6 Hy kan hom eerstens ondersteun deur meer inligting te bekom en soos die kursusse, kursusse by te woon en wees lief vir hulle, wys vir hulle jy gee om en want hulle is mos ons medemens, ons moet mekaar lief het en dis daardeur wat ons hulle grootliks kan help.

L7 Jy kan hom ondersteun deur die persoon te motiveer en die persoon wys jy kan nie sommer net dood gaan van MIV nie....dit hang af van die kennis wat jy het en die regte kosse wat jy eet. So motiveer die persoon, dis nie net 'n ding van jy gaan sommer môre net dood nie, jou tydperk kan net heeltemal verleng word.

L8 Wys vir hulle jy gee om vir hullemaak hulle deel van die gemeenskap. Ons kan nie teen hulle diskrimineer nie, want hulle het ons ondersteuning en liefde nodig.

L9 As jy die persoon se vriend is dan moet jy by hom staan, nie skielik wegbly en sê jy kom nie meer nie. Jy moet hom nog altyd soos 'n normale, gesonde persoon behandel.

L10 Ek dink wat hulle die meste nodig het is liefde en om vir hulle deel te maak van die vriendekring en nie vir hulle weg te stoot nie, emosioneel dink ek hulle benodig baie help en die beste wat ons vir hulle kan doen is om vir hulle te ondersteun en nog altyd 'n goeie vriend te bly.

L11 Deur hulle by te staan, deur hulle te help, deur hulle... hulle siekte, net om daar vir hulle te wees.

L12 Deur meer liefde te betoon aan sulke mense en vir hulle ook wys hulle is nog steeds deel van die gemeenskap.

L13 Deur nog altyd vriende te bly met hulle en vir hulle te wys dat jy nog omgee vir hulle en hulle is nog deel is van die gemeenskap.

L14 Om te verstaan wat hulle deur gaan. As jy meer weet dan kan jy verstaan waardeur hulle gaan en om by hulle te staan en te help.

L15 Jy moenie snaaks is met daai persoon nie, sodat hy nou voel... ek weet ek is nou siek...maar dit gaan my seker nou nog sieker maak nou wil niemand met my te doen hê of as ek aan jou raak dan gaan ek die virus kry,... so mense moet hulle ondersteun deur nie lelik te wees met hulle nie of vir hulle lelike woorde te sê nie, en so.

L16 Hulle moet baie liefde en help kry, hulle is mense soos almal wat 'n siek het...ons moet hulle help waar ons kan en praat met hulle soos met enige ander mens.

L17 Om so 'n persoon te ondersteun wat MIV/VIGS het is om so persoon te behandel soos u as persoon behandel wil word.

L18 Deur hulle te hanteer net soos enige ander persoon en as hulle miskien hospitaal toe moet gaan ondersteunend te wees en te help.