

The knowledge, attitudes, beliefs and reported sexual behaviour relating to HIV/Aids amongst adolescents in a General Practice population in Port Elizabeth. By Sean Volkwyn

Abstract

Background

HIV /Aids is a global epidemic which has caused tremendous human suffering around the world. Young people are especially vulnerable to HIV, due to the period of adolescence being one of experimentation and risk-taking. With South Africa having one of the most severe HIV/Aids epidemics in the world, it is crucial that the family physician is familiar with the local drivers of the epidemic and health needs of their practice population, and be able to initiate or support appropriate community based interventions designed to either prevent the spread of HIV, offer care or support treatment.

Objectives

This study aimed to assess the knowledge, attitudes, beliefs and reported sexual behaviour amongst adolescents in a general practice population in Port Elizabeth. A better understanding of the drivers of the epidemic in this setting should inform the development of a general practice based HIV/Aids intervention.

Methods

A descriptive cross- sectional study of grade 11 adolescents at 2 schools in an urban general practice catchment area in Port Elizabeth was conducted. Both quantitative (questionnaire) and qualitative (focus group interviews [FGI]) research techniques were utilised in order to triangulate the results. One hundred and thirty nine adolescents (52 males and 85 females) completed a confidential, self-administered questionnaire. Two focus group interviews were held with 22 volunteers from the original sample that had completed the questionnaire.

Results

Knowledge levels about HIV/Aids were found to be moderately high, although gaps in their knowledge and a few misconceptions were noted. Sexual knowledge was low, as only 17% thought that oral sex was really sex, and 33% that anal sex was really sex. The majority of the adolescents exhibited a mostly positive attitude towards people who were living with HIV/Aids. Some, however, were uncertain, and displayed contradictory attitudes. Almost half (49%) of the participants indicated that they were sexually active. Forty percent of the sample had been sexually active in the last year. The median age of first sexual debut was 16. Of those who were sexually active 32% had 1 partner, 10% had 2 partners and 7% had 3 partners. The use of condoms received much negative attitude from participants in the FGI's, with many reasons being given for not using condoms. Of those who were sexually active, 69.7% reported that they always used condoms, 35.7% that they used condoms sometimes, while 12.5% reported that they never used condoms during sex in the last year. It was found that alcohol and drug use and 'sugar -daddyism' were high risk activities which contributed to risky sexual behaviour. A number of key factors which influenced adolescents' sexual decision-making emerged as physical appearance, reputation, whether or not someone uses drugs, peer pressure when making decisions about whether or not to have sex with a prospective partner. The preferred sources for HIV/Aids information by the participants were health care workers (45%), trained peer educators (41%) and parents (21%). It was also evident from the study that peers (81%) were the group that adolescents confided in the most about sex., followed by parents/guardians (53%). Participants in the FGI's were unanimous in recommending that HIV/Aids education should be presented in 'fun' ways in order to bring the message across.

Conclusion

The study has provided some insight into the knowledge, attitudes, beliefs and practices of adolescents in an urban general practice area. It highlighted the factors which may contribute to the spread of HIV/Aids among adolescents. Although the level of knowledge regarding HIV/Aids was moderate, this did not translate into safer behaviour and practices, or improved attitudes towards people affected by HIV/Aids. Gaps in their knowledge need to be filled and misconceptions corrected. The results of this study could be

used to make recommendations to the departments of education and health, and other non-governmental organizations to develop a programme which is focused on the needs of similar adolescents in the broader community. Recommendations are based on the principles of family medicine and the physician as an advocate for school-based health promotion.

Background

HIV /Aids is a global epidemic which has caused tremendous human suffering around the world. An editorial in the Lancet described HIV/Aids as a “global disaster” which has “catastrophic” effects on the population, health systems, economy and social stability.¹ The number of people living with HIV at the end of 2007 has risen to 33.2 million. It is particularly a problem in sub-Saharan Africa, where 22 million people are affected. In South Africa, the burden of the disease affected 5.7 million people at the end of 2007 and the country has the fastest growing HIV epidemic in the world.² With no cure in sight, and with limitations for provision of antiretroviral medication, the major strategy for reducing the spread of HIV should be health information aimed at improving knowledge and changing sexual behaviour.

Young people are especially vulnerable to HIV, due to the period of adolescence being one of experimentation and risk-taking. They are thus at high risk for unplanned pregnancies and sexually transmitted infections (including HIV infection). A number of behavioural and social characteristics of adolescents are thought to determine their high HIV risk status. These include the onset of sexual activity during the teen years, the probability of multiple partnerships, general non-use or inconsistent use of condoms and the reported tendency of adolescents to perceive themselves both physically and psychologically invulnerable which is related to a variety of risk-taking behaviours.³

According to UNICEF, in 2002 more than half of all new HIV infections occurred in young people aged 15-24 years.⁴

The consequences of HIV/Aids can be far-reaching for young people. Not only does it cause morbidity and mortality, but it has the potential to trigger negative social reactions⁵, (e.g. child-headed households, absenteeism, loss of income, increased health costs, stigmatization etc) It stands to reason therefore that the adolescent age group should be the focus of interventions to curtail the transmission of HIV/Aids.

With South Africa having one of the most severe HIV/Aids epidemics in the world, it is crucial that the family physician is familiar with the local drivers of the epidemic and health needs of their practice population, and be able to initiate or support appropriate community based interventions designed to either prevent the spread of HIV, offer care or support treatment.⁶

A clear understanding of young people and their needs is required to design and successfully implement interventions to stem the tide of infections among young people.

Without this information, the scale of the response required and the focus and relative urgency of the intervention remain unknown.⁷

The family physician or general practitioner (GP) is ideally situated in the community and provides continuity of care to his or her patients. In this way, the GP can promote

sexual health in their adolescent patients. This should take the form of a comprehensive approach that provides knowledge, encourages the development of positive attitudes and self esteem and develops skills to cope with negative social and cultural norms.⁸

Aim of the study

Understanding one's own adolescent practice population is critical in establishing a relevant way forward in terms of an HIV/Aids strategy. This study therefore aimed to assess the knowledge, attitudes, beliefs and actual reported sexual behaviour amongst adolescents in my practice area. A better understanding of the drivers of the epidemic in my setting should inform the development of a general practice based HIV/Aids intervention. The results of this study could also be used to make recommendations to the departments of education and health, and other non-governmental organizations to develop a programme which is focused on the needs of similar adolescents in the broader community.

Objectives of the study

1. Determine the knowledge, attitudes, beliefs and reported sexual behaviour amongst adolescents in my practice community.
2. Explore the reasons why adolescents do not heed advice about HIV/Aids risk activities.
3. Make recommendations regarding an HIV/Aids intervention which will enable the relevant Health, Educational authorities, and other NGO's to implement comprehensive preventive strategies.

Literature review

Numerous studies have been conducted around the world to assess the knowledge, attitude, behaviour and practices of high school students regarding HIV/Aids.

A Korean study evaluating knowledge, attitudes, related behaviours and sources of information, showed that the levels of knowledge of respondents was moderate, attitudes towards persons with HIV/ Aids were generally negative, and that 40% of those who had engaged in sexual intercourse (4.4%) had used condoms. It was found that the two major sources of information about HIV/Aids was television and school classes.⁹

A study of high school students from Tanzania showed that knowledge levels were moderate, with 70% of students achieving 'good scores' for HIV transmission and prevention. The average age of sexual debut was 15.4 years for boys and 15.8 years for girls. It was reported that 54% of the respondents were sexually active, and that 13% of these had multiple partners in the last year. Thirty percent of those who were sexually active used condoms.¹⁰

A Kenyan study of 3018 secondary school students described a high level of knowledge (77% answered correctly). Prior sexual experience was reported by 28.7% of females and 74.8% of males. Multiple sexual partners were reported by 41.2% of those males and

7.3% of females who were sexually active. Only 40% of those who were sexually active reported using condoms during sex.¹¹

A South African study which aimed to determine the knowledge, attitudes and practices associated with Aids among adult patients attending Sexually Transmitted Diseases (STD) clinics in the Cape Peninsula, showed many risky sexual practices: 70.4% of male attendees reported 2 or more partners in the last year; 39.5% of males reported more than one STD in the previous 2 years. There was a low perception of risk to self, and intent to change behaviour was low.¹²

Another local study explored the prevalence rates for selected aspects of sexual behaviour among Cape Town high school students and found that a large proportion were sexually active.¹³ This study found that students who have had sex do so infrequently, do not have multiple partners, and have known their partners for more than a week. It is based on this that the authors of the study suggested that health promotion efforts should build on these positive health behaviours, and find ways to maintain them.¹³

The South African Youth Risk Behaviour Study (2002) found that with regard to sexual behaviour, 41% of learners had had sex, and the age of initiation of sexual activity was under 14 years for 14% of them. Among the learners who had had sex, 54% had more than one sexual partner, 70% had had sex in the past 3 months, 14% had had sex after consuming alcohol or drugs, only 29% practiced consistent condom usage, 16% had been pregnant, and overall 72% had received education regarding HIV/Aids.¹⁴

A study which explored the sexual behaviour of youth in the Anglican Church in the Western Cape also found that a large proportion of its youth were sexually active. This implied that church-based youth did not have significantly different behaviour patterns from their larger peer group.¹⁵

In the literature, there is a growing body of research which shows the importance of using appropriate interventions with adolescents to help them increase their knowledge about HIV/Aids, to avoid risky sexual behaviour, and to adopt positive health attitudes.¹⁶

HIV education interventions do increase knowledge and change attitudes towards risky sexual behaviour.¹⁷ A systematic review on Aids Risk Reduction in adolescents concluded in those studies that found a significant impact the outcome was as follows¹⁸: The percentage of studies reporting a positive intervention impact were-

- 88% of studies assessing changes in knowledge
- 58% changes in attitude
- 60% changes in intention to use condoms
- 73% changes in condoms use
- 64% a decrease in number of sexual partners

The study concluded that Aids risk reductions interventions were effective in improving knowledge, attitudes, and behavioural intentions and in reducing risk practices.

In South Africa, scholars are presently receiving guidance about HIV/Aids in school-based Life Orientation classes which have been mandated in all public schools²³, but this has clearly not resulted in a shift in behaviour.¹³ Although desirable, interventions that increase knowledge alone have not proven effective in changing behaviour.²⁰

A report was released at the XVIth International Aids conference in Toronto in 2006. This report summarised and analysed a number of HIV prevention strategies targeted at young people at risk of contracting HIV.²⁴ Evidence from 80 studies from developing countries were reviewed and classified, so as to make it simpler for policy makers and researchers to take effective action and to achieve the global goals and commitments on HIV and young people. The report categorises the strategies in terms of usefulness and makes recommendations for future prevention strategies for young people.

Interventions were graded as:

- **Go**-Stop asking for evidence and get on and do it.
- **Ready**-implement widely, but evaluate carefully.
- **Steady**- Not yet ready.

The “Ready... Steady... Go...” report makes specific recommendations for schools. It states that programmes should be curriculum based and designed using the characteristics shown to be associated with effectiveness. (See box below)

Characteristics of effective curriculum based programmes:

A) Developing the curriculum:

- Involve multiple people with different backgrounds in theory, research and sex/HIV education.
- Assess relevant needs and assets of target group.
- Use a logic model to develop the curriculum that specifies the health goals, the behaviours affecting these health goals, the risks and protective factors affecting those behaviours, and the activities addressing those risk and protective behaviours.
- Design activities consistent with community values and available resources (e.g. staff time, staff skills, facility space and supplies).
- Pilot test the programme

B) Content

- Focus on clear health goals e.g. prevention of STI's and HIV and /or pregnancy
- Focus narrowly on specific behaviours leading to these health goals (e.g. abstaining from sex, or using condoms or other contraceptives), give clear messages about these behaviours and address situations that might lead to them and how to avoid them.
- Address multiple sexual-psychosocial risk and protective factors affecting sexual behaviours- e.g. knowledge, perceived risks, values, attitudes, perceived norms and self efficacy

Activities and teaching methods:

- Create a safe environment in which youths can participate.
- Include multiple activities to change each of the targeted risks and protective

factors

- Use instructionally sound teaching methods that actively involve participants, personalize the information, and that are designed to change each group of risk and protective factors
- Use activities, instructional methods and behavioural messages that are appropriate to the culture, developmental age and sexual experience of the participants.
- Cover topics in a logical sequence.

C) Implementation:

- Secure at least minimal support from appropriate authorities-e.g. Ministries of Health, Education and community organizations.
- Select educators with desired characteristics, train them and provide mentoring, supervision and support.
- If needed, implement activities to recruit and retain youths and overcome barriers to their involvement (e.g. publicize the programme, offer food, or obtain consent from youths and their parents)
- Implement virtually all activities as designed

A major obstacle for delivering sexual risk reduction interventions for HIV/Aids is that parents/teachers fear that informing teenagers about these matters will encourage sexual behaviour; however a meta analysis has shown that risk reduction interventions do not increase the overall frequency of sexual activity.²¹

This study is important because it explores the knowledge, attitudes, behaviour and sexual practices of adolescents in a general practice catchment area where no previous studies have been conducted and ascertains whether similar findings are obtained as in other local and international studies. Thus, the drivers of the HIV epidemic in the area can be understood and suitable interventions can be designed and implemented to reduce the sexual risk behaviour of the adolescents for contracting HIV.

To the researcher's knowledge, no local studies are available of General practice- based studies which describe the knowledge, attitude, behaviour and sexual practices of adolescents in their practice settings.

Method

Study design

A descriptive cross- sectional study of adolescents (age group 16-20) at 2 schools in an urban private general practice catchment area in Port Elizabeth was conducted from May

–August 2008. Both quantitative and qualitative research techniques were utilised in order to triangulate the results.

Study setting

The general practice catchment area included two schools, both of which were included in the study. One of the schools is situated in a traditionally coloured area (low-middle income area), where the pupils are of coloured and African descent. The other school is a former Model C school (in a low-middle-income area), where the pupils are of white and coloured descent.

Selection of students

Letters were sent to the regional Education Department as well as to the principals of the 2 schools explaining the purpose of the study. Once approval was obtained letters were sent to the parents, fully informing them about the details of the study, and asking them to respond if they objected to their child's inclusion in the study. The participants were also asked to give their own consent (assent). The informed consent document was made available in English, Afrikaans and Xhosa. Two grade 11 classes from each school were randomly selected and a sample of 139 participants was obtained.

Collection of data

For the quantitative methods, a self-administered, semi-structured Questionnaire, with both closed and open questions was administered during school hours in a classroom setting. The questionnaire used was adapted from the "Fikela" Agents of Change programme,¹⁵ and explored general HIV/Aids knowledge, sexual knowledge, goals and beliefs, attitudes, reported sexual behaviour, talking about sex and sexually transmitted infections.

Two Focus Group Interviews (FGI), one from each school, were conducted to provide more in-depth insight into the sexual experiences of the participants. The FGI were meant to complement the information gathered in the questionnaire and to allow some triangulation of different methods focusing on the same topic.

Twenty two respondents out of the 139 who had participated in the questionnaire survey volunteered to take part in the FGI's, which were held after the administration of the questionnaire. The FGI were kept small to encourage maximum participation (12 students in FGI 1 and 10 in FGI 2). The groups consisted of both male and female participants. In the FGI's a set of key exploratory questions were used to provide a consistent framework.

Prior to the commencement of the actual research, a pilot study was conducted with the questionnaire and FGI to check on the clarity of the questions and to identify any difficult or ambiguous questions. Some of the questions were changed when difficulties with their comprehension were encountered. This pilot was conducted amongst a group of adolescents from another school to ensure no contact with the research participants.

Analysis

Statistical support was obtained from the Center of Statistical Consultation at the University of Stellenbosch. Data was analysed using Stastisca version 7 and simple frequencies, means and standard deviations obtained.

Qualitative data was analysed by reviewing notes which were made during the interviews and by transcribing the tape-recorded interviews verbatim. Confidentiality was ensured by not including any names of the participants. Major themes which emerged from the FGI about adolescent's knowledge, beliefs attitudes, and practices were identified.

Ethical issues

Ethical approval for the research study was obtained from the Human Research Ethics Committee of the University of Stellenbosch. The participants were made aware that they were not forced to take part in the research study. The right to withdraw from the study at any stage was explained to the participants and their parents. The parents and the participants were made to understand that any information obtained during the study would be kept strictly confidential, and that no names would be used in the study under any circumstances.

Results

Questionnaire

The sample was composed of a total of 139 respondents and their demographic characteristics are shown in Table I. All of the respondents were from an urban environment.

Table I: Social and demographic characteristics of the respondents (n= [139])

| Characteristic | N | % |
|-----------------------|----------|----------|
| Age: | | |
| 16 | 21 | 15.1 |
| 17 | 78 | 56.1 |
| 18 | 23 | 16.5 |
| 19 | 12 | 8.6 |
| 20 | 5 | 3.6 |
| Sex: | | |
| Males | 52 | 37.4 |
| Females | 85 | 61.1 |
| Blank | 2 | 1.4 |
| Live with: | | |
| Both parents | 74 | 53 |
| One parent | 46 | 33 |
| Another relative | 16 | 12 |
| Friend | 3 | 2 |
| Religion: | | |
| Christian | 136 | 98 |
| Other | 3 | 2 |
| Race: | | |
| African | 37 | 27 |
| Coloured | 49 | 35 |
| White | 53 | 38 |
| Asian/Indian | 0 | 0 |

Table II describes when the respondents last received any HIV/Aids education and what their perceptions were about who should provide them with this education.

Table II: HIV/Aids information received and perceptions of sources of information (n=139)

| HIV/Aids information last received: | N | % |
|---|----|----|
| 2008 | 82 | 59 |
| 2007 | 44 | 32 |
| 2006 | 7 | 5 |
| 2005 | 3 | 2 |
| 2004 | 2 | 1 |
| 2003 | 1 | 1 |
| HIV/Aids information should be given by: | | |
| Health care workers e.g. nurses and doctors | 62 | 45 |
| Trained peer educators/People living with Aids | 57 | 41 |
| Parents | 29 | 21 |
| Class teachers | 24 | 17 |
| Teachers from another school | 1 | 1 |

The majority of the participants 108 (78%) in the survey said that they received their information about HIV/Aids from life skills programmes such as those given in Life Orientation classes at school, 19 (14%) stated they also received information from media sources such as the Love Life programmes on television, radio and newspapers. Eighteen (13%) indicated that they received information about HIV/Aids from their peer group.

Figure 1 shows the preferred methods of HIV education as indicated by the respondents.

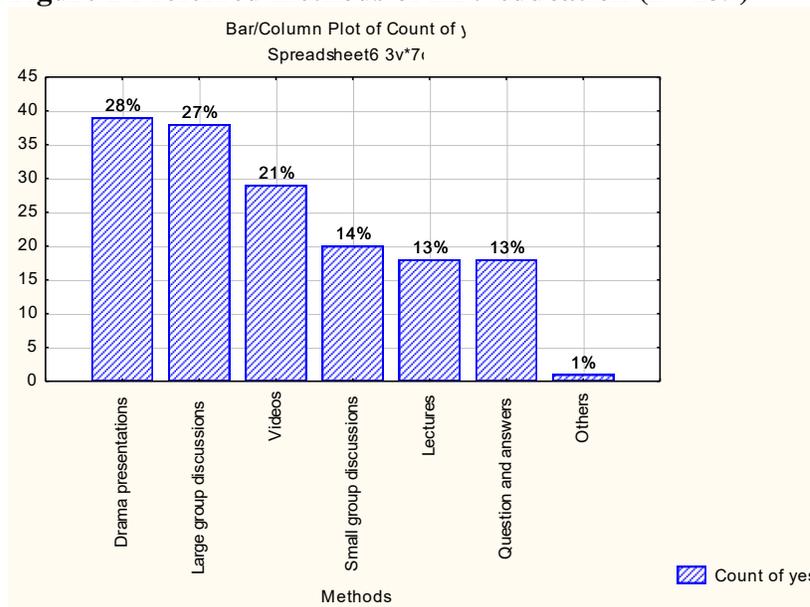
Figure 1 Preferred methods of HIV education (n= 139)

Table III describes the beliefs of the respondents in terms of their self esteem and self efficacy.

Table III: Beliefs of respondents: self esteem and self efficacy (n= 139)

| | N | % |
|--|----|----|
| Self-worth – feeling as important as others in the peer group | | |
| Never | 12 | 9 |
| Sometimes | 46 | 33 |
| Often | 19 | 14 |
| Always | 62 | 45 |
| Life-goals – believing that one can have and reach ones goals | | |
| Never | 2 | 1 |
| Sometimes | 27 | 19 |
| Often | 13 | 9 |
| Always | 97 | 70 |
| Standing up for your beliefs | | |
| Never | 1 | 1 |
| Sometimes | 38 | 27 |
| Often | 27 | 19 |
| Always | 73 | 53 |

Table IV shows the attitudes of the respondents towards people who are affected by HIV/Aids.

Table IV Attitudes of the respondents towards people who are affected by HIV/Aids (n= 139)

| Attitudinal statement | AGREE | | DISAGREE | | Unsure | |
|--|-------|----|----------|----|--------|----|
| | N | % | N | % | N | % |
| 1. Isolate patients with HIV/Aids as a preventative measure. | 28 | 19 | 48 | 35 | 65 | 47 |
| 2. People with Aids should be isolated. | 28 | 20 | 60 | 43 | 51 | 37 |
| 3. I am not afraid to meet people with HIV/AIDS. | 130 | 94 | 3 | 2 | 6 | 4 |
| 4. I would change schools if I have a classmate with HIV/AIDS. | 6 | 4 | 126 | 91 | 7 | 5 |
| 5. Being around someone with HIV/Aids would <u>not</u> endanger my health. | 93 | 67 | 20 | 14 | 26 | 19 |
| 6. People living with HIV/Aids should <u>not</u> be looked down upon by others. | 127 | 91 | 9 | 6 | 1 | 2 |
| 7. I am not afraid to take care of a family member who has HIV/Aids. | 114 | 82 | 10 | 7 | 15 | 11 |
| 8. People with HIV/Aids should not be allowed to work in public places. | 19 | 14 | 108 | 78 | 12 | 9 |
| 9. If people had more information, they would not be afraid of people with HIV/Aids. | 106 | 78 | 14 | 10 | 19 | 14 |

Table V summarizes the respondent's knowledge about HIV/Aids .The percentages of those who gave correct responses is indicated. It should be noted that all of the respondents had received some kind of instruction with regards to HIV/Aids in the school curriculum in their Life Orientation classes. Overall 76.2% gave correct answers to the 14 questions.

Table V: Knowledge about HIV/Aids (n=139)

| Question | Correct Response | Correct Answer | |
|--|------------------|----------------|----------|
| | | N | % |
| 1. HIV weakens the body's natural defence. | Agree | 117 | 84 |
| 2. HIV does not lead to Aids. | Disagree | 97 | 70 |
| 3. Drugs and alcohol contribute towards people's vulnerability to HIV/Aids. | Agree | 66 | 47 |
| 4. Sex with multiple partners is a risk factor for HIV/Aids. | Agree | 127 | 95 |
| 5. Responsible sexual behaviour is a way to stop the spread of HIV/Aids. | Agree | 123 | 88 |
| 6. HIV is only transmitted through unprotected sex. | Disagree | 96 | 69 |
| 7. It is very easy to see when someone is infected with HIV/Aids. | Disagree | 108 | 78 |
| 8. Aids is a Gay disease as it only occurs among men who have sex with men, and that abuse drugs. | Disagree | 125 | 90 |
| 9. HIV can be passed from mother to the foetus (unborn child) via the placenta. | Agree | 102 | 73 |
| 10. HIV can be spread by sharing cups, plates and personal things. | Disagree | 106 | 76 |
| 12. HIV is not transmitted by infected needles and blood products | Disagree | 124 | 89 |
| 13. At present there is a cure for HIV/Aids. | Disagree | 89 | 64 |
| 14. Using protection e.g. a latex condom when having sex (vaginal, oral or anal) lowers the risk of HIV transmission | Agree | 95 | 68 |

The respondent's sexual knowledge is summarized in Table VI.

Table VI: Sexual knowledge of the respondents (n=139)

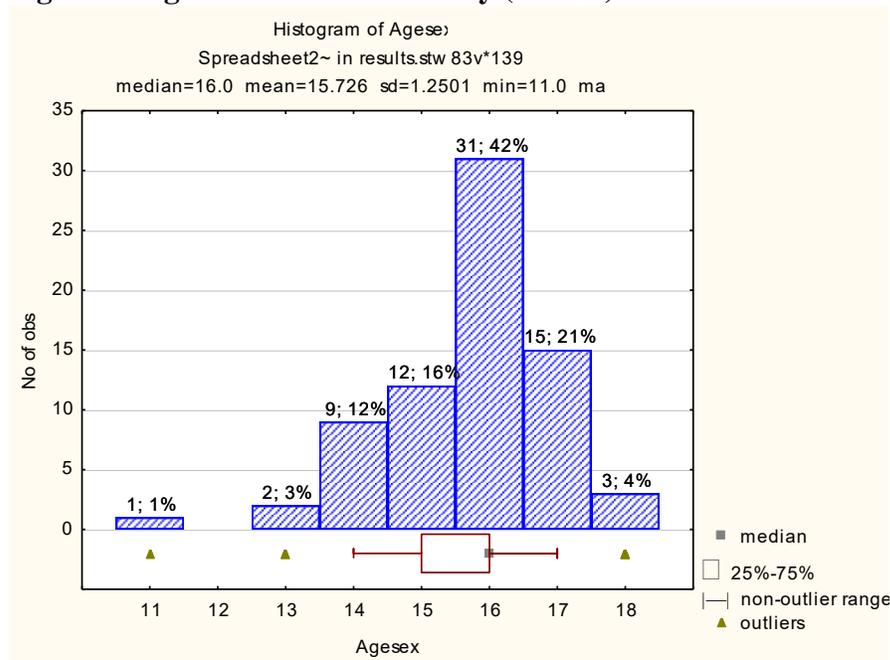
| Sexual Knowledge | Correct response | Correct answer | |
|--|------------------|----------------|----------|
| | | N | % |
| 1. Is oral sex really sex? | Yes | 24 | 17 |
| 2. Is anal sex really sex? | Yes | 46 | 33 |
| 3. A person has to have sex to show love? | No | 111 | 80 |
| 4. Girls do not have the right to refuse sex with their boyfriend? | No | 106 | 76 |
| 5. Is it rape if you are physically forced to have sex without your consent? | Yes | 132 | 95 |

Table VII shows the sexual behaviour of the respondents.

Table VII: Sexual behaviour of the respondents (n=139)

| Sexual Behaviour | Yes | |
|-----------------------------------|----------|----------|
| | N | % |
| 1. Have you ever had sex? | 68 | 49 |
| 2. Have you ever had vaginal sex? | 64 | 46 |
| 3. Have you ever had oral sex? | 28 | 20 |
| 4. Have you ever had anal sex? | 11 | 8 |

Figure 2 shows the age distribution for the first sexual activity of the respondents.

Figure 2: Age of first sexual activity (n= 139)

As can be seen from Figure 2, the median age of first sexual activity (in the sample of those who were sexually active) was 16.0 years (42%), and the mean is 15,7years. The minimum age for first sexual activity for this sample was 11 years (1%), and the maximum age for first sexual activity was 18years.

Fifty six (40%) of the sample had been sexually active during the last year. Of these, 44 (32%) had 1 partner, 14 (10%) had 2 partners and 9 (7%) had 3 partners.

Regarding the use of condoms among those who have had sex in the last year (n= 56), 39(69.7%) reported that they always used condoms, 20(35.7%) that they used condoms sometimes, while 7 (12.5%) reported that they never used condoms during sex in the last year.

Table VIII describes the prevalence of the various types of high risk behaviour which the respondents may have been exposed to.

Table VIII: High risk behaviour (N=139)

| | N | % |
|--|----------|----------|
| Have you had sex under the influence of drugs in the last year? | | |
| Yes | 5 | 4 |
| No | 64 | 46 |
| I've never had sex | 70 | 50 |
| Have you had sex under the influence of alcohol in the last year? | | |
| Yes | 15 | 11 |
| No | 53 | 38 |
| I've never had sex | 70 | 50 |
| Not answered | 1 | 1 |
| Have you had sex with someone in order to get food, clothes money etc in the last year? | | |
| Yes | 15 | 11 |
| No | 53 | 38 |
| I've never had sex | 69 | 50 |
| Not answered | 1 | 1 |
| Did you force someone to have sex with you in the last year? | | |
| Yes | 2 | 1 |
| No | 137 | 99 |
| Did you try to 'sweet talk' someone into having sex with you in the last year? | | |
| Yes | 17 | 12 |
| No | 122 | 88 |

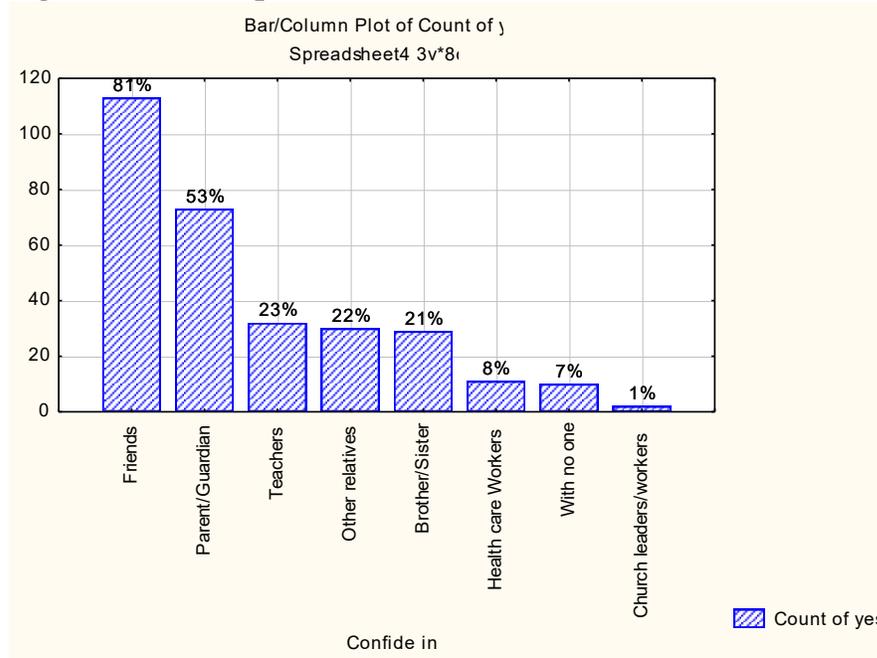
Table IX describes communication about sex between the respondents and their parents/guardians.

Table IX: Discussing sex with parents/guardians (n=139)

| | N | % |
|--|----------|----------|
| Have you ever had a conversation about sex with your parents? | | |
| Yes | 93 | 67 |
| No | 46 | 33 |
| How comfortable are you about speaking about sex with your parents /guardian? | | |
| Very uncomfortable | 36 | 26 |
| Uncomfortable | 58 | 42 |
| Comfortable | 40 | 29 |
| Not answered | 5 | 4 |

Figure 3 shows whom the respondents were able to confide in about sex.

Figure 3: Who respondents confide in about sex



It is of note that friends/peers (81%) ranked highest in terms of whom teenagers confided in about sex, followed by parents/guardians (53%), teachers (23%). Only 8% of the respondents reported that they discussed sex with health care workers.

Table X describes the incidence of reported sexually transmitted infections amongst the respondents. The overwhelming majority (96%) of the sample have never suspected an STI. Only 11 (8%) had undergone voluntary testing and counseling for HIV in the last year.

Table X: Reported rates of STI's

| | N | % |
|--|-----|----|
| Have you ever had an STI in the last year? | | |
| Yes | 5 | 4 |
| No | 134 | 96 |
| Have you ever had a genital ulcer in the last year? | | |
| Yes | 2 | 1 |
| No | 136 | 98 |
| Not applicable | 1 | 1 |
| Have you ever had a penile or vaginal discharge in the last year? | | |
| Yes | 23 | 17 |
| No | 116 | 83 |

Focus Group Interviews:

Major themes which emerged from the Focus Group Discussions about adolescents knowledge, beliefs attitudes, and practices are recorded in Table XI.

Table XI. Summary of thematic framework

| |
|--|
| <p>Theme 1: Knowledge:</p> <ul style="list-style-type: none"> • Knowledge of spread • Knowledge of Risk • How HIV is not spread • Gays • Differences between HIV and Aids • Misconceptions <p>Theme 2: Behaviour:</p> <ul style="list-style-type: none"> • Unprotected sex • Drugs and alcohol • Condom use <p>Theme 3: Attitudes:</p> <ul style="list-style-type: none"> • Stigma • Effects of HIV/Aids on the individual and family <p>Theme 4: Practices:</p> <ul style="list-style-type: none"> • Sexual Activities • Age of first intercourse • Multiple partners • Infection despite prevention programmes • What influences sexual activity in teenagers <p>Theme 5: Perceptions:</p> <ul style="list-style-type: none"> • Appearance • Friend affected by HIV/Aids • Death sentence? • Information overload? • Youth suggestions for HIV/Aids prevention |
|--|

Theme 1: Knowledge

The findings suggest that knowledge about HIV/Aids was high. Adolescents indicated that they knew the major routes of transmission for HIV:

“Through unprotected sex-sex without a condom.”

“Blood transfusion and blood.”

“Unsterilized needles-e.g. if you have your ears pierced, and the person before yours blood is still on the needle.”

“Teenagers being sexually active without a condom. Through irresponsible sex”

*“Through blood, you know, if you get hurt and have open wounds, when helping someone
“Blood Transfusions.”*

“During Pregnancy, from the mother to baby.”

There appears to be a general understanding about the differences between HIV and Aids, as is evident by this comment by one of the participants:

“HIV is when you get the virus, but Aids is when HIV becomes full blown, and is now a sickness. Aids runs down the immune system. Can’t fight infections.”

When asked about behaviours which put young people at risk for contracting the HIV virus, the participants answered as follows:

“Unprotected sex, whether vaginal oral or anal.”

“Sleeping around. Being promiscuous.”

“Taking alcohol or using drugs. You lose perspective on what you are doing, and then might have unsafe sex.”

“Having more than one partner.”

“Not being careful. Not having safe sex.”

“Not thinking about it careful. Not being responsible for what you do.”

“One night stands. At parties, most of the times it is boys from other schools who come expecting to have sex with girls from our school.”

“Rape, sometimes the guy forces himself on the girl. They just want to use the girl.”

“Most girls don’t want to be virgins anymore. They want to be in the ‘in group.’ By being a virgin you are being boring. So they do it to get it over with”

The participants were able to define safe sex as follows:

“Having sex with a condom.”

“Having a monogamous relationship-just one partner.”

“Not having any sex”

When asked how HIV was not transmitted, participants generally had the correct knowledge, with no misconceptions.

“Have only one partner.”

“Test yourself.”

“Look after yourself.”

“You can’t get HIV from crockery and cutlery”

“Also not from using the same toilet or hugging someone. Can’t get it from kissing someone, except if sores in the person’s mouth.”

“Drinking water or sharing a cup.”

“You can share a bathroom with someone with Aids.”

“Abstaining.”

“Do it yourself, in other words, masturbating.”

Participants in both focus groups were mostly of the opinion that Aids was not a homosexual disease per se as can be seen in the following excerpts.

“Here, it is mainly between men and women and amongst some gays.”

It is a heterosexual, bisexual and homosexual disease in South Africa. It affects everybody.”

Unfortunately, a misconception emerged from one of the focus groups, when one of the participants made the comment:

“People in our community (coloured) think that HIV/Aids is a ‘black disease’ and that it can’t happen to them”.

Having sex with a virgin will cure Aids is a common misconception which has been spread in some communities. This was brought up for discussion in the focus groups, and the participants were all of the consensus that this was not so.

“No, not true.”

“A virgin can also have the illness and give it to someone else, if she got it by blood transfusion or from her mother.”

Theme 2: Behaviour

Most of the participants agreed that adolescents in their group were practicing high risk behaviour with regards to sex. When asked which factors influenced young people’s decision of whether or not to have unprotected sex, comments were as follows:

“If the person is easy on the eye, i.e. looks clean and good looking, most teenagers would go out and have sex with that person without worrying about getting HIV/Aids.

“If a guy has a reputation of being a ‘playa,’ won’t have sex with him”

“If someone uses drugs, consider them to be unsafe. But not a lot of people inject drugs here. It is too expensive.”

“This does not usually happen. Young people of today just go with the flow. Their attitude is that you’re gonna die anyway, so just go with the flow, man.”

“Most of my friends are sexually active, and just want to get laid.”

“When you have a boyfriend and you think you love him, then you have sex to show him that you love him.”

“If you have both been together for a while, and tests are done and they are negative.

“Looks can be deceiving. You can’t see if they are clean or not.”

Discussion with participants in both focus groups revealed that there was a lot of abuse of alcohol and drugs amongst their peers, and these made them more vulnerable to risky sexual behaviours. On further questioning it emerged that alcohol was most common, followed by dagga, cocaine (‘rocks’), mandrax, ecstasy (‘E’s), tik, and other tablets. Participants mentioned that drugs were easily obtainable.

“You buy it from the Nigerians. People usually look for them first.”

“You even get school girls who are willing to sleep around if they don’t have money so that they can get drugs.”

On asking the question if they would have unprotected sex with someone who was using drugs, one participant responded:

“No, but there a lot of girls that don’t care when they are high.”

Participants in both focus groups named condom use as a means to protect against not only HIV/Aids, but sexually transmitted diseases and pregnancy as well. However, it was revealed that there were a lot of negative attitudes towards condom use. A number of sub-themes emerged when asked why the use of condoms was so inconsistent and not popular amongst adolescents including: Using condoms was seen as not enjoyable, uncomfortable embarrassing or difficult to obtain. Adolescent males may overpower females into not using condoms, and respondents were wary about the efficacy of condoms obtained at the clinics.

“Many young people feel that it is not cool to use a condom. They say you don’t eat a sweet with a paper on. There is no flesh to flesh with a condom on”

“Wearing a condom is not comfortable. It minimizes the pleasure.”

“When in love, teenagers are blinded by love. When a boy says to a girl trust me if you love me, then there is no need for a condom”

“Some boys just make fool with condoms and brag about having them.”

“You do not know that you are going to have sex. You go to a club or a house party and are not prepared. Emotions get high, and there is no time to put a condom on even if there is one.”

“Guys try to get the girl not to want a condom. They want to show love without a condom. They want the skin to skin feel. People say you don’t eat a banana with the peel on.”

“Too embarrassed to buy one. People look at you funny.”

“When you go to the clinic, people look at you, like, what is your reason for being here.”

“Sometimes the girls want to trap the guy by getting pregnant, so they don’t want to use a condom. They use the excuse that condoms don’t work anyway.”

“The girls say that the stuff inside the condom gives you a rash.” They also say that condoms are gross because of the inside substance.”

“Some brands of condoms are not safe, such as the free ones from the clinic called ‘First Choice.’ They say that they break. People rather buy ‘Durex.’

“Condoms received from the clinic are not as safe as people say.”

Theme 3: Attitude

In response to a question about why there was so much stigma towards people who were living with HIV/Aids, discussion from the focus groups indicated that they felt that the stigma arose due to a lack of education about the disease:

“People do not have knowledge about the disease. They have no right to stigmatize people who have Aids.”

“People should be taught about the disease so that they have more knowledge.”

“People are ignorant. They don’t talk good of it.”

“People judge unfairly.”

The participants were asked if they would share a cup with someone who had Aids, and these were some of the responses which showed how some of the participants still harboured negative attitudes towards people with HIV/Aids, despite appearing to be knowledgeable about its transmission. This shows that the participant's attitudes toward people with HIV/Aids were contradictory.

"I would, because I know that there is no way that I would get it."

"I will not touch a person or talk to a person or share a cup with a person who has HIV/Aids." (FG1)

"No, won't share a cup with anyone"

"What if there is a cut on the person's lip. No I won't share a cup."

"I would have to get to know the person well first."

Participants felt that there was much embarrassment and discrimination towards individuals living with Aids in family situations, as is evident from these comments:

"They feel that they will be rejected."

"They rather distance themselves."

"They don't care about themselves because they feel that they are going to die anyway."

"They may spread the virus deliberately because they don't want to be the only ones that have it."

"They get a lower self esteem."

"Families are embarrassed to let others know that someone in their house is HIV positive."

"People are too scared to let others see that they are getting thin"

"Many people with Aids are being discriminated against. This forces them out of the community, and just to stay at home and hide away."

"Some may think of suicide, because there is no life for them."

Theme 4: Practices

To be able to assess the context of sexual behaviour amongst adolescents, participants of the focus groups were asked to describe what sort of sexual activities were currently taking place amongst adolescents. Participants of both focus discussion groups were generally forthcoming in disclosing the nature of the sexual activities which take place.

"Teenagers are having sex. The real deal. Vaginal, oral (blow jobs, muffing), anal sex, you name it. Many dry hump-there is no penetration. Just rubbing against each other. With or without clothes. Dry humping is huge. Also tea bagging (described as when a girl juggles a boy's testicles in her mouth) and ring jobs (described as an activity where one partner licks the anus of the other partner) Teenagers think that these type of sexual activity will not get them pregnant. They do not think that this could give them HIV or an STI."

"They experiment with anal sex because they think that the guy wants it. Anal sex allows the guy to keep the girl, because she would not want him telling everyone about it if they should break up. She would be too shy to say that the boy did that to her."

"Lots of sex happens at clubs and house parties. Many people are drunk or high on drugs, e.g. "E's". People are having sex all over the place-in the toilets, up against the walls, on the grass or open fields, in the car...."

“Kids have sex in clubs, some on the dance floor, especially in funk clubs.”

Adolescents were having multiple partners and were unfaithful to their girlfriends or boyfriends.

“For guys it’s all about the numbers. They do it like rabbits.”

There are lots of one- night stands. A guy will pick a girl up at a club or a party, even if he already has a girlfriend. Then he will have a one night stand.” “If a guy is popular, he has more than two girls. If a girl likes him, he must make a move. He will tell her he loves her just to get sex.”

“Most teenagers, boys and girls, have more than one partner. If the chance comes and your boyfriend is not with you, for example you are away for the weekend and clubbing, you do not think twice about cheating.

“It happens a lot. On a Monday, when you get to school, you hear about the weekends activities. You hear about kids that have four, five or six partners in one night, with or without a condom, just to be part of the ‘in crowd.’ Sometimes it is a competition to see how many partners they can get in one night.”

“Some of the girls have so many partners that they do not even remember how any. Some girls just get used by boys.”

This male participant described how freely some adolescents were having risky sex:

“Some guys will have ‘tournament’ (take turns) with a girl that they know to be a ‘slegte’ (promiscuous) girl. They won’t even use a condom.”

Another context in which sexual activities was taking place, was that of ‘sugar- daddies’ and ‘Taxi Queens’, as these participants explained:

“Girls have ‘sugar –daddy’s’-older men with money and cars, to get what they want. They ‘badge’ from them e.g. clothes, deodorant, and ‘bling.’ (Jewelry) They use sex to gain something.”

“It’s very important. They must have money and a car.”

“Boys also have ‘sugar- mommies’ to get what they want (Badge)”

“There are ‘taxi-queens’, girls who pay for their transport by giving sex to the taxi drivers.”

Participants were of the opinion that the average age of first sexual intercourse was younger than 16:

“Many girls are younger than 16.”

“Others are 16 and have older guys.”

“Many begin at 13. The moment they get their periods they feel they are big.”

“The grade 8’s want to be popular, then they do it.”

Reasons given for what influenced adolescents to get involved in sexual activities included:

“They are influenced by what they see on TV. Just look at ‘Bold and Beautiful’ and ‘Days of our Lives.”

“There is easy access to porn. You can get it on your cell phone, on the internet, and on E-TV.”

“Teenagers are influenced by their friends.”

“Some even record themselves having sex on their cell phones, and then show everyone.”
“It also depends on the social circumstances of families. People live in one-bed roomed houses. The adults think that the children are sleeping, and then they have sex. The children then see them having sex.”

The consequences of these sexual activities were described as:

“Pregnancy and STI’s.”

“HIV.”

“Most teenagers are more scared of falling pregnant than of contracting an STI or HIV.

“Their parents tell them ‘don’t come home pregnant.’ They don’t tell them about the diseases they can get. Because getting pregnant is ‘groot skandes’ (a scandal)”

Theme 5: Perceptions

On asking the participants what someone with HIV/Aids looked like, they were aware that you could not just tell if someone had HIV or Aids or not. The following excerpts from some of the participants demonstrate this point:

“You can’t tell who has or who doesn’t”

“They have pimples. They were fat and then all of a sudden, now they are thin.”

“One person that I know with HIV is pretty normal looking.”

There was some disagreement, and negative sentiments expressed amongst the participants when the question was put to them about how a close friend’s diagnosis with HIV/Aids would affect their relationship. This participant from felt quite strongly: *“I would stop being his friend. Finished.”*

Another added:

“Our friendship will be up and down, there will be a change in our relationship.”

“Things may be different, especially because have got to get used to the idea. Not everyone is used to people with Aids.”

Some other participants appeared to be more understanding if they had a friend affected by HIV/Aids.

“We must support, listen and communicate. Be positive. Our friendship will be stronger

“No, I won’t push that person away.”

“Will stand by that person.”

The participants were in agreement that HIV/Aids was not a death sentence, as can be seen from the following excerpts:

“You can have a healthy life, you could live very long if you look after yourself.”

“Get pills and live a healthy life.”

“Eat healthy, don’t drink and smoke, no sex, talk about the disease.

“No. It is handled the same as diabetes and Blood pressure.”

Participants were asked if they felt that they were being bombarded with information about HIV/Aids. One participant responded:

“We become more educated by information.”

Another participant felt that there was too much information:

“Yes, we are being bombarded. Aids is no longer serious. We are getting too much information. Therefore it is not taken seriously.”

Another participant shared this view:

“Everyone is always on about HIV. It is everywhere. Wherever you go there is information.”

The participants agreed that the youth should be involved in the prevention of HIV/Aids. They were asked how HIV/Aids prevention education could be improved, and these were some of the suggestions which were made enthusiastically by the participants on the best way to get the message across:

“Use drama and music. It will keep teenagers interested.”

“The youth should get involved. They should use music in the programmes. Music attracts the youth. They should use proper music. Old people play old music.”

“Lectures are a waste of time. You will always find someone giggling and poking fun.

“They don’t concentrate.”

“A celebrity should come out and speak. They know how to attract teenagers”.

“Someone already infected with Aids should talk to people, because they already know how it feels to live with Aids. You can see that they are not dying. You can see that there is life after being infected.”

“Teenagers should be personally involved with the programmes and they should say what they are going through.”

“Start health clubs at schools where teenagers can talk about these things.”

“Fun ways.”

Discussion

Knowledge

This study found that the level of HIV/Aids knowledge among most of the adolescents in the sample was moderate. Some misconceptions were apparent, such as 36% of the respondents thought that there was a cure for HIV/Aids and 53% of the respondents did not think that drugs and alcohol contributed towards people’s vulnerability to HIV/Aids. Only 68% of the participants believed that using barrier protection would lower the risk of HIV/Aids. Twenty four percent of the sample was unable to correctly identify that HIV was not spread by sharing cups plates and personal things. A gap in the knowledge of transmission of HIV was also evident by the fact that 27% did not correctly identify that HIV can be passed from mother to the foetus. However, only a minority of participants (11%) did not know that HIV could be spread by needles and infected blood products. Findings from the FGI showed that the participants had a good knowledge about HIV/Aids and its transmission. However, some gaps in the adolescents’ knowledge need to be filled. These findings were consistent with those of previous studies in Africa.^{11,22}

The sexual knowledge of the adolescents in the study is low, as the majority of the participants were unable to define oral (not that risky) and anal sex (high risk) as being

sex. This is a matter of concern, as it would appear as if having oral sex or anal sex is condoned by adolescents, and as was evident from the FGI, these sexual activities are taking place. They think that these activities will prevent pregnancy, which they are more afraid of than of contracting an STI or HIV.

Attitudes

The 2005 South African National HIV prevalence HIV incidence, Behaviour and Communication Survey found that attitude to people with and affected by HIV/Aids was generally positive, especially in relation to being willing to care for family members with Aids, and general perceptions about People living with HIV/Aids.²⁵

This study demonstrated that the majority of the adolescents exhibited a mostly positive attitude towards people who were living with HIV/Aids, with most of the participants stating that they were not afraid to interact with someone who was HIV positive. Some however, were uncertain. This attitude was also evident from the FGI where, although most of the participants showed a favourable attitude towards people living with Aids, this one participant passionately stated that *"I will not touch a person or talk to a person or share a cup with a person who has HIV/Aids."*(FGI). This too showed the contradictory attitudes of the participants, which is of concern, and shows a gap in knowledge of the adolescents. Thus it is evident that knowledge about HIV/Aids does not equate to changes in attitude.

Behaviour

Data from the study demonstrates that 49% of the sample was sexually active, and that the median age for sexual debut was 16 years. Of these, 32% had 1 partner, 10% had 2 partners and 7% had 3 partners.

This is consistent with that of a South African review which concluded that at least 50% of young people are sexually active by the age of 16 years, the majority had at the most 1 partner and that between 50 and 60% of sexually active youth never used condoms.²⁶

Condom use among adolescents in the study has received much negative attitude, as is evidenced from the excerpts from the FGI, where numerous reasons were given for not using a condom. This is despite the fact that most of the participants in the study were aware of the fact that condom use helped to prevent the spread of HIV/Aids. Another South African study which examined details of secondary school students knowledge about STI's and HIV/Aids has shown that despite the positive aspect of wide acceptance and the favourable attitude towards condom use, actual use and confidence about how to use a condom was low among both male and female students.²⁷

Another study in the North West Province, South Africa also found positive results regarding the accessibility and awareness of condoms, but this did not lead to the desired behavioral change of using condoms in risky sexual interactions.²⁸

This once again reiterates the fact that adolescents' knowledge does not necessarily equate to behaviour change.

Other high risk activities which contribute towards risky sexual behaviour are alcohol and drug use. As was reported in both the survey and FGI, these activities take place on a wide scale amongst adolescents. Taylor M et al in a study of high school students in Kwazulu- Natal, South Africa found that drinking alcohol influenced learner's sexual activity, with the odds of learners drinking and being sexually active being 3.2 times that of learners who did not drink.²⁹

'Sugar-daddyism' is another risk factor for risky sexual behavior, which was apparent in the FGI. A study by Frank S et al of high school pupils in Wentworth, Durban showed that having partners who were a few years older increased the risk of HIV infection. As older partners had higher earning power than same-age partners, and pupils might seek after relationships that were profitable.³⁰

A number of key factors which influenced adolescents' sexual decision-making emerged as physical appearance, reputation, whether or not someone uses drugs, peer pressure when making decisions about whether or not to have sex with a prospective partner. These decisions could put them at a higher risk for contracting HIV.

Looking at the goals and perceived self efficacy of the participants (Table 3), the results give the appearance of two groups of learners: the one larger group with a high self esteem and a clear sense of future who respond "always," and a second smaller group who responded "sometimes". Poor self esteem and a lack of clear goals in adolescents could result in poor sexual decision-making skills, such as not abstaining from sex, unable to negotiate condom use, and not limiting the number of sexual partners. In Project Right Choices, a teenage pregnancy prevention programme, the author concludes that helping students gain a sense of future and develop goal setting will increase the probability of remaining abstinent until marriage, as well as preventing other at risk behaviours among youth.³¹

It is interesting to note that the preferred sources of HIV/Aids information by the group of adolescents should be health care workers (45%) followed by trained peer educators (41%) and parents (21%). It was also evident from the study that peers (81%) were the group that adolescents confided in the most about sex., followed by parents/guardians (53%). A number of studies have demonstrated the usefulness of peer educators to spread the HIV/Aids prevention message. Research studies suggest that people are more likely to hear and personalize messages and to make changes in their attitudes if they believe that the messenger is similar to them and faces the same concerns and issues.³² The study which explored the sexual behaviour of Anglican Church youth also recommended that peer educators should be closer in age to the youth, so that they can act as role models for change.¹⁵

Another South African study found that peer education contributed to the delay in the initiation of sexual activity in secondary school learners. The study suggests that peer

education can contribute towards changing peer group norms in culturally accepted ways.³³

Participants in the focus groups were unanimous in recommending that HIV/Aids education should be presented in 'fun' ways in order to bring the message across. They suggested using celebrities and people living with Aids. In a study on the impact of utilizing HIV positive speakers in Aids education, it was found that having a speaker talking from firsthand experience about living with HIV was emotionally engaging and that young people were able to relate to someone who was able to share their intimate thoughts, feelings and experiences in an open, honest way. The validity of the speaker was also valued highly as they could see the emotional response of the speaker.³⁴

There was a low incidence in STI's as was reported by the participants and the majority of the participants have never tested for HIV. This is of concern, as judging by the level of sexual activity and high risk sexual behaviour amongst the sample, they are putting themselves at risk for HIV/Aids and for the transmission of STI's.

Conclusions

The study aimed to determine the knowledge, attitudes, beliefs and reported sexual behaviour of adolescents in an urban general practice area. It has highlighted the factors which may contribute to the spread of HIV/Aids among adolescents. It has provided some insight into the knowledge, attitudes, beliefs and practices of adolescents in the area. Although the level of knowledge regarding HIV/Aids was moderate, this did not translate into safer behaviour and practices, or improved attitudes towards people affected by HIV/Aids. Gaps in their knowledge need to be filled, and misconceptions corrected.

Although schools are having the desired effect of disseminating information about HIV and its transmission, they are failing in imparting the necessary skills for adolescents to make behavioural changes which can lead to safer sexual practices and to enhance their sexual decision-making skills.

Limitations

The study has several limitations. The relatively small sample and the restriction of the number of participating schools to just 2 may limit the generalizability of the results. This study was conducted within the context of schools in an urban, low-middle economic community in Port Elizabeth. Thus other contexts have not been considered (e.g. rural and upper socio economic communities).

Because the questionnaire was self reported, the possibility exists that young people may be reluctant to provide information about their sexual activity, and may tend towards more socially acceptable answers. The limitations of the FGI are that group dynamics have a more pronounced effect on some individuals than on others, and that the participants may attempt to provide desirable responses.

Recommendations

The results of this study could be used to re-evaluate the current programmes available for adolescents in schools in the researcher's practice area, and recommendations could be made to the relevant Departments of Education and Health.

Recommendations for a GP-based intervention are made on the strengths of family medicine principles and the GP or family physician as an advocate for school-based health promotion.

The principles of family medicine as described by McWhinney³⁵ state that the family physician sees his practice as a population at risk, and should thus venture out of his office into the community to work on high risk groups (e.g. adolescents at risk for contracting HIV). He or she should work in collaboration with community, colleagues and other people in organizations to make effective interventions that improve the health of the population.³⁶

Sexual health education to adolescents should be a routine part of the GP's practice. In the context of a continuing doctor-patient relationship, the family physician has the opportunity for early detection of high risk behaviours and prevention of disease.³⁷ However, family physicians or GP's are able to reach a small fraction of adolescents in their practices, and only for a short time.

Family physicians or GP's can play a leading role in designing and implementing effective HIV education programmes. As a primary care provider, the family physician can be an important contributor to the planning processes for community based health programmes.³⁷ They should develop effective collaborations and partnerships with school principals and teachers, parents, community leaders, primary health care nurses and trained peer educators.

Schools are ideal vessels for HIV/Aids education programmes, because they reach a large number of young adults. Consideration should be given to those students who have dropped out of school.

Working with schools is one way that GP's or family physicians can support the communities that they serve. The Canadian Association for Health has described the following role for family physicians in the community regarding school-based health and the physician as advocate.³⁸

1. Advising schools on educational programs and materials.
2. Advocating for school health programmes and health services for youths.
3. Arranging for hospitals (practices) to 'adopt' a school for research and training.
4. Participating on school boards and in community organizations.
5. Contributing to awareness campaigns aimed at youth.
6. Advising peer helper programmes.
7. Advocating for policies, laws and regulations.

8. Participating in clinics on reproductive health, sports medicine clinics, health fairs and street clinics.

These recommendations can be applied when considering what GP's or family physicians can do to develop strategies to improve HIV interventions:

Based on the study findings, recommendations will be made to the school principals to move away from just focusing on knowledge and awareness about HIV/Aids (didactic classes), and move in the direction of training teachers and peer educators about decision-making skills in order to effect behaviour change. Gaps in knowledge need to be addressed.

Creative adolescent friendly programmes need to be established, which aims to increase age of sexual debut, increase safer sex behaviours (e.g. sex with a condom) and decrease sexual risk behaviours (e.g. drug and alcohol abuse, increased number of sexual partners, "sugar daddy's" etc)

Adolescents should be involved in the planning of any intervention, as they are more likely to "buy-in" to a programme that they were involved in designing. This would help to ensure the relevance of the programme to young people.

Schools should be encouraged to form health clubs for its adolescents, which not only focuses on HIV/Aids, but other health matters as well. These health clubs would encourage debate around health and sexual issues, and members of the health clubs can be encouraged to take part in outreach programmes-e.g. to care for people living with Aids or to support Aids orphans. Health Care workers or people living with HIV/Aids could be invited to speak to the club, and in such a way reduce the stigma attached to HIV/Aids.

Schools should liaise with nurses from local clinics, or GP's or family physicians from local practices. They can be used for regular healthcare workshops, presentations or discussions, including sexual /reproductive health and HIV prevention.

Mobile Clinics should come to schools and provide adolescents with comprehensive health services, not only relating to HIV/Aids. Voluntary Counselling and Testing (VCT) can be offered at these clinics and condoms should be made available.

Once an intervention for a school has been realized, further research needs to be undertaken of such an HIV/Aids prevention intervention with pre- and post –studies to evaluate whether it is effective.

The Ready ... Steady Go... criteria should be used in the evaluation of any intervention which has been designed. Policy makers in the Health and Education departments should make every effort to ensure that "Go" interventions are widely implemented as these interventions are effective in contributing to the global goals for

increasing knowledge, skills and access to health services, and they will ultimately contribute to reducing the prevalence of HIV among young people.²⁴

The theme for the XVIth international Aids conference held in Toronto in 2006 was “Time to deliver.” Both prevention and treatment are needed urgently to heed the call of this conference.³⁹

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Appendix 1

QUESTIONNAIRE²¹

The Aids pandemic has reached catastrophic proportions in the world, and especially right here on our own doorstep, in Sub-Saharan Africa.

The attached questionnaire is intended to determine the level of knowledge, attitudes and perceptions among adolescents.

Confidentiality:

The information you provide shall be used for research purposes of a Masters degree in Family Medicine. (MFam Med) at the University of Stellenbosch. It will not be identified to you in any way, and shall be treated with extreme confidentiality. No personalized information shall be given to your parents, teachers or school principal. Please do not write your name in any section of this questionnaire.

A facilitator who is assisting me with this research will read out the questions, so that everyone can answer the questions at the same time, and necessary translation can be made.

Where there are options, please circle your answer. You can provide more information if you so wish, or if your answer is not one of the options. If more than one option applies to your answer, you can circle more than one option. Please give us your honest opinion and feelings. At the end of the exercise, please place your own questionnaire in the sealed box, which is provided. This will help us to maintain confidentiality.

Your assistance in completing this questionnaire as part of my research is much appreciated.

Thanking you.

Dr Sean Volkwyn

Part 1: Biographical and general

Questions

Response

- 1.1 What is the year of your birth?
- 1.2 What sex are you? Male (Boy)
Female (Girl)
- 1.3 Who do you live with?
1. Both parents
2. One parent
3. Another relative
4. A friend
- 1.4 Which part of Port Elizabeth do you live in? (Suburb)
- 1.5 What HIV/Aids programmes have you attended?
1. Love Life
2. Peer education
3. Life skill programme (In Life Orientation class)
4. Other please state.....
- 1.6 If yes, in which year was the last time you received HIV/Aids education
- 1.7 What is your religion?
1. Christian
2. Muslim
3. Other
- 1.8 What is your race?
1. African
2. Coloured
3. White
4. Indian/ Asian

Question

Response

1.9 By which of the following people do you think Learners should be taught about HIV/Aids?

1. Class teachers
2. Teachers from another

- School.
- 3. Health Care workers
(Doctors or Nurses)
- 4. Parents
- 5. Trained Peer Educators.
- 6. Others. Please state.....

1.10 Which of the following methods do you think would be the best to present HIV/Aids education?

- 1.Small group discussions
- 2. Large group discussions
- 3. Lectures
- 4. Question and answers.
- 5. Drama presentations
- 6. Videos
- 7. Others. Please state.....

Part 2: Goals and beliefs

2.1 Do you think that you are as important as other people in your group.

- 1. Never
- 2. Sometimes
- 3. Often
- 4. Always

2.2 Do you have life-goals and do you believe that you can reach them?

- 1. Never
- 2. Sometimes
- 3. Often
- 4. Always

2.3 Can you stand up for your beliefs even if your friends believe in something else?

- 1. Never
- 2. Sometimes
- 3. Often
- 4. Always

Part 3: Attitudes

| <u>Question</u> | <u>Response</u> |
|--|--------------------------------------|
| 3.1 Aids patients should be isolated as a preventive measure. | 1. Agree 2. Disagree 3. Unsure |
| 3.2 We should not be afraid to meet People living with Aids | 1. Agree 2. Disagree 3. Unsure |
| 3.3 I would rather change schools than study with a learner who has HIV/Aids. | 1. Agree 2. Disagree 3. Unsure |
| 3.4 Being around someone with HIV/Aids would not endanger my health. | 1. Agree 2. Disagree 3. Unsure |
| 3.5 People with HIV/Aids should not be looked down upon by others. | 1. Agree 2. Disagree 3. Unsure |
| 3.6 I would not be afraid to take care of a family member with HIV/Aids. | 1. Agree 2. Disagree 3. Unsure |
| 3.7 People with HIV/Aids should not be allowed to work in public places. | 1. Agree 2. Disagree 3. Unsure |
| 3.8 People would not be afraid of HIV/Aids if they had more information about the disease. | 1. Agree 2. Disagree 3. Unsure |

Part 4: Knowledge

| <u>Question</u> | <u>Response</u> |
|--|-----------------|
| 4.1 HIV weakens the body's natural defence against infections. | 1. Agree |

- | | |
|--|--------------------------------------|
| | 2. Disagree 3. Unsure |
| 4.2 HIV does not lead to Aids | 1. Agree 2. Disagree 3. Unsure |
| 4.3 Drugs and alcohol contribute towards the vulnerability of people to HIV/Aids. | 1. Agree 2. Disagree 3. Unsure |
| 4.4 Sex with multiple partners is a risk factor for HIV/Aids. | 1. Agree 2. Disagree 3. Unsure |
| 4.5 Responsible sexual behaviour is a way to stop the spread of HIV/Aids. | 1. Agree 2. Disagree 3. Unsure |
| 4.6 HIV <u>is only</u> transmitted through unprotected sex. | 1. Agree 2. Disagree 3. Unsure |
| 4.7 It is very easy to see when someone is infected with HIV. | 1. Agree 2. Disagree 3. Unsure |
| 4.8 Aids is a “Gay disease,” because it is only occurs among men who have sex with men and that abuse drugs. | 1. Agree 2. Disagree 3. Unsure |
| 4.9 HIV can be passed from mother to the foetus (unborn child) via the placenta. | 1. Agree 2. Disagree 3. Unsure |
| 4.10 HIV can spread if an HIV positive person shares cups, plates or personal things. | 1. Agree 2. Disagree 3. Unsure |

- 4.12 HIV is not transmitted by infected needles and blood products.
1. Agree
 2. Disagree
 3. Unsure
- 4.13 At present, there is a cure for HIV/Aids.
1. Agree
 2. Disagree
 3. Unsure
- 4.14 Using protection such as a latex condom when performing sex (oral, vaginal or anal) lowers the risk of HIV transmission.
1. Agree
 2. Disagree
 3. Unsure

Part 5: Sexual: Knowledge

Before you fill in the next section, let us define some terms. There are different types of sex e.g. vaginal, anal and oral sex.

Vaginal sex- is when the penis of a male is placed into the vagina of a female.

Anal sex –with someone is when the penis is inserted into the anus.

Oral sex-is with a male or a female -when either of you or your partner's mouth is on the penis or the vagina.

This can have been done to you or you could have done it to someone. Therefore, someone who is sexually active has any type of sex (vaginal, anal or oral) with someone else.

Question

Response

5.1 Is oral sex really sex?

1. Yes
2. No
3. Unsure

5.2 Is anal sex really sex?

1. Yes
2. No
3. Unsure

5.3 A person has to have sex to show love.

1. Yes
2. No
3. Unsure

5.4 Girls do not have the right to refuse sex with their boyfriends

1. Yes
2. No
3. Unsure

5.5 Is it rape if you are physically forced to have sex without your consent?

1. Yes
2. No
3. Unsure

Part 6: Sexual Behaviour

Please note once again that the answers you provide will be kept in the strictest confidence, and will not be divulged to anyone else. It will not be possible for you to be identified in any way. The questionnaire will be used for research purposes only.

| <u>Question</u> | <u>Response</u> |
|---|--|
| 6.1 Have you ever had sex? | 1. Yes 2. No |
| 6.2 Have you ever had vaginal sex? | 1. Yes 2. No |
| 6.3 Have you ever had oral sex? | 1. Yes 2. No |
| 6.4 Have you ever had anal sex? | 1. Yes 2. No |
| 6.5 At what age did you first do any of the above? | |
| 6.6 In 2007/8, did you have sex-vaginal, anal or oral? | 1. Yes 2. No |
| 6.7 How many sexual partners did you have in 2007/8? | 1. 1 partner 2. 2 partners 3. >2 partners 4. >3 partners 5. I've never had sex |
| 6.8 In 2007/8, how often did you or your partner(s) use a condom? | 1. Never 2. Sometimes |

- 3. Frequently
- 4. Always
- 5. I've never had sex

6.9 In 2007/8, have you ever had sex under the influence of drugs?

- 1. Yes
- 2. No
- 3. I've never had sex

6.10 In 2007/8, have you had sex under the influence of alcohol?

- 1. Yes
- 2. No
- 3. I've never had sex

6.11 In 2007/8, have you had sex with someone in order to get food, clothes, cell phone etc/anything else from them?

- 1. Yes
- 2. No
- 3. I've never had sex

6.12 Did you force someone to have sex with you in 2007/8?

- 1. Yes
- 2. No

6.13 Have you tried to persuade (sweet talk) a girl or a boy into having sex with you in 2007/8?

- 1. Yes
- 2. No

6.14 If you have tried to sweet talk someone, did the boy or girl agree to have sex with you?

- 1. Yes
- 2. No
- 3. Not applicable

Part 7: Talking about sex

| <u>Question</u> | <u>Response</u> |
|--|---|
| 7.1 Have you ever had a conversation about sex with your parent(s) or guardian(s)? | 1. Yes 2. No |
| 7.2 How comfortable do you feel about speaking about sex with your parent(s) or guardian(s)? | 1. Very uncomfortable 2. Uncomfortable 3. Comfortable |
| 7.3 In 2007/8, whom did you speak to about sex? (Circle as many as you need) | 1. Parent(s)/Guardian(s) 2. Brother(s)/Sister(s) 3. Other relatives 4. Health care Workers State which..... 5. Church leaders/workers 6. Teachers 7. Friends 8. With no one |
| 7.4 Would you feel comfortable speaking about sexual health matters to your General Practitioner or a Primary Health Care Nurse? | 1. Very uncomfortable 2. Uncomfortable 3. Comfortable |

Part 8: Clinic

| <u>Question</u> | <u>Response</u> |
|--|-----------------|
| 8.1 Have you ever had a sexual transmitted infection? (STI) | 1. Yes 2. No |
| 8.2 In 2007/8, have you ever had a genital ulcer? | 1. Yes 2. No |
| 8.3 In 2007/8, have you ever had a discharge from the penis or vagina? | 1. Yes 2. No |
| 8.4 In 2007/8, have you gone for HIV/Aids Voluntary Counselling and Testing (VCT)? | 1. Yes 2. No |

Reply slip for Focus Group Interviews:

Please indicate on this slip (by circling the appropriate option) if you would be willing to participate in the Focus Group Interview. The slips can be handed in separately at the end of the session. These discussions are entirely voluntary, and no pressure will be put on you to take part in them. These discussions will be handled with the strictest confidence, and no personalised information will be made available to anyone (including your parents, teachers or principal)

Yes / No

Name.....

END

Thank you for your participation

Questions/Framework for Focus Group Interviews:

A) Knowledge:

1. In which ways is HIV spread?
2. What behaviours put you at risk of being infected with HIV?
3. What is the difference between HIV/Aids.?
4. How do you not get HIV?
5. Is HIV/Aids just a gay disease?

B) Attitude/ Behaviour:

1. What possible factors would influence young people's decision of whether or not to have unprotected sex with someone?
2. What are the attitudes of young people towards condom use?
3. Why is there so much stigma around HIV/Aids and people living with HIV/Aids? How can this be overcome?
4. How do you think that HIV/Aids affects the individual patient and their families?
5. Would you share a cup or other utensil with someone who has HIV/Aids?
6. How would a close friend's diagnosis with HIV/Aids affect your friendship?

C) Practices:

1. What sexual activities do young people of your age engage in?
2. What is meant by risky sexual behaviour?

D) Perception:

1. What does someone who has HIV/Aids look like?
2. Do young people think that they could contract HIV/Aids?
3. Do you think that the youth are being bombarded with information about HIV/Aids?

E) Suggestions

1. Why do you think that HIV is still spreading among the youth in South Africa despite the many programmes available?
2. Should the youth be involved in the development of HIV/Aids prevention programmes?
3. How can HIV/Aids prevention education be improved and what methods should be used?
3. Are there any problems with access to information about HIV/Aids?

Any other comments?