GRADE SIX AND SEVEN LEARNERS’ PERCEPTIONS OF
THE HIV/AIDS LIFE SKILLS EDUCATION PROGRAMME

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ABSTRACT

At present there is no cure or vaccine for Human Immuno-deficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) therefore prevention programmes are seen as the only means of reducing the spread of the disease. HIV/AIDS education programmes in schools have been identified as the most effective intervention because billions of children can be reached worldwide and because schools are the one social institution with which most children come into contact. Young people in particular have been identified as the age group most in need of a preventative programme. The aim of this study is to explore the perceptions of grade six and seven learners with regard to the Life Skills programme focusing on HIV/AIDS education in the Port Elizabeth region.

In order to fulfil the above aim a qualitative study was undertaken within an exploratory descriptive approach. A non-probability, convenient sample of six schools were selected. Focus groups, utilising an unstructured interview, were used to gather qualitative data about the perceptions of grade six and seven learners. The focus groups consisted of 10-12 participants. The data was thematically analysed using Tesch’s approach.

The major findings of the present study included the following:

1. Learners’ perceptions of completing the questionnaire were generally positive in nature. Negative perceptions related to practical issues such as the length of the questionnaire and the time of administration.
2. Learner’s perceptions of the programme were generally positive.
3. Learners’ felt more comfortable discussing HIV/AIDS with parents and teachers.
4. Learners’ appeared to be well informed about high-risk behaviour related to HIV/AIDS and existing myths.

5. Contact with HIV+ people is non-existent. However, learner’s felt that the programme had fostered positive attitudes towards HIV+ people.

6. Learner’s felt that schools had an important role to play in sharing information about HIV/AIDS.

These findings seem to indicate positive outcomes for the programme as a whole, in that is was successful in terms of conveying information regarding HIV/AIDS; it led to positive changes in attitudes, especially towards HIV+ people; and it confirmed the school as the best setting for implementing HIV/AIDS Life Skills programmes.

**Key words:** AIDS, HIV, life skills, prevention programmes, schools, young people
CHAPTER ONE
INTRODUCTION

Since it was first discovered in 1981, AIDS has continued to spread unabated in many parts of the world. Early research has provided much in terms of increasing the understanding with regards to the spread of the disease and how it has progressed to date (Aggleton & Rivers, 1993). However, this understanding seems to have achieved very little in terms of kerbing the spread or reducing the impact of the disease. Nevertheless, the knowledge obtained through early research should not be excluded since it not only provides a context and a base for the understanding of the disease, but also provides an understanding and a context for prevention programmes.

The growing global impact of the disease has somehow clouded the fact that AIDS is almost entirely preventable. Primary prevention through behaviour change involving safer-sex practices aimed at the groups most vulnerable to HIV infection, still continues to be the most viable and potentially effective option to halting the spread of the disease (Joint United Nations Programme on HIV and AIDS (UNAIDS), 2002).

Research has shown that much more than information is required to stop the spread of the disease (Aggleton & Rivers, 1993; The World Bank, 2002; Valentich & Gripton, 1989). Prevention programmes have provided basic information about issues such as sex, sexually transmitted infections (STI’s), and HIV dynamics (i.e., transmission, risk factors and how to avoid infection). However, this has proved insufficient to bring about behavioural change. It is recognised that prevention programmes should aim to develop the knowledge, attitudes, values, and skills- including interpersonal skills, critical and creative thinking, decision making, and self-awareness
needed to make sensible health-related decisions (Perkel, 1992; The World Bank, 2002; Van Dyk, 2001).

HIV/AIDS has been described as socially toxic for three reasons: It is a global epidemic affecting millions of people; it strikes at the very act critical for human survival and human life, that is, sex; and it mostly affects those in the debut of their lives, that is, children; adolescents and young adults (Marcus, 2001). These are the groups that recent research indicates are at the heart of the HIV/AIDS epidemic and are therefore seen as the only hope for a reduction in the impact of the disease through the use of prevention programmes that aim to bring about changes in knowledge, attitudes and consequently behaviour (Clark, 2002; National AIDS policy report, 2001; “Preventing HIV/AIDS”, 2000; UNAIDS, 2002).

**Problem formulation**

This study forms part of a larger project, which aimed to implement a prevention strategy in order to reduce high-risk sexual behaviour amongst the youth and consequently reducing the transmission of HIV. It further aimed to evaluate the pre-intervention knowledge, attitudes and perceptions of the target population of learners, so as to monitor the process and evaluate the initial impact of the intervention.

The general aim of the present study was a qualitative investigation of the perceptions of grade six and seven learners with regards to a Life Skills programme focusing on HIV/AIDS education implemented in their schools. Therefore, this study forms part of the second aim of the larger project.
Outline of chapters

The background to the present study is provided in Chapter two and three. Chapter two describes the context of HIV and AIDS, the historical background of the disease, and how it is transmitted throughout the world. Chapter three expands on building an understanding of the disease by providing statistical information regarding the impact of the disease worldwide, in Africa, South Africa and in the Eastern Cape. Particular attention is given to the impact of the disease on young people.

Chapter four, after considering the effects of the disease on young people from a statistical point of view, provides an understanding of the reasons why this group continues to be at the forefront of the epidemic. An investigation into the cognitive, emotional, social, sexual, and moral development of young people is provided. In addition, the role that this understanding of the development of young people plays in prevention is provided. Finally, the ideal setting for approaching prevention with young people is explored.

After reviewing research which points to prevention programmes as the best option for approaching the problem of HIV/AIDS, theories related to designing an effective programme are presented in Chapter five. This includes: the theory of reasoned action, the health belief model, the AIDS risk reduction model and social cognitive theory. The rest of the chapter focuses on previous prevention programmes, successes and failures and lessons learnt from these prevention programmes. Particular reference is be made to lessons that could be applied to presenting HIV/AIDS education to young people. Because the present study is presented in the African context, barriers relating to
HIV/AIDS education in the African, and especially the South African context are presented.

Chapter six provides the details of the research approach and methods used to conduct the present study. Description of the participants, data collection methods, procedures and data analysis techniques are given. The chapter concludes with an outline of the techniques employed to ensure the trustworthiness of the data collected.

The results of the data collected in this study are presented and discussed in Chapter seven. This includes a discussion of the main themes that emerged from the qualitative investigation and how this relates to the theories mentioned in Chapter four and five.

Finally, a critical evaluation of the present study is conducted in Chapter eight, which also outlines the conclusions drawn from the research results. The limitations of the study are examined and recommendations for further research are suggested.
CHAPTER TWO
AIDS: THE DISEASE

Introduction
This chapter focuses on the HIV/AIDS phenomenon and thus provides a context in which the HIV/AIDS Life Skills Programme referred to in this study, was implemented. In order to introduce this context, information regarding HIV and AIDS, the historical background, as well as modes of transmission are provided. In addition, prevention programmes are mentioned in light of the information that has been researched regarding HIV and AIDS.

The acronym HIV stands for the Human Immuno-deficiency Virus, a virus that attacks the body’s immune system. The acronym AIDS stands for Acquired Immune Deficiency Syndrome, a collection of diseases which attacks the body once the immune system has become severely compromised [AIDS Virus Education and Research Trust (AVERT), 2002; National Institute for Allergy and Infectious Diseases (NIAID), 2001; Van Dyk, 2001].

Historical background of HIV and AIDS
AIDS was first discovered in 1981 in the United States of America (USA). Since then it has reached pandemic proportions (Harvey & Reiss, 1991; Svenson, Carmel & Varnhagen, 1997). These first cases of HIV infection shared a number of common characteristics: the individuals were young homosexual men with damaged immune systems, they presented with an unusual clustering of cases of rare diseases such as
Kaposi's sarcoma (KS) and opportunistic infections such as Pneumocystis carinii pneumonia (PCP), as well as cases of unexplained, persistent lymphadenopathy (NIAID, 1995). As the initial cases were reported to be found in homosexual men, this led some people to assume that a homosexual lifestyle was specifically related to the disease (Van Niekerk, 1991). These assumptions were later discarded when AIDS was found in both male and female intravenous drug users; in haemophiliacs and blood transfusion recipients; among female sex partners of bisexual men, recipients of blood or blood products, or injection drug users; and among infants born to mothers with AIDS or with a history of intravenous drug use (NIAID, 1995).

In 1983, this baffling disease, called the ‘slimming disease’ in Africa, was found to be caused by a virus which at this stage was called LAV (lymphadenopathy-associated virus) and HTL-III (human T cell lymphotropic virus Type III). In 1986 the virus causing this disease was renamed HIV or human immuno-deficiency virus (Van Dyk, 2001). The intense scientific research and extraordinary discoveries during the 1980’s resulted in a growing understanding of the pandemic (Tarantola, Malley & Mann, 1993).

Understanding HIV and its origin is important in the development of a vaccine and more effective treatments in the future. In order for a vaccine or drug to work, it must know what it is fighting. In addition, knowing the origin of HIV is important in being able to map out the future course of the disease and developing effective education and prevention programmes (Fritzen, 2000; Kanabus & Allen, 2002). Ten years after the intense research carried out on HIV in the 1980’s, every country had adopted a national
AIDS programme, even if these programmes were in various stages of maturity and of diverse quality. The initial complacency towards AIDS was followed by an exceptional international response (Tarantola, et al., 1993).

Since the discovery of HIV, the growing understanding of the virus has been clouded by myths and conspiracy theories related to its origin and how it is spread. AIDS is a disease that opens itself up to the spread of myths, conspiracy theories and to different forms of denial. Two main reasons for this are firstly, that myths respond to people's emotional needs or to a desire to reassure themselves that they can avoid changing their behaviour. Secondly, visible symptoms of AIDS only appear after many years, making it easier for people to deny that HIV will eventually cause AIDS. By denying this, people believe that if a cause other than HIV exists for AIDS that surely a cure would be found (NIAID, 2001).

Theories about the origin of AIDS include a great number of conspiracy theories. According to Van Dyk (2001), one of the more widely held beliefs is that AIDS began with the Central African Green Monkey. The monkey is believed to have carried a related strain of the HIV virus. Research has shown however, that the genetic make-up of humans compared to the green monkey is too distant for this myth to be a possibility (Crewe, 1992). Another myth involves the belief that AIDS began in America and was developed by the CIA or FBI for germ warfare. The United States government made use of U.S. servicemen as guinea-pigs to spread the disease. Other myths include the view that AIDS is a by-product of the nuclear age, in that nuclear arms testing resulted in a reduction in the human-immune system and paved a way for HIV (Crewe, 1992). Still other myths include the belief that AIDS is nature’s way of countering overpopulation
and also as punishment for our ecological carelessness (Quirke, 1991). These conspiracy theories provide a major barrier to slowing down or kerbing the impact of HIV/AIDS since people either believe that the disease does not exist or that it could not affect them because they are limited to certain groups. Therefore, the only way to prevent transmission of HIV and to eliminate these mistaken beliefs is by fostering a proper understanding of the disease through prevention programmes (Aggleton & Rivers, 1993; Hedgepeth & Helmich, 1990; Laver, 1993; Perloff, 2001; Van Niekerk, 1991; Zimmerman & Olson, 1992). For that reason, the rest of the chapter will be dedicated to research findings, which provide a proper understanding of HIV and AIDS.

What has been proven to date regarding the origin of HIV is the following:

1. The strongest evidence to date is that HIV-1 originated in non-human primates;
2. HIV is part of a family of viruses called lentiviruses, which are found in non-human primates. This virus is called Simian (monkey) viruses (SIV);
3. In February 1999 researchers found that SIV carried by chimpanzees are identical to HIV-1 which are common in west-central Africa;
4. A species of chimpanzee called Pan troglodytes appears to be the "Adam" of HIV-1;
5. As a result, researchers claim that SIV, which has come to be known as the source of HIV-1, has somehow crossed species. However, SIV rarely infects chimpanzees which suggests that both humans and chimpanzees were infected from a third unidentified primate species;
6. While the chimpanzees are not affected by the virus (SIV), it remains deadly to humans;
7. The theory regarding the polio-vaccine as an origin of HIV has been refuted by research conducted in February 2000 by the Wistar Institute in Philadelphia which found no trace of HIV or chimpanzee SIV in the polio-vaccine;

8. The earliest instances of HIV infection have been officially reported as: A plasma sample taken in 1959 from an adult male living in what is now known as the Democratic Republic of Congo; HIV found in tissue sample from an African-American teenager who died in St. Louis in 1969; and HIV found in tissue from a Norwegian sailor who died in 1976 [Centre for Disease Control (CDC), 2002; Cowley, 2002; Dawson, 1999; Fritzen, 2000; Kanabus & Allen, 2002].

Genetic analysis of the blood sample from 1959 (stated in point number 8) suggests that the HIV-1 virus found in the blood sample originated from a single virus in the late 1940’s or early 1950’s (Kanabus & Allen, 2002; Lachman, 1991).

**Human immuno-deficiency virus (HIV)**

HIV, as the name suggests, is a virus that attacks humans and in particular attempts to destroy the immune system to the point that it becomes deficient and is unable to protect the body from other illnesses. HIV causes the immune system to become deficient by attacking the T4 cells of the body, cells that are vital to the body’s immune system (Crewe, 1992; NIAID, 2001). The extent to which HIV affects the body’s immune system denotes stages through which the infected person passes from the point of infection.

A person infected with HIV passes through three stages after infection. Firstly, the infected person becomes an infectious carrier. It is important to note that not all
individuals experience symptoms immediately after infection. However, other individuals may begin to experience flu-like symptoms a month or two after infection including fever, headaches, and enlarged lymph nodes. These symptoms however, may be written off as another viral infection and disappear within a short time. This early period in HIV infection is known as the “asymptomatic period” (CDC, 2002). Although people may remain asymptomatic for an extended period of time after infection, they are infectious to others, a point that should be stressed in any information or education programme (Cusack & Singh, 1994). During this period, HIV actively attacks the body’s immune system. This is indicated by a continued reduction of the T4 cells in the body’s immune system (NIAID, 1998).

Secondly, as the immune system becomes more compromised, symptoms begin to mount. This onset of early symptoms can occur between one month and up to ten years before the onset of AIDS. These symptoms include a lack of energy, weight loss, frequent fevers and sweats, persistent or frequent yeast infections (oral or vaginal), persistent skin rashes or flaky skin, pelvic inflammatory disease, or short-term memory loss. Some individuals develop recurrent and severe herpes infections that cause mouth, genital or anal sores, or a painful nerve disease known as shingles (NIAID, 1998). The final stage of HIV infection is marked by more severe illness or death. All infected people eventually progress from one stage to the next, with variations in the time taken, and the whole process from infection to death may take up to ten years (CDC, 2002).
Acquired immune deficiency syndrome (AIDS)

Van Dyk (2001) explains that, AIDS is acquired because it is a disease which is not inherited; immunity refers to the body’s natural defences against illnesses; deficiency refers to the body’s inability to protect itself from further infections; and syndrome refers to a collection of signs and symptoms that make up a particular condition.

According to the CDC, an individual is said to have AIDS if they have fewer than 200 CD4+ T cells. This is compared to a healthy individual who has 1,000 or more CD4+ T cells (NIAID, 1998; NIAID, 2001). CD4 is a type of T cell. T cells help to protect the body against infections (Van Dyk, 2001). This definition of AIDS also includes 26 clinical conditions, which affect the individual during this late stage of HIV infection. These clinical conditions are known as ‘opportunistic infections’, which normally do not cause serious harm to an individual. However, because of the compromised immune system due to HIV infection even milder infections such as measles and influenza prove to be fatal. These opportunistic infections include: tuberculosis, typhus, typhoid, malaria, yellow fever and polio-myelitis. It is these infections, which eventually cause death in ‘full-blown’ AIDS patients (Crewe, 1992; NIAID, 1998; NIAID, 2001; Quirke, 1991).

However, in many developing countries, where diagnostic facilities may be minimal, healthcare workers use a World Health Organisation (WHO) case definition to diagnose HIV/AIDS. The WHO definition of HIV/AIDS is based on the presence of clinical signs associated with immune deficiency and the exclusion of other known causes of immunosuppression, such as cancer or malnutrition. This came to be known as the Bangui definition and is used in rural Africa where laboratory facilities are scarce (CDC, 2002).
At present, in spite of much research, no cure exists for HIV or AIDS. Therefore, it is almost certain that once people are diagnosed with AIDS the infection is lifelong and they will eventually die (Cusack & Singh, 1994; Ingham, 2002). Therefore, in order to control the symptoms of AIDS, anti-retroviral therapy (ART) was developed. ART is not a cure for AIDS as it merely slows down the production of more viruses in the body and in so doing prolongs life. It also does not prevent transmission of HIV to other individuals (NIAID, 1998; Van Dyk, 2001). Despite the benefit of a prolonged life that ART offers to those already infected with HIV, ART is very expensive and is therefore easily available only to those who live in wealthy western countries. In addition, recent research reveals that people are developing a resistance to the antiretrovirals, that is, the drugs that prevent people with HIV for developing “full-blown AIDS” (Van Dyk, 2001).

Regarding a possible vaccine, scientists caution that even a partially effective vaccine is several years away at least (Ingham, 2002). Therefore, we cannot stop the current development of the AIDS pandemic. However, we can ensure an AIDS-free future, and the best way to do this is to prevent infection in the first place. As a result, HIV/AIDS prevention programmes aimed particularly at children are seen as the greatest hope of changing the future course of the AIDS pandemic (UNAIDS, 2002; Van Dyk, 2002).

**HIV transmission**

For HIV to be transmitted from one person to another there must be an exit point for the virus to pass out of the infected person and an entry point into the body of the uninfected
person. Therefore, HIV is transmitted in very specific ways (Lachman, 1991; Van Dyk, 2001).

Exit and entry points for the virus exist where the skin is not intact and body fluids such as blood and sexual fluids can enter through this break in the skin or through the direct introduction of body fluids from one individual to another (Lachman, 1991; Van Dyk, 2001). Seventy-five percent of HIV transmitted worldwide occurs through sexual contact (NIAID, 1998). During the early phase of HIV infection the main mode of transmission was through homosexual contact. However, at present the main mode of transmission world-wide and in sub-saharan Africa is through heterosexual contact (AVERT, 2002; UNAIDS, 2002).

The increase in a heterosexual mode of transmission has resulted in a sharp increase in infection amongst women. This in turn has resulted in an increase in mother to child transmission. Infection occurs from a mother to her baby pre- or peri-natally or during breastfeeding. However, with AZT treatment during pregnancy, the chances of transmitting HIV from mother to child are significantly reduced (Lachman, 1991; NIAID, 1998; Quinn, 1996; Van Dyk, 2001).

Another main mode of HIV transmission occurs through infected blood, for example, contaminated blood transfusions. Prior to the screening of blood for viruses and heat-treating technology, there was a high transmission of HIV through infected blood. However, with new technology the chances of being infected in this way are very small (Lachman, 1991; NIAID, 1998; Quinn, 1996; Van Dyk, 2001).

HIV infection also occurs through sharing of needles and syringes contaminated with small quantities of blood of someone with the virus. In some areas infection due to
intravenous drug users (IDU’s) has increased whereas in other areas this mode of infection has either stabilised or decreased (Cusack & Singh, 1994; Harvey & Reiss, 1991; NIAID, 1998; Lachman, 1991; Quinn, 1996; van Dyk, 2001).

A number of factors have been highlighted as the reasons for effective preventative programmes aimed at reducing HIV infection due to IDU’S. These factors included confidential HIV testing and counselling, outreach and education, successful and appropriate drug abuse treatment, and access to sterile injecting equipment through needle exchange programmes (Cusack & Singh, 1994; Harvey & Reiss, 1991; Lachman, 1991; NIAID, 1998; Quinn, 1996; van Dyk, 2001).

In addition to blood, semen, vaginal fluid and breast milk, other body fluids that health care workers come into contact with that have been found to transmit the virus include: cerebrospinal fluid surrounding the brain and the spinal cord; synovial fluid surrounding bone joints; and amniotic fluid surrounding a foetus (CDC, 2002).

HIV is not spread through casual everyday contact with people. It is not transmitted through touching, hugging, coughing or sneezing. It is not spread in air, water or in food, or by sharing cups, bowls, cutlery, clothing or toilet seats (Cusack & Singh, 1994; Lachman, 1991; Van Dyk, 2001).

In the global context three patterns of HIV infection exist, based on a combination of these particular modes of transmission. The first pattern is found in the West, North America and Western Europe, where HIV is transmitted via homosexual contact and intravenous drug use. The second pattern is found in Sub-Saharan Africa, Brazil and Latin America, where HIV is spread mainly through heterosexual contact, from mother to child and through blood transfusion. A third pattern is found in Asia and Latin America,
which is a combination of these two patterns of infection. However, it should be noted
that since 1987 Pattern 1 and 2 have been identified in South Africa. The reason for this
has been established that in South Africa we have centres of high industrialisation linked
to less developed areas by migrant labour (Crewe, 1992; Lachman, 1991).

Conclusion
In this chapter the researched information regarding HIV and AIDS, its history, how the
disease developed and how it is transmitted has been presented. Providing this basic
information about HIV and AIDS in prevention programmes has been found to be
inadequate in kerbing the disease (Aggleton & Rivers, 1993; The World Bank, 2002;
Valentich & Gripton, 1989). However, providing this information about the disease is
still regarded as an important facet of prevention especially in dispelling fears and myths
related to the disease (Aggleton & Rivers, 1993). Since an understanding of HIV/AIDS
has been presented on the basis of researched findings, it is important to provide a
statistical overview of the impact of the disease, which will be presented in the next
chapter.
CHAPTER THREE
AIDS STATISTICS

Introduction
Chapter three provides a review of current statistics related to the AIDS pandemic beginning with the global impact of the disease. Thereafter Africa, South Africa, and eventually statistics related to the Eastern Cape and Port Elizabeth will be provided, with particular reference to the impact of AIDS on young people.

Global incidence of HIV/AIDS
In the last twenty years, more people have died from AIDS than any other disease in human history (Barks- Ruggles, 2001). According to the Report on the global HIV/AIDS epidemic released in July 2002 by the UNAIDS, in collaboration with the WHO, the number of people currently living with HIV/AIDS worldwide is 40 million. In addition, AIDS has already killed more than 20 million people worldwide (UNAIDS, 2002).

In all parts of the world except sub-Saharan Africa, there are more men infected with HIV and dying of AIDS than women. Altogether, an estimated 2.2 million men aged between 15-49 became infected during 2001, bringing the number of adult males living with HIV or AIDS by the end of the year to 18.6 million (UNAIDS, 2002).

The number of people newly infected with HIV in 2001 currently stands at 5 million and the number of AIDS deaths in 2001 stand at 3 million. (A further breakdown of these numbers is provided in Figure 1) (UNAIDS, 2002). According to UNAIDS (2001), it is estimated that there were 14000 new infections worldwide per day in 2001.
Of these 14000, 2000 are children under the age of 15 years, and about 12000 are persons aged 15 to 49 years. Of these 12000 people between the ages of 15 to 49, 50% are aged between 15-24 years. More than five young people worldwide contract HIV every minute, that's 7000 people each day, and more than 2.6 million each year (Wilder, 2001). These statistics indicate on a global scale the vulnerability of young people to HIV infection on a daily basis.

The vast majority of people with HIV, some 95% of the global total, live in the developing world. That percentage is set to grow even further as infection rates continue to rise in countries where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus (AVERT, 2002). An illustration of this is, even though survival with HIV-1 infection is similar in Africa to industrialized countries before the use of antiretroviral therapy; when Africans do die, many are severely immunosuppressed and most have clinical features of AIDS because of social issues such as poverty, poor health systems and limited resources (Morgan, 2002).
UNAIDS predicts that by the year 2020, AIDS will have claimed the lives of 68 million more people in the 45 countries of the world where the disease is most prevalent, mainly in the nations of Africa. (Susman, 2002).

**AIDS in Africa**

In Africa, the epidemic continues to be spread by heterosexual contact. In 2001 approximately 3.4 million Africans became infected with HIV, as depicted in Figure 2 (UNAIDS, 2002). This brings the total number of adults and children living with
HIV/AIDS to approximately 28.1 million (see Figure 3) (UNAIDS, 2002). Some 2.3 million Africans died of AIDS in 2001 (see Figure 4) (UNAIDS, 2002). It is projected that between 2000 and 2020, 55 million Africans will die earlier than they would have in the absence of AIDS (UNAIDS, 2001).

Figure 2. Estimated number of adults and children newly infected with HIV during 2001 (UNAIDS, 2002)

Altogether, there are now 16 countries in Africa in which more than one-tenth of the adult population aged between 15-49 is infected with HIV. HIV prevalence rates vary widely between countries. They range from under 2% of the adult population in some West African countries to around 20% or more in the southern part of the continent, with countries in Central and East Africa having prevalence rates midway between these (AVERT, 2002). Infection rates in East Africa, hover above those in the West of the
continent but have been exceeded by the rates now being seen in the southern cone of the continent where at least one in five adults are HIV positive (AVERT, 2002).

![Adults and children estimated to be living with HIV/AIDS as of end 2001](image)

**Figure 3.** Adults and children estimated to be living with HIV/AIDS as of end 2001 (UNAIDS, 2002)

At the end of the year 2000 there was hope that southern Africa's epidemic - the most severe in the world - had reached its 'natural limit', beyond which HIV prevalence rates would not rise. At the International AIDS Conference held in Durban, South Africa in 2000, the general feeling at the conference was that the worst was apparently over for Africa regarding the AIDS pandemic (Susman, 2002; UNAIDS, 2001). However, new data shows that this is not the case. At the 14th International AIDS Conference held in Barcelona, Spain in 2002, researchers now realise that the epidemic has, in fact, worsened in Africa (Susman, 2002; UNAIDS, 2001). At present, southern Africa carries
70 percent of the global HIV burden and witnesses 90 percent of deaths attributed to AIDS (“Dispelling AIDS myths”, 2002).

Figure 4. Estimated adult and child death from HIV/AIDS during 2001 (UNAIDS, 2002)

In southern Africa it is estimated that 19 percent of the adult population is HIV positive (AVERT, 2001). What is even more frightening is the fact that only 5% of those afflicted are aware that they are HIV positive, and therefore unsuspectingly infect others (Barks-Ruggles, 2001). Currently, Botswana and South Africa are the two countries in southern Africa that have by far the highest infection rates, with as many as one in three adults affected (Clark, 2002). In Botswana 38.8% of adults are infected with HIV and in South Africa 20.1% are HIV positive. On the optimistic side though, major inroads have been made in Uganda which has brought its estimated prevalence rate down to around
5% from a peak of close to 14% in the early 1990s, with strong prevention campaigns. In addition, there are encouraging signs that Zambia's epidemic may be following the course charted by Uganda (AVERT, 2002).

Women account for the majority of persons living with HIV in Southern Africa (58%). Young women, in particular, have consistently been found to have higher prevalence rates than men in the same age group (UNAIDS, 2001; Susman, 2002) due to a number of factors such as: young women are more physiologically susceptible to sexually transmitted infections than young men; and socio-cultural systems in many cases also limit the control women have over their sexual lives (UNAIDS, 2002).

It is expected that half a million African youth between the ages of 15 and 24 will die from AIDS by the year 2005. In African countries, half of all people acquire HIV before their 25th birthday and die by the time they are 35 (Wilder, 2001). Therefore, in Africa children are particularly vulnerable to HIV infection. Up to a third of children in Africa are born infected with HIV and may not survive until school age. Also, many children have lost their parents to AIDS, or are living in households which have taken in AIDS orphans (AVERT, 2002).

AIDS in South Africa

The South African Department of Health has estimated that in 2001, in the general South African population, 2.65 million women and 2.09 million men between the ages of 15 to 49 were living with HIV (AVERT, 2002; Department of Health, 2002). Research shows that the number of young adults in South Africa who will die as a result of AIDS is likely to peak in 2010-2015, when it is estimated that there will
be more than 17 times as many deaths among persons aged 15-34 as there would have been without AIDS (UNAIDS, 2001).

A report released by the Health Minister Manto Tshabalala-Msimang, shows that the AIDS infection rate among young South Africans appears to have dipped slightly and overall infection rates appear to be stabilizing. An antenatal survey conducted across all nine provinces between 1st and 31st October 2001 by the Department of Health shows that until 1998 South Africa had one of the fastest growing epidemics in the world (Table 1). The 2001 survey confirms that this is no longer the case, and it does seem that the rapid growth of the South African epidemic may be slowing down. This the health minister attributes to the widespread prevention programme undertaken by the Department of Health (AVERT, 2002; Department of Health, 2001).

Table 1

| Estimated HIV prevalence 1999-2001 by province among antenatal clinic attendees |
|---------------------------------|-----------------|-----------------|-----------------|
|                                 | 1999 Prevalence % | 2000 Prevalence % | 2001 Prevalence % |
| National                        | 22.4             | 24.5             | 24.8             |
| Kwazulu-Natal (KZN)             | 32.5             | 36.2             | 33.5             |
| Mpumalanga (MP)                 | 27.3             | 29.7             | 29.2             |
| Gauteng (GP)                    | 28.9             | 29.4             | 29.8             |
| Free State (FS)                 | 27.9             | 27.9             | 30.1             |
| North West (NW)                 | 23.0             | 22.9             | 25.2             |
| East Cape (EC)                  | 18.0             | 20.2             | 21.7             |
| Limpopo (LP)                    | 11.4             | 13.2             | 14.5             |
Note. Information provided by the South African Department of Health October, 2001.

In addition, the number of 4.7 million infected people in South Africa has remained stable since 2000 and no exponential increase in HIV prevalence has been noted since 1998 (see Figure 5). The health minister credited the government's AIDS prevention program for bringing down the number of new AIDS cases (AVERT, 2002; Department of Health, 2002).

AIDS in the Eastern Cape

At the end of 2001, the number of new infections in the Eastern Cape Province of South Africa stood at 7537. (A further breakdown of this number is available in Table 2). This indicates an increase of 9% from 2000. The average age of those who had tested positive...
is 29 years and the average age at time of death is 29.4 years. The total number of deaths at the end of 2001 stood at 1200.

Table 2

<table>
<thead>
<tr>
<th>Total Cases</th>
<th>Male</th>
<th>%</th>
<th>Female</th>
<th>%</th>
<th>Paediatric</th>
<th>%</th>
<th>Unknown</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>7537</td>
<td>2544</td>
<td>33.7</td>
<td>4429</td>
<td>58.9</td>
<td>480</td>
<td>6.3</td>
<td>84</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Note. Information provided by AIDS Training, Information and Counselling Centre (ATICC) Port Elizabeth, July, 2002.

It should be noted however, that these figures reflect the number of people who had presented themselves for testing and the actual total figures are merely an estimation. Underreporting as well as lack of interest in presenting oneself for testing should be taken into consideration (ATICC, 2001).

An estimated 10500 babies are born HIV-positive every year in the Eastern Cape Province. This is also one of the highest figures with regards to the number of babies born HIV-positive in South Africa. Although, when compared to Kwa-Zulu Natal infection rates are not as high (see Figure 6) (UNAIDS, 2002), the Eastern Cape is the poorest province in the country and access to health care is the most disrupted of all the provinces in South Africa. This is further complicated by an inadequate welfare system and lack of social security safety nets (“Dispelling AIDS myths”, 2002).
In Port Elizabeth HIV infection is growing exponentially. A shocking comparison has been made that “the city of Port Elizabeth has more HIV positive laboratory confirmed cases than the whole of Australia and New Zealand combined” (Pailman, 2000).

**Conclusion**

According to the statistics presented, young people experience a high incidence of HIV infection. Therefore, young people are presently regarded as the most vulnerable group regarding HIV infection. Consequently, prevention programmes aimed at young people before they become susceptible to HIV infection, are viewed as the best intervention to prevent the spread of the AIDS pandemic (UNAIDS, 2002). However, it is important to present evidence, other than the statistics presented, which explains the vulnerability of
this particular group. Therefore, the focus of the next chapter will be on young people and the reasons for their susceptibility to HIV.
CHAPTER FOUR
AIDS AND YOUNG PEOPLE

Introduction
As indicated by the statistics in the previous chapter, young people have been found to be particularly vulnerable to HIV infection. However, these are just statistical representations of their vulnerability. Therefore, the focus of this chapter would be to develop an understanding of possibly why this group consistently proves to be the most vulnerable group.

AIDS and young people
For the purpose of this study it was decided to refer to the population being studied as ‘young people’ or ‘learners’ because the population consists of learners between the ages of 10 and 13. This is considered the pubescent stage and therefore, according to Gerdes (1988), does not fall into the definition of adolescents (13-18), or youth (between adolescence and early adulthood). Instead they do fall into the World Health Organisation’s definition of young people, that is, people between the ages of 10 and 24 (WHO, 2002) as well as puberty (pre-adolescents) (Gerdes, 1988). Therefore, it was decided to use the terms ‘young people’ or ‘learners’.

According to Kalichman (1996, in Perloff, 2001), “it is not as much a matter of who a person is as what a person does” (p.5), that places him or her at a higher risk of HIV infection. Therefore, people are considered to fall into a high-risk group if they engage in high risk behaviour such as unprotected sex and sharing needles and syringes.
These risk groups differ from country to country depending on the culture as well as the way in which the virus has spread. In the United States, the virus is spread primarily through unprotected male-to-male intercourse and injection drug use. In Asian countries, especially Vietnam and Thailand, commercial sex workers are vulnerable to HIV infection and are the means by which the disease is spread. In Africa, HIV is spread mainly through heterosexual sex, thus placing a large part of the population at risk of infection (Perloff, 2001). Despite these differences in risk groups based on the spread of the disease, the group that has been found to be most exposed and vulnerable to HIV infection on a global scale is young people, especially those between the ages of 15 to 24 years (UNAIDS, 2002).

Young people are and continue to be at the forefront of the AIDS pandemic (Baldo, Metcalf, Bathes, Comns, Ricardo, Marx & Schaama, 1993; Clark, 2002;Marcus, 2001; National AIDS policy report, 2001; “Preventing HIV/AIDS”, 2000). The statistics presented by UNAIDS (2002), showed that half of new daily infections are among young people. When considering the incubation period between HIV infection and the onset of AIDS, i.e., nearly ten years, the high incidence of AIDS in 20-29 year olds can be attributed to infection during the adolescent years (Svenson, et al., 1997). These statistics, which indicate the dramatic spread of HIV/AIDS in children and young people, as well as the morbidity and mortality rates, have alarmed many. In addition to being deprived of the opportunity of a healthy adult life as a result of being infected with HIV, young people are also affected either by having to take care of family members living with AIDS or being left without any parents (UNAIDS, 2002). However, the question remains
regarding the factors which place young people at such a high risk of infection in the first place.

Young people are vulnerable to HIV infection due to their particular age of development, which is characterised by a sense of invincibility, which invariably causes them to engage in risky experimental behaviour particularly risky sexual behaviour (American Association for World Health, 1998; Hall, 2001). Livingston (1992, p.10 in Umeh, 1997) supported this suggestion by stating, “Adolescents’ perceptions of invincibility may inflate their risk of HIV transmission, especially when combined with their misconceptions and misinformation about AIDS”.

Besides their sense of invincibility, this stage of development is also marked by an interest in and curiosity about sexual relations. Regrettably, research indicates that the main mode of transmission of HIV among young people is through sexual intercourse, which continues to account for the majority of new HIV cases (American Association for World Health, 1998; American Foundation for AIDS Research (amfAR), 2000; Brown, Lourie, Pao, 2000). The reason being that, sex during this stage of development, tends to be unplanned and frequently coerced through sexual abuse, incest, rape or forced prostitution (“Preventing HIV/AIDS”, 2000; UNAIDS, 2002). In addition, young people become sexually active at an early age (Svenson, et al., 1997) and as a result they tend to engage in less safe sexual activity due to either a lack of information on how to protect themselves or unavailability of health services (UNAIDS, 2002). Therefore, adolescents have been identified as the group in need of education regarding HIV/AIDS (Aggleton & Rivers, 1993) and continue to be seen as the greatest hope of changing the future course of the epidemic (“Preventing HIV/AIDS”, 2000; UNAIDS, 2002).
The increasing rates of HIV infection among young people, their lack of information and knowledge about protecting themselves, indicates that more emphasis on HIV prevention is needed (American Association for World Health, 1998). This impressionable age group provides the best opportunity to distribute health knowledge, develop appropriate values and attitudes, and encourage healthy behaviour patterns. In Southern Africa, a large majority of young people are still free from HIV infection. This provides an excellent opportunity for prevention programmes in order to help adolescents stay free of HIV infection (Mugabe, 2001).

In developing a prevention programme relevant to this target group, an understanding of how this particular age group develops cognitively, emotionally, socially, morally, and sexually, as well as how they develop their self-concept, should be considered. Van Dyk (2001) and Gerdes (1988), provide an understanding of this stage of development. This understanding assists in the development of prevention interventions.

**Cognitive development**

Cognition refers to the acquisition of information, how this information is transformed into knowledge, and how this knowledge is used (Gerdes, 1988). Specific aspects of cognition such as egocentric thinking, concrete thinking and the ability to classify are especially relevant for HIV/AIDS education.
**Egocentric thinking**

The thinking style of young children (six to seven years) is characterised by egocentric thinking. Egocentricism refers to the child’s inability to see the views of others other than its own. However, as they get older, they begin to understand that other people hold views that are different to their own. They are also able to postpone behaviour until they have evaluated these alternative views. Therefore, the egocentric thinking pattern gives way to logical thinking (Gerdes, 1988).

This egocentric pattern of thinking can be applied to HIV/AIDS education, particularly with regards to the way in which young people perceive people who have HIV/AIDS. Younger children tend to associate HIV/AIDS with certain groups such as drug users, adults, etc. They tend to dissociate themselves from these vulnerable groups, which may be a defence mechanism in order to cope with their own fears about HIV/AIDS. However, with maturity this egocentricism decreases and young people begin to understand that other people’s points of view differ. They also begin to experience a greater compassion for people with HIV/AIDS due to their personal contact with people with HIV/AIDS. The development of logical thinking by considering alternative views before engaging in behaviour, could be used in prevention where logical decision-making could be fostered and therefore engagement in healthy behaviour patterns encouraged. (Van Dyk, 2001).

**Concrete thinking**

According to Piaget (1971, in Gerdes, 1988), young people have the ability to apply operational thinking. In other words, they are able to see the relationship between things
and ideas. Therefore, they move away from making judgements based on things they see to making judgements based on the consequences of their own reasoning. They also begin to develop the ability to contemplate different possibilities (Newcombe, 1996).

Operational thinking can be linked to young people’s perception of illness, including HIV and AIDS. Although young people are capable of operational thinking, their thinking is still more concrete. Therefore when answering their questions, young people feel more comfortable with concrete answers. However, the thinking style of this group is less absolute and they are therefore able to understand that there is a time lapse between HIV infection, the final stage of AIDS and death, a concept which is too abstract for younger children to understand (Van Dyk, 2001).

The ability to classify

The ability to classify develops through three stages: young children (younger than 6 years) do not possess specific criterion when classifying objects and they often change criteria; the next stage (children from 6 to 9 years) is characterised by the ability to classify objects on the basis of only one criterion; older children (ages 9 to 12 years) are able to classify on the basis of more than one criterion simultaneously (Newcombe, 1996; Piaget, 1973, in Van Dyk, 2001). The ability, or inability to classify is linked to a very important aspect in HIV/AIDS education, that is, the eradication of myths.

Young people in this stage are susceptible to the acquisition of myths. This may be due to the fact that they are not yet fully capable of classifying things into subcategories of cause and effect. As a result they find it difficult to distinguish between fact and fantasy. Therefore, prevention programmes aimed at this group should eradicate
myths and misconceptions since they not only lead to severe anxiety but also tend to lead to prejudices and negative attitudes towards people with HIV/AIDS (Van Dyk, 2001).

**Emotional development**

According to Mussen, Conger, Kagan and Huston (1990), it can be concluded from children’s everyday conversations that happiness, fear, sadness and many other emotions are pivotal to their everyday experiences and interactions with others. Young people are able to express a wide range of emotions. The emotion that is of particular interest to HIV/AIDS education is the expression of fear.

**Fear**

Children between the ages of six to eight years increasingly experience fear of imaginary objects such as aliens or monsters. Young people are afraid of specific things such as dogs, spiders or snakes. In addition, young people experience fear of things such as examinations, physical injury and school performance (Sarafino, 1985). Research indicates that young people experience fears based on the times they live in, which they learn about through the media and listening to discussions. Today’s young people report fears of AIDS, pollution and nuclear war (Mussen, et al., 1990; Van Dyk, 2001). This concrete fear is linked to HIV/AIDS prevention in terms of the transmission of HIV.

As indicated above, fears at this stage of development are more concrete and become less vague or imagined. Therefore, young people’s fear of potential HIV transmission is also more concrete. However, because they have still have a difficulty in
distinguishing between fact and reality, and cause and effect, they may develop irrational fears about HIV/AIDS (Van Dyk, 2001).

**Social development**

During socialisation children acquire behaviour, beliefs, values, skills and characteristics that are considered appropriate in their cultures. Socialisation plays an important part in a child’s social development and in turn an important part in HIV/AIDS education, since it involves a child’s ability to socialise and his or her ability to develop prejudice (Mussen, et al., 1990; Van Dyk, 2001).

**Peer groups**

Peer groups are an important part of a child’s development since they provide the child with an opportunity to experience friendship and relationships; to experiment with new forms of behaviours; and provides them with the opportunity to exercise a limited degree of independence. Through the peer group, children are exposed to varied opinions, that assist them to progress away from an egocentric way of thinking. An unhealthy attachment to, and conformity with the peer group, results in undesirable behaviours such experimenting with drugs and sex (Erwin, 1993; Mussen, et al., 1990). The peer group also plays an important role in influencing young people’s perception of AIDS. On the one hand, peer groups can be a source of misinformation and myths about sex, including HIV and AIDS, and they could encourage each other to experiment with harmful behaviour (Van Dyk, 2001). On the other hand, peer groups provide children with the
opportunity to develop social skills such as negotiation and assertiveness. Skills have become necessary in the age of AIDS (AIDS Action, 2001).

**Prejudice**

Although children usually develop prejudice during pre-school, these continue to develop in young people where they become reinforced through modelling and imitation. Therefore teachers and parents play an important role in the development of prejudice in children. Prejudice is not only developed through the information that is presented to children but also the manner in which this information is communicated, that is, through facial expressions, body language and tone of voice (Louw, 1991).

As a result of misinformation received from their peers, children develop prejudice and negative attitudes towards others. Therefore special attention should be given to eradicating myths related to HIV/AIDS and prejudice related to certain groups (Van Dyk, 2001).

**Moral development**

Moral development refers to the child’s ability to make judgements regarding behaviour that is right or wrong, good or bad (Lievegoed, 1997). Of particular interest to HIV/AIDS education is the child’s ability to regulate his or her own behaviour in ways that take the needs and feelings of others, such as HIV+ people into account. At the same time the child has the ability to conform to the standards, which they judge to be rational, put forward by his or her own society and culture, such as engaging in low risk sexual behaviour (Barkowitiz, 1964; Mussen, et al., 1990).
**Rules and punishment**

According to Kohlberg (1964, in Gerdes, 1988) at this stage of development, young people develop an internal motivation to comply with rules, which are not only the need to avoid punishment as in younger children, but as a means of showing respect to those in authority. They are now able to judge acts on intentions not merely on the basis of their consequences. Young people have also begun to grasp the concept of treating others the way that they would like to be treated (Barkowitz, 1964; Van Dyk, 2001). This internalisation of rules can be linked to health and safety issues related to HIV/AIDS. Therefore, they follow rules not because they have to but because they understand that these rules are rational and useful (Van Dyk, 2001).

**Sexual development**

According to Mussen, et al. (1990), among the developmental changes that occur during puberty and adolescents, none are more dramatic than the physical and psychological changes that are associated with sexual development. Young people, during this stage of development are found to be particularly aware of their own sexual feelings and are more comfortable discussing human sexuality (Van Dyk, 2001).

**Curiosity about sex**

This stage of development in young people is characterised by a growing interest in sex, which is usually indicated by their engagement in sexual play. Young people’s attitude towards sex is formed during this stage, therefore parents have to be very careful how they react to this increasing sexual exploration. If parents react with anger or disgust,
young people will get the message that sex is bad or dirty. In addition, they will find it
difficult to ask questions and would therefore, seek alternative sources of information.
Most children turn to their peer groups for information, which often contains
misinformation and distortion (Van Dyk, 2001). As a result, prevention and education
programmes can use this opportunity to provide accurate information regarding sexuality.
In addition, young people at this stage are better able to understand the sexual
transmission of HIV because of their interest in learning about sexuality, gender role and
human relationships (Van Dyk, 2001).

Conclusion

The vulnerability of young people to HIV/AIDS has been discussed, not only from a
statistical point of view but also from a developmental point of view. As the numbers of
HIV infected young people have increased, concerns have been raised about the risk
factors for children, and meaningful attempts at preventing further spread of the virus
continually appears in literature (Grier & Hodges, 1998). One of the proposed methods
has been through HIV/AIDS prevention programmes. The next chapter will review
previous prevention programmes, successes and failures and lesson learnt, including
references to HIV/AIDS prevention and education with young people.
CHAPTER FIVE
HIV/AIDS EDUCATION

Introduction

Since no vaccine currently exists for HIV and no cure exists for AIDS, researchers agree that education is the only tool available to stop the spread of HIV infection (Aggleton & Rivers, 1993; Hedgepeth & Helmich, 1990; Laver, 1993; Perloff, 2001; Van Niekerk, 1991; Zimmerman & Olson, 1992). From the early 1990’s it was apparent that even if a cure or a vaccine was found for HIV/AIDS, thus converting it into a chronic illness, that this would not break the epidemic. Instead, it was argued that radical changes in behaviour are required (Van Niekerk, 1991).

The focus of this chapter will be on theories related to AIDS prevention, which aim to bring about behavioural change on an individual level. Particular attention is paid to previous prevention programmes including successes and failures as well as the lessons that could be learnt from these prevention programmes for the effective implementation of future prevention programmes. In addition, the Life Skills programme focusing on HIV/AIDS education for senior primary school youth in the Port Elizabeth region, which forms the basis of the present study, will be introduced.

Theories of AIDS prevention

Theories help practitioners to develop more effective prevention campaigns. Scientifically proven theories provide guidelines with regards to designing a prevention campaign, and define terms and important concepts (Perloff, 2001). In addition, there is
growing evidence that well-designed, targeted, theory-based behaviour change interventions can be effective in reducing the spread of HIV. Although each behaviour is unique, there are only a limited number of theoretical variables that serve as the determinants of any given behaviour. Understanding these variables and their role in behavioural prediction can guide the development of effective behaviour change interventions (Fishbein, 2000).

The following section of this chapter will briefly discuss theories that have been applied to AIDS health-related behaviour. The following theories have been chosen because they focus on the individual psychological processes, such as attitudes and beliefs, in explaining human behaviour and secondly because they are the psychological theories and models that have been most instrumental in the design and development of HIV prevention interventions (King, 1999).

**Theory of Reasoned Action (TRA)**

The TRA was developed in the mid-1960’s by Fishbein and Ajzen who believed that most behaviour is considered and thought through reasonably before action is taken (King, 1999; Perloff, 2001). Before taking a decision people consider the consequences of the action within a given context and at a given time. Therefore, most behaviour is under people’s control (King, 1999). According to this theory three factors determine whether behaviour will occur. These factors include: intention, attitude towards the behaviour, and subjective norms (Perloff, 2001). Intention refers to whether the person is willing to try or how much effort the person is planning to use in order to perform the behaviour. A person’s intention is the function of two basic determinants, that is, ‘attitude
towards the behaviour’ and subjective norms (see Figure 7). The person’s ‘attitude towards the behaviour’ depends on the judgement about whether performing the behaviour is good or bad. Subjective norms refer to the tendency of the person to engage in behaviour as recommended by people he or she respects or just his desire to go along with what people say (Perloff, 2001).

![Diagram of the Theory of Reasoned Action (TRA)](image)

**Figure 7.** TRA, Perloff (2001)

For example, for a person to start using a condom (intention) he has to have the attitude that ‘having sex with a condom is just as good as having sex without a condom’ and he should use a condom because all his peers are using condoms (subjective norms). Interventions, which use this theory focus on the attitudes about risk reduction, responses to social norms and intentions to change risky behaviour (King, 1999).
Health belief model (HBM)

The HBM (see Figure 8) focuses on assigning an important role to beliefs related to the threat of a particular disease and how to cope with illness. According to this model, people should hold the following beliefs in order to change behaviour:

1. Perceived susceptibility, the person’s perception of the chances of contracting the disease (“am I at risk for HIV?”).
2. Perceived severity, assessments of consequences of the health threat (“how serious is AIDS, how hard would my life be if I got it?”).
3. Perceived benefits, beliefs about the effectiveness of various coping actions (“condoms are effective against HIV transmission”).
4. Cues to action (“witnessing the death or illness of a relative or close friend due to AIDS”).
5. Perceived benefits of prevention action (“If I start using condoms I can avoid HIV infection”).
6. Perceived barriers, perceptions of negative consequences of coping actions (“I don’t like using condoms”) (King, 1999; Perloff, 2001).
According to this model changing behaviour requires changing beliefs. Using this model, prevention programmes usually focus on the perception of risk; the beliefs in severity of AIDS, for example there is no cure; the benefits of using a condom; or delaying the onset of sexual activity (King, 1999).

**AIDS Risk Reduction Model (ARRM)**

According to the ARRM (see Figure 9), people modify AIDS prevention behaviour according to a three-stage process:

1. Behaviour labelling.
2. Commitment to change.
3. Taking action.

During the first critical stage people have to label their behaviour as problematic, in other words, they have to realise that their actions put them at risk of contracting HIV. The
second stage involves commitment to change the behaviour labelled as problematic by reducing unsafe sex practices and engaging in less risky behaviours. The third stage refers to enactment whereby people take steps to change risky behaviour (King, 1999; Perloff, 2001).

Figure 9. ARRM, Perloff (2001)

Prevention programmes that use this model focus on:

1. The participant’s assessment of risk through behaviour labelling.
2. Influencing the decision to reduce risk.
3. Participants’ support to enact change (King, 1999).
**Social cognitive theory**

According to the social cognitive theory, all behaviour is learned either through modelling the behaviour of others or through direct experience. This theory places a premium on:

1. **Self-efficacy**, that is, the belief that one can bring about necessary changes (“I know that I can insist that my partner wears a condom”).

2. **Outcome expectancies**, that is, the belief in outcomes such as the belief that condoms will prevent HIV infection (King, 1999; Perloff, 2001).

Applied to HIV prevention, prevention programmes that use this theory integrate information and attitudinal change and therefore aim to enhance motivation, and reinforce risk reduction skills and self-efficacy (King, 1999). The social cognitive theory has been used to study a wide range of health problems, from medical therapy compliance, to alcohol abuse, to immunizations. One particularly fruitful area of investigation to which the social cognitive theory has been employed is the study of moral and value internalisation among children. In fact, it has been argued that the greatest contribution of the social cognitive theory is its aid in understanding how children are socialized to accept the standards and values of their society (Johnston, O’Malley & Bachman, 1994). This brings us to the next section of this chapter, that is, looking at previous prevention programmes and the successes and failures of these programmes as well as what can be learnt from these programmes.
Previous prevention programmes: successes and failures

Following the intense phase of scientific research and discoveries in the 1980’s, 1987 marked the launch of a global mobilisation against AIDS. In response to the growing concern regarding the impact of AIDS, 167 member states of the World Health Organisation developed a Global Strategy for the Prevention and Control of AIDS. Within this framework the Global Programme (GPA) was launched. The three main goals of this Global Strategy was to prevent HIV transmission, reduce the personal and social impact of AIDS, and unify national and international efforts against AIDS. In October 1987, AIDS became the first disease to be discussed at the United Nations General Assembly. The result of that forum was a strong and co-ordinated international action including UN Agencies, other than WHO. By 1990, nearly every country in the world had a national AIDS programme (Tarantola, et al., 1993).

According to UNAIDS (2002), in the past two years the global response to AIDS has intensified. However, this response is by no means universal with some governments and countries still in denial with regards to HIV/AIDS. Nonetheless, where prevention programmes were implemented many startling successes, costly failures and many lessons learnt along the way were reported. According to the AIDS action group (2001), what can be said with confidence after 20 years of HIV/AIDS prevention is that prevention works, it is cost effective and HIV/AIDS prevention promotes better health overall.

Besides the now familiar success of Senegal, Thailand and Uganda, successes are being reported on every continent. Special mention is made of countries like Cambodia,
Brazil and Zambia. Cambodia has reported a decline in not only HIV infection, but also in high-risk behaviours. HIV infections in pregnant women decreased by a third between 1997 and 2000. These successes are mainly due to strong prevention efforts and the mobilisation of community and business organisations (UNAIDS, 2002). Brazil continues to be an example regarding the successful integration of comprehensive care and a renewed commitment to prevention. In other words, ‘treatment optimism did not lead to prevention pessimism’ as suggested by Lert (2000). According to a study conducted by Lert (2000), the transformation of HIV into a chronic condition has lead many people to be pessimistic regarding the future of HIV prevention. However, Brazil has been able to keep infection rates lower than what was anticipated a decade ago, whilst establishing a legal right to free medication (UNAIDS, 2002). Zambia’s fight against AIDS is proving successful due to its focus on the youth in HIV prevention and their involvement of business, farmers, schools and religious groups in HIV prevention (UNAIDS, 2002).

A review covering studies conducted in the United Sates, Europe, Asia and Latin America found that prevention has a slow, yet significant impact. For example, the number of sexually active 17 year old boys was reduced by 11% in Switzerland between 1985 and 1997, and sexually active 15 year old boys were reduced by 8% in the USA between 1988 and 1995. There is also extensive data confirming that prevention leads to abstinence and a delay in first sexual experiences among children and adolescents (UNAIDS, 2002).

In a recent study (UNAIDS, 2002) conducted on effective prevention programmes, a reduction in teenage pregnancy and sexually transmitted disease were
found in countries such as France, Sweden and Canada. These programmes covered a wide range of topics and presented options for safer sexual behaviour. The deduction is therefore, the more information provided the better the outcome in terms of reducing teenage pregnancy and sexually transmitted infections (STI’s) including HIV. Successful programmes were also found to present consistent messages regarding the risks of sexual activity and how to either avoid intercourse or to protect oneself against pregnancy and sexually transmitted infections. Adequately trained teachers also presented these programmes. Less successful results were noted in schools where abstinence was provided as the only options and contraceptives were presented as ineffective in preventing pregnancy and infection (UNAIDS, 2002).

Unfortunately, not much is available regarding the evidence of success of prevention programmes in Africa thus emphasising the need for greater monitoring and evaluation of prevention programmes in the continent most greatly affected by this pandemic (The World Bank, 2002). However, Mukoma and Flisher (date unknown) (in Flischer, 2001) found in a recent review of prevention programmes in South Africa, that despite methodological limitations these programmes did lead to positive effects on knowledge, attitudes and the amount of communication about sexuality. In addition, recent surveys conducted in South Africa reported that 55% of sexually active teenage girls use condoms during sex. It appears that the country’s large-scale prevention programmes including informative campaigns and condom distribution efforts are delivering some results (UNAIDS, 2002). However, negative or no effects were also noted in terms of perceived susceptibility to infection, behavioural intention or behaviour itself (Flischer, 2001). What has been noted from this review of the successes and failures
of prevention programmes presented, is that each country developed its own approach to prevention, based on the culture of that country as well as the main mode of HIV transmission which resulted in more successful implementation of prevention programmes. Additional generic lessons for more effective prevention programmes have also been noted that could be applied to all countries. These lessons are discussed below, with special mention made of the lessons learnt from previous programmes implemented with young people.

**Lessons learnt**

The traditional epidemiological approaches to prevention fail to take into account individual behavioural changes in response to a disease, and the impact that information has on behaviour. In addition, the difficulty with HIV prevention programmes has been the inappropriate focus on individuals or certain populations, for example gay men, instead of specific behaviours. This approach to education has been proven limiting in light of growing evidence, which indicates that, as many as 75% of AIDS cases worldwide are attributed to heterosexual transmission (NIAID, 1998; Umeh, 1997). According to Umeh (1997), successful AIDS prevention programmes incorporate an understanding of the various risks and dynamics involved in behaviour changes as well as an awareness of the cultural contexts in which this behaviour change will be carried out. In addition programmes that focus mainly on distributing information about AIDS and how it is transmitted are not enough. Instead, issues such as attitudes and motivation and its influence on behavioural change over long periods of time should be highlighted.
As a result of the factors mentioned above, many researchers have suggested guiding principles and strategies that should be kept in mind when developing a prevention programme. The guiding principles as proposed by Van Dyk (2001), are the most recent and comprehensive strategies. These principles are:

1. The recognition that national support is required for a successful prevention programme (i.e. with political support, commitment and high-profile advocacy of a country’s leaders).

2. The importance of peer support through youth programmes run by youth who educate and empower their peers.

3. The need for the involvement of people living with HIV/AIDS who are the best advocates and activists of social and behavioural change.

4. The acknowledgement of cultural, religious and social sensitivity by contextualising programmes to local customs, cultural practices, religious beliefs and values, traditional norms and practices.

5. The facilitation of empowerment by empowering individual, groups and communities to address their own health concerns and come up with their own plans and solutions.

6. The need for condom distribution, which includes easy access for both men and women.

7. The combating of stigma, isolation, stereotypes and discrimination of people living with HIV/AIDS by showing support for all people regardless of their health status.
8. The availability of volunteer counselling and testing services which not only raise awareness about HIV/AIDS, but many studies show that knowing one’s status is key in effecting behavioural change and applying safer sex practices (Van Dyk, 2001).

Since young people are the target population of this study, lessons learnt as well as strategies for improving prevention programmes aimed at this group have also been included. A lesson learnt from previous HIV/AIDS education programmes aimed particularly at young people, is that these programmes are too narrow and lacking in participatory methods (Mugabe, 2001), such as group work, role-plays and exercises to encourage open discussions (Aggleton & Rivers, 1993). In addition, people develop their own perceptions and bring with them their own cultural backgrounds. Therefore, AIDS education programmes cannot impart information in isolation.

Participatory methods thus aim at focussing on the individual’s established beliefs and providing them with an opportunity to identify their personal concerns without imposing any on them (Aggleton & Rivers, 1993). However, it should be noted that effective programmes not only address social, psychological and biological issues but also impart knowledge and convey attitudes (Valentich & Gripton, 1989). When considering our target population of young people, this participatory approach allows young people to be more open in their discussions about AIDS and sexuality, and allows them to integrate these issues into their lives (Aggleton & Rivers, 1993).

Prevention strategies that have been found to work with young people include:

1. Age-appropriate and developmentally appropriate interventions.
2. Early sexuality education.
3. Peer education.

4. School-based peer-led programmes.

5. Small group counselling.

6. Intensive, repeated education.

7. Skill building to build self-esteem, for negotiating safer sex, for proper use of condoms.


Of particular interest to this study was the hypothesis put forward by UNAIDS (2002) in its report on the global HIV/AIDS epidemic, which states that, earlier programmes have shown us that prevention/education should be implemented before puberty and should continue into the school years. There are those who do not believe that such prevention/education should be done before children become sexually active. However, the argument put forward by UNAIDS is that, the age at onset of sexual activity differs so widely and that in order to instil good health behaviours, especially regarding sexual health habits, HIV/AIDS and other STI’s, prevention/education should begin at an early age. The belief that prevention/education should not begin before sexual onset, is but one of many barriers to prevention that exist. The rest of the chapter focuses on the barriers, including cultural barriers particular to Africa and South Africa that have been found to present a problem to prevention.
Barriers to prevention

Obstacles are bound to exist in providing HIV/AIDS education because of the sensitive nature of behaviour related to HIV transmission. Other obstacles include the reality that “in many regions of the world, formal education on sexual matters either does not exist, is inadequate or is provided too late in adolescence” (Isaksson, Nahri, Byrne, Chowdhung, Reinders & Fraser, 1993, p.23). Still other obstacles such as poverty, and other forms of social insecurity and gender inequality exist. These obstacles play against protective actions such as male or female condom use, abstinence, monogamy or fewer partners, delayed onset of sexual activity or non-penetrative sex, and early STI’s diagnosis and treatment for self and partners (Jackson, 2000). Because HIV is contracted through sexual and drug-using behaviour, adults find it difficult or refuse to talk to young people about it and continue to hang onto the belief that young people do not have sex or even use drugs (AIDS Action, 2001).

A study conducted in Botswana found that the reluctance of young people to obtain condoms was a result of the difficulties in the interaction between adolescents and the public sector providers, who tend to question adolescent behaviours, the stigmatisation of condom use, and the limited distribution of condoms in the private sector. These researchers therefore suggested improvements in all these areas as well as the use of peer sales agents and educators to improve the possibility for success of HIV/AIDS prevention campaigns (Meekers, Ahmed & Molatthegi, 2001).

According to UNAIDS (2002), the barriers for youth in particular include their lack of access to information, advice and reproductive health services, treatment of STI’s, concerns about lack of confidentiality and unresolved issues about parental consent. One
of the main barriers or difficulties in providing HIV/AIDS prevention programmes, especially in Africa including South Africa, is the consideration of cultural issues. Therefore, special mention is made of these cultural barriers.

**Cultural barriers in Africa and South Africa**

AIDS education amongst other things also focuses on promoting safer sex. However, within certain cultures and religions this may prove to be difficult and provide impediments to safer sex. Certain cultures have a problem with using condoms and ejaculating outside of the vagina which they see as seed wantonly spilled. In other cultures still it is taboo to even talk about sex. The desire to create offspring and the avoidance of disgrace and ostracism as a result of not being able to bear children, impacts on condom use (Perloff, 2001). In still other cultures it is unheard of that women could request or insist on the use of a condom by her partner (Crewe, 1992).

In African cultures, sex is viewed in a positive light in that it is viewed as a means to overcome death and is seen as a symbol of immortality. Children are seen as important for personal mortality as well as for day-to-day functioning. People are kept in a state of personal mortality through their remembrance by close relatives, and procreation is one way of ensuring that your personal immortality is not destroyed. Children also ensure the existence of traditional African lifestyles in that they assist in the day-to-day functioning by participating in duties such as looking after the cattle, babysitting and working the fields. The number of children is a reflection of the strength of a man’s tribe and consequently his wealth (Perloff, 2001; Van Dyk, 2001). The use of condoms is therefore not viewed in a positive light considering the desire to produce offspring as well as fears
as a result of lack of knowledge about the use of condoms. The implication for prevention then is to find ways to work with or around these cultural issues (Van Dyk, 2001).

Other traditional practices in the African context that could present barriers to HIV/AIDS education include: the practice of a father-in-law having sex with the bride; sharing of a wife by brothers, sex practiced early after childbirth, and the belief that STI’s can be cured by intercourse with a virgin. However, practices such as high bride prices, result in less extramarital sexual contact. Therefore, African ethnic groups have some taboos that prohibit sex, which could contribute to the control of AIDS (Van Dyk, 2001).

The understanding among young people of illness as the result of being bewitched, has tremendous consequences for HIV/AIDS prevention in Africa. Suffering and misfortune are seen as signs of being bewitched, in other words someone close to them is wishing them harm. The impact on HIV/AIDS prevention is that treatment and prevention of HIV are put down to witchcraft and therefore, do not lie with the use of condoms, anti-retroviral therapy or education (Van Dyk, 2001; Walker, Reid & Searle, 2001). In this context many black people distinguish between illness as having an immediate cause and an ultimate cause. As a result, many black people would consult a traditional healer who would address the ultimate cause, as well as western health care professional who would address this problem. The implications for HIV/AIDS education are that these programmes should not ignore these beliefs and should rather attempt to integrate them into programmes. This particular stance has been found to work in areas such as Uganda where scientific fact was coupled with witchcraft theory, at a time when AIDS had become widespread.
Another belief within the African culture is that ‘pollution’ causes illness. ‘Pollution’ here refers to impurities due to failure to perform appropriate rituals that have been prescribed for every life. Ritual impurities usually refer to sexual intercourse with a prohibited person or contact with a corpse and death. This person is said to be impure and should engage in cleansing rituals such as washing, vomiting and purging. The prohibited person relates to the beliefs such as the belief that men should not have sex with a women while she is menstruating as this leads to delirium; the prohibition of having sexual intercourse with a widow before she is cleansed (her husband might have died from AIDS) and a women who has had an abortion or miscarriage. HIV/AIDS education programmes could integrate these beliefs, especially those related to sexual prohibitions because they can prevent HIV infection (Van Dyk, 2001).

Two views exist regarding African traditions. On the one hand they do have a role to play, which could be beneficial, but on the other hand some of the practices need to be reviewed or discarded altogether in the fight against AIDS. In particular a review of lost moral codes especially in urban areas where traditions have been lost, and the use of religion and family influence (Voeller, Reinisch & Gottlieb, 1990).

According to Parker, Dalrymple and Durden (1998), language, literacy and culture, urban and rural contexts and gender should be considered when providing HIV/AIDS prevention programmes in the South African context. South Africa has 11 official languages, which include English, Afrikaans, Zulu, Xhosa, Sotho, Twana, Pedi, Ndebele, Siswati, Venda and Tsonga. HIV/AIDS programmes are usually presented under the assumption that the target audience understands one of the more dominant languages, that is, English, Afrikaans, Xhosa, Zulu, Tswana or Sotho. It is important that
people be provided information in their home language or at least in their language of choice. The level of literacy also needs to be considered. This refers not only to the ability to read text but also the ability to interpret visual information such as charts and photographs. In addition, different cultures will interpret visual information in different ways with hand gestures and colours for example having different meaning across cultures. The context in which people find themselves, that is rural or urban could place them in a greater position of contracting HIV/AIDS because of their limited accessibility to information and resources to cope with infection. In addition, although people in the rural areas may be reached through the mass media, this medium does not consider factors such as the influence of traditional leaders and their modes of communication.

School setting

Two ways have been identified to reach young people in implementing HIV/AIDS education, that is, in schools and youth centres (Aggleton & Rivers, 1993). Schools have been specifically identified as the setting for such programmes (Bunde-Birouste & Jones, 1993; Dunn, Ross, Caines, & Howorth, 1998), since they have the potential to reach billions of children worldwide. Schools are also the only social institution that children and youth have contact with, in some areas. As they have little or no access to primary health care services, schools are the next best route to follow (Dick, Warren, Jones, Davidson & Jha, 1993). Schools also have the benefit of: staff equipped with the tools of teaching and learning; teachers assume an important role in the community; and schools are often the only place where young people can obtain accurate information on reproductive health (The World Bank, 2002).
AIDS education has largely concentrated on secondary schools. This is understandable considering the high percentage of sexual involvement in this age group. However, the Guideline for Educators (2000) acknowledges that learners as young as 12 are sexually active. In addition, there is growing recognition that attitudes and beliefs are formed early in life as can be seen from the information provided in the previous section. For this reason strong consideration has been given to the implementation of AIDS education programmes in primary schools before children become sexually active and therefore instil positive attitudes and beliefs towards healthy sexual behaviour (The World Bank, 2002).

In the context of the information presented above the researcher will now detail a Life skills programme focusing on HIV/AIDS education, which was presented to senior primary school learners in the Port Elizabeth region.

**Life skills programme focusing on HIV/AIDS education for senior primary school learners in the Port Elizabeth region**

The present study forms part of a larger research project. The larger research project is the result of the partnership between the Nelson Mandela Metropolitan Municipality (NMMM) Health Department as lead agency; department of Education (Western region of the Eastern Cape) as facilitator; Planned Parenthood Association of South Africa (PPASA), Lifeline, ATTIC, and Scripture Union as implementing agencies; the University of Port Elizabeth Health and Development Research Institute as researcher; together with the CDC and Delta Motor Company of South Africa as support structures in a life skills, HIV/AIDS education pilot study for grade six and seven learners in
selected primary schools in the Port Elizabeth region (Pailman, 2000). The aim of the larger project was to introduce an effective and culturally acceptable life skills and HIV/AIDS education programme to grade six and seven learners in the Port Elizabeth region, and in so doing empower learners with knowledge and decision making skills to promote appropriate sexual behavioural practices which in turn would prevent the spread of HIV/AIDS (Pailman, 2000).

In conceptualising the programme the need for a monitoring and evaluation procedure was viewed as an important part of the programme. Therefore the larger project together with the research process was introduced. The research process, in keeping with the focus of the national initiative, focused on Grade six and seven learners. The research process consisted of three phases, which are referred to as the exploratory phase (pre-pilot), the pilot study and a potential expansion of the project over a three-year period. The exploratory phase was completed in November 2000. This study formed part of the next phase of the research process, that is, the pilot study.

**Pilot Project: Research aim and objectives**

The aim of the research was to develop a monitoring and evaluation procedure by which the effect of the HIV/AIDS Life Skills programme for grade six and seven learners could be assessed. The research consisted of the following objectives:

1. Refinement of the research instrument and procedure for monitoring and evaluation, based on the outcomes of the exploratory phase.

2. Application and testing of the refined instruments and procedures.
3. Third generation refinement of the monitoring and evaluating instruments and procedure as integral part of a model for an HIV/AIDS Life Skills Training Programme for grade six and seven learners (Pailman, 2000).

The aim of the present study, which was to explore the perceptions of grade six and seven learners with regards to the Life Skills programme focusing on HIV/AIDS, contributed to the achievement of the pilot project’s objectives.

**Methodology**

The methodology employed for the pilot project consisted of two basic methods, i.e. the experimental design and focus groups. The pilot project was divided into the following phases:

1. Content and editorial refinement of the pre- and post-test questionnaires administered to learners.
2. Administering the pre-tests to the learners to establish a base line and to statistically refine the questionnaire.
3. Administering the post-tests to learners to assess possible changes from the base line to determine whether and to what extent the programme intervention has brought about change in knowledge, perceptions, and to some extent, behaviour relating to HIV/AIDS.
4. Focus group sessions with learners to capture qualitative data to complement the quantitative data obtained through pre- and post-tests.
5. A further refinement of the instrument in terms of content and editorial and statistical properties, with the objective of developing a short index of questions
and questionnaires that can be easily administered by the teachers or other internal staff of the Department of Education themselves.

The present study fell into the phase which involved conducting focus groups with senior primary school learners. The aim of the study was to explore the perceptions of grade six and seven learners with regards to the Life Skills programme focusing on HIV/AIDS.

The target population for the pilot phase consisted of teachers and learners of 50 selected primary schools in the Port Elizabeth region. The selected primary schools consisted of randomly selected black, coloured and white schools that were not involved in the pre-pilot stage of the HIV/AIDS Life Skills Programme (Pailman, 2000).

The teaching modules employed for the HIV/AIDS Life Skills programme included the following:

1. Self-awareness
2. Peer pressure
3. Assertiveness
4. Sexuality
5. Coercion and sexual assault and harassment
6. Serious and non-serious illness
7. HIV/AIDS
8. Decision-making

The HIV/AIDS Life Skills programme therefore, incorporated elements of behavioural theories and modules as presented above. The programme recognised that several factors can influence a person’s intentions and behaviours through the application of the teaching
modules. Such factors include the person’s a) perception of susceptibility to a given disease or illness; b) attitude toward performing the behaviour; c) normative beliefs, including the perception that others in the community are also changing behaviours; d) self-efficacy, or belief that one can perform the recommended behaviour under various circumstances; e) acquisition of the social and physical skills necessary to perform the behaviour; and f) readiness to change behaviour. Therefore, the HIV/AIDS Lifeskills programme does well by replicating the important aspects of the theories and models as mentioned previously.

**Conclusion**

This chapter reviewed literature regarding the theories most often used in HIV/AIDS prevention programmes as well as the successes and failures of these prevention programmes as well as the lessons learnt. The larger project which the HIV/AIDS skills programme forms part of, was outlined above and the methodology followed for the larger project.

The next chapter will outline the methodology followed for the present study in order to determine the perceptions of the grade six and seven learners regarding the extent to which this theory-based behaviour change intervention has brought about change in knowledge, perceptions, and to some extent, behaviour relating to HIV/AIDS.
CHAPTER SIX
RESEARCH METHODOLOGY

Introduction
This chapter outlines the methodology followed for the present study. The research design, participants and sampling procedure employed, the data gathering technique used, the research procedure followed as well as the data analysis of the present study will be outlined to give an overview of the research methodology used for the present study.

Problem formulation
As was discussed in Chapter 3 and 4, AIDS has reached pandemic proportions reaching every continent in the world, and affecting people from all walks of life regardless of socio-economic status, race, gender or age. Research indicates that the future course of AIDS remains inevitable with a projected 68 million people dying worldwide from AIDS by the year 2020 (UNAIDS, 2002). This will include a majority of young people, the group found to be the most vulnerable to HIV infection (AVERT, 2002; UNAIDS, 2002). This reality is made more likely with the realisation that the discovery of a cure or a vaccine is not expected in the near future (Ingham, 2002). Therefore prevention, particularly prevention programmes aimed at young people, are seen as the only hope in discontinuing any further devastation caused by AIDS (Perloff, 2001; Van Dyk, 2002).

Many successes and failures have been noted with the implementation of HIV/AIDS Life Skills programmes around the world. However, there is growing concern that the region most affected by AIDS, that is, South Africa, does not have specific
methods in place to evaluate the successes or failures of HIV/AIDS Life Skills programmes that have been implemented (The World Bank, 2002). The aim of this study therefore was:

To explore and describe the perceptions of grade six and seven learners with regards to the Life Skills Pilot Project focusing on HIV/AIDS Education.

The findings of this study will be combined in a separate report with quantitative data obtained from the same population, which will be presented to the different agencies involved. They will then be able to set up effective training and education programmes specifically suitable to the population under study, that is, young people in the Port Elizabeth region.

**Research design**

Scientific research has four general goals, that is, to explore, describe, explain, and predict or evaluate. Therefore, a specific scientific study is determined by the aim of that research, that is, whether to explore, describe, explain, predict or evaluate (Cozby, 1993). In exploratory research very little previous research has been conducted and the researcher will typically attempt to collect new data and formulate, rather than test, hypotheses and determine priorities for future research. Descriptive research aims to identify variables that exist in a given situation and, at times, to describe the relationships between or among variables, in other words, to describe how things are. Experimental research, on the other hand, attempts to identify casual relationships between variables, by manipulating the independent variable under controlled conditions and observing consequent effects in the dependent variable(s) (Bailey, 1997; Cozby, 1993; Mouton,
The purpose of utilising an exploratory-descriptive approach was to elicit data from a population, about whom little knowledge exists, with the aim of gaining insights into their perspectives and thus developing hypotheses and determining priorities for future research.

In deciding on a research approach, the differences in how qualitative and quantitative approaches answer questions regarding the nature of reality and human behaviour was considered. Quantitative research sees an external, objective reality and explains it in terms of cause-effect laws; the researcher is detached from the object of study; and the hypotheses are stated and empirically tested. Qualitative research, on the other hand, doesn’t separate the individual from his reality; the researcher interacts with the subject, and in this interaction discovers the subject’s world and interpretations (De Vos, 1998). The latter fits well with the objectives of this study.

Qualitative research is defined as “a multiperspective approach (utilising different qualitative techniques and data collection methods) to social interaction, aimed at describing, making sense of, interpreting or reconstructing this interaction in terms of the meaning the subjects attach to it” (Denzin & Lincoln, 1994, in De Vos, 1998: 240). The goal of qualitative research and its methods is to contribute to the researcher’s unique understanding of the phenomenon under study (Morgan, 1997). In addition, qualitative research is deemed advantageous for this study as it enable the researchers to identify unanticipated outcomes and explore emerging ideas, thus ensuring the richness, quality and depth of data (Denscombe, 1998).

Qualitative research is often used in the initial stages of a study, when not enough is known about the research topic, either from theory or from previous research, to
determine which questions to ask. Qualitative research is seen as the best strategy to employ when exploring a new area and developing hypotheses. Qualitative research has strong potential for testing hypothesis and is very useful when needing to complement, validate, explain, illustrate or re-interpret quantitative data gathered from the same setting (Bailey, 1997).

While qualitative research is invaluable when used at the right time and for the right purposes, there are some disadvantages when using this approach. Research findings are often not generalisable, as qualitative studies are usually concerned with an in-depth study limited to one or a few individuals, or a specific phenomenon, situation or programme. The aims of such studies, including this particular study, however, usually do not include finding generalisable results. Another disadvantage of qualitative research is the threat to the validity of the data posed by the subjective involvement of the researcher, referred to as observer bias. Qualitative researchers have to constantly acknowledge and take into account their own opinions and prejudices as a method of dealing with them (De Vos, 1998). In order to guard against the pitfalls of the above limitations, validity checks have been included. These methods of ensuring trustworthiness of qualitative data are elaborated upon when addressing data analysis later in this chapter.

**Participants and sampling procedure**
As mentioned earlier, it was decided to refer to the population being studied as ‘young people’ or ‘learners’. The target population of the larger project consisted of grade six and seven learners of 50 selected primary schools in Port Elizabeth. The researchers of the larger HIV/AIDS Life Skills Project selected the 50 schools. Non-probability
sampling was used to select schools from a list representing those schools not involved in the pre-pilot study (Pailman, 2000).

For the purpose of this study six schools were selected from the 50 schools in the larger project to form the sample. These six schools were specifically selected because they were the only schools at this phase in the project that had completed all the teaching modules of the programme. Focus groups were conducted with groups of 12 learners from each school. Learners in the study represented both lower and upper socio-economic status area, and were selected conveniently to participate in the study. Grade six and seven class lists for each selected primary school were collected. The population under investigation can be described as Grade six and seven learners from six selected schools in the Port Elizabeth area.

The sampling method in this study was non-probability, purposive sampling. Non-probability sampling is defined as the uncertainty regarding the possibility of any particular member of the population being chosen (Cozby, 1993) for the study. Non-probability sampling was considered since generalisation of results will not occur. Glasser and Strauss (Morgan, 1997) and Patton (Morgan, 1997) state that, it is more important “to think in terms of minimising sample bias rather than achieving generalisability” (Morgan, 1997: p. 35). Purposive sampling was used in order to select only those schools and learners who had completed all the modules of the HIV/AIDS Life Skills programme, as outlined in Chapter five.
Data gathering technique

Focus groups were conducted with learners to capture qualitative data regarding the research objectives, and to compliment the quantitative data obtained through the pre- and post-tests administered to learners as part of the larger project. The use of focus groups was considered for this study since the goal of self-contained focus groups - that is, the use of focus groups without the combination of other methods - is to learn about participant’s attitudes, and opinions on the researcher’s topic of choice (Morgan, 1997). The strengths of focus groups include: their ability to produce concentrated amounts of data on the research topic of interest; they are quick, easy and time saving in that many ideas are produced in 10 interviews as with one focus group consisting of 8-10 participants (Morgan, 1997). Focus groups are however less controlled than individual interviews and the presence of the researcher as moderator might produce researcher-directed data. Martin, Loubser and Van Wyk (1996) identified the following advantages of using focus groups as an exploratory technique:

1. Synergism, referring to the fact that a group of people can produce a wider range of information, insight, and ideas than individual responses secured separately.
2. Snowballing, in other words, one participant’s remark may trigger a chain reaction from other participants.
3. Stimulation, meaning the group setting encourages participants to express their ideas and provides for a general level of excitement about the topic.
4. Serendipity refers to the fact that original ideas are more likely to arise out of a group than an individual interview.
5. Scientific scrutiny refers to the fact that the process of data collection can be closely observed and recorded for later analysis.

6. Structure, combined with flexibility, results in in-depth exploration of the topic. Martin, et al. (1996) have summarised the disadvantages of using focus groups as follows:

1. Misuse: Focus groups can be misused when the results are considered to be conclusive rather than exploratory.

2. Misjudge: The interpretation of data is susceptible to interpreter bias.

3. Moderation: Successfully moderating a focus group requires professional skill training.

4. Messy: The unstructured nature of focus groups makes coding, analysis and interpretation very difficult.

5. Misrepresentation: Typically, results cannot be generalised or seen as conclusive, and therefore should be seen purely within an exploratory framework.

For the purposes of this study, the advantages of focus groups are seen as outweighing the disadvantages. In addition, employing the services of an independent coder and viewing the data generated by the focus groups within an exploratory framework helped to minimise the potential impact of the above disadvantages.

The semi-structured interview for focus groups interviewing is recommended since open-ended questions allow the researcher to indicate the broad aims of the study and to see what the participants bring to light when the issues are uncertain (Gillham, 2000). Therefore, for this study semi-structured interviews, together with prompts and open-ended questions were used to elicit free discussion regarding the topic of interest.
Bailey (1997) highlights the following advantages of open-ended questions:

1. They can be used when the possible categories of answers are unknown or when the researcher wishes to see what the participants deem as important answer categories.
2. They allow participants to clarify and qualify their answers, providing as much detail as they like.
3. They are useful when there are too many possible answer categories to be included in an interview/questionnaire.
4. They are useful when complicated information cannot be condensed into a few small categories.
5. They allow participants to answer in any manner they wish without giving suggestions.

According to Bailey (1997), the disadvantages of open-ended questions are as follows:

1. They may produce useless and irrelevant information.
2. Coding of information is very difficult and subjective, resulting in low inter-coder reliability.
3. Open-ended question require superior verbal abilities, and a higher educational level than close-ended questions.
4. Open-ended questions which are designed to be general, may be too general for participants to understand what it meant, requiring the use of probing by the interviewer.
5. Open-ended questions require much more of the participant’s time and effort and may produce a higher refusal rate.

Once again the advantages and disadvantages with regards to open-ended questions were considered and it was decided that the advantages exceeded the disadvantages. In keeping with the aims of the larger project, the semi-structured interview with the focus groups consisted of the following open-ended questions, which were formulated by the stakeholders in the larger project:

1. Could you share with the group what you thought about filling out the questionnaire both the first and the second times?
2. How did you experience the HIV/AIDS education intervention and education programmes as run by the teachers?
3. Should teachers tell you about HIV/AIDS or someone else?
4. How old do you think children should be when they are taught about HIV/AIDS?
5. With who have you discussed HIV/AIDS?
6. Do you know anyone who has HIV/AIDS?
7. Do you know what puts people at risk for HIV/AIDS?
8. What are your attitudes now towards HIV/AIDS issues after having been through the programme?
9. Do you have any suggestions for making the programme better?

The analysis of the answers to these questions will be discussed later in this chapter.
Research Procedure

This study, as well as the larger project, strictly adhered to the ethical requirements for research projects set out by the University of Port Elizabeth. During the exploratory phase of the larger project, consent forms and explanatory notes were developed which parents of learners in the selected schools were asked to sign. For the pilot study, the protocol that includes the parent consent, the pre- and post-test instruments for learners and teachers, as well as the semi-structured interviews and focus group guidelines were served before the Ethics Committee of the University of Port Elizabeth. This was the procedure adopted for previous phases of the project, and was followed for this study as well.

The sample was selected according to the procedure described under participants and sampling procedure above. The telephone numbers of the six selected schools were obtained and a letter informing the school of the current phase of the larger project, as well as a request for their co-operation was forwarded to the selected schools. Upon receiving confirmation from the selected schools, a list of the learners in every grade six and seven class was requested. From the lists the researcher selected 10-12 participants from each school and these lists together with the times of the focus groups were forwarded to the schools.

The researcher was the primary tool of data collection and ran the focus groups. Tape recorders and one 90-minute tape per school were provided to each moderator to make audiotapes of the focus group sessions. The tapes were clearly labelled and numbered before the sessions to avoid confusion. Lists of open-ended questions, which served as focus group guidelines, were compiled to obtain uniformity appropriate to the
focus groups. The location for the focus groups was considered with the tape recordings in mind. Therefore, principals or contact persons were requested to provide a quiet room in the school. At the start of each focus group session, the participants were briefed regarding the purpose of the interview, asked permission to make the recording, and confidentiality was emphasised. The Institute for Health and Development Research Institute (HDRI) transcribed the data obtained from the audiocassette recordings into written verbatim records. The researcher conducted the coding and an independent coder was utilised.

**Data Analysis**

A thematic content analysis of the data collected from each focus group was conducted. This content analysis method is used to make inferences by objectively and systematically identifying themes in response to the open-ended questions. De Vos (1998) described a number of different approaches to qualitative data analysis: Morse and Field, Huberman and Miles, Marshall and Rossman, and Lincoln and Guba. Tesch’s (1990) approach seems the most logical (De Vos, 1998). In addition, it generates unbiased information from the world of the participants. Tesch (1990) in De Vos (1998) provided easy to follow steps in analysing qualitative data. These include:

1. Reading through the transcripts carefully and jotting down any ideas that come to mind;
2. Selecting a focus group transcript and asking, “What is this about?” Thinking about the underlying meaning of the information. Writing thoughts down in the margin and continuing to do this for all focus groups/transcripts.
3. Making a list of all the topics that emerge and clustering similar topics together. Arranging these into major topics, unique topics and left-overs.

4. Taking the list and returning to the data. Abbreviating topics as codes and writing these codes next to the appropriate segments of the text. Trying out this organising scheme and seeing if new categories and codes emerge.

5. Finding the most descriptive wording for the topics and turning them into categories. Trying to reduce the total list of categories by grouping together topics that relate to each other. Drawing lines between categories to show interrelationships.

6. Making a final decision on the abbreviation for each category and alphabetising the codes.

7. Assembling the data material belonging to each category in a place and performing a preliminary analysis.

8. Recoding existing data if necessary (De Vos, 1998).

In line with the guidelines for qualitative data analysis as provide by Tesch (De Vos, 1998), transcriptions were coded and analysed per school to obtain information regarding perceptions of learners in that specific school. The general themes and sub themes that emerged over the six schools were coded using a specific coding unit. The transcripts from the focus groups held at each school were named A, B, C, D, E, and F, thereafter numbers were assigned to specific themes and sub themes as they emerged (Appendix B).
Trustworthiness of the data

Since the researcher had been concerned about the criticism which qualitative research has received regarding validity and reliability of the information generated, the reliability and validity of information generated in this study were carefully addressed.

The worth of most quantitative research is determined by assessing its reliability and validity (Krefting, 1991). According to Agar (Krefting, 1991), qualitative research is no different other than the use of terms such as reliability and validity. Agar (Krefting, 1991) suggests the use of terms such as credibility, accuracy of representation, and the authority of the writer in determining the worth and trustworthiness of qualitative research. In terms of the question of the reliability of the findings in a qualitative study, Bogdan and Biklen (1992) state that qualitative researchers do not aim at consistency in the results of different researchers, or of the same researchers over time. Rather, qualitative researchers are concerned with the accuracy and comprehensiveness of their data. They tend to view reliability as “a fit between what they record as data and what actually occurs in the setting under study” (Bogdan & Biklen, 1992). With regards to validity, Bailey (1997) points out that qualitative studies are more likely to be valid than quantitative studies since qualitative researchers base their conclusions on the subject’s reality, with questions and observations being guided by the what the subject feels is important and relevant (Bailey, 1997).

Guba (Krefting, 1991) presents a model of trustworthiness, which includes four aspects, namely: truth value; applicability; consistency; and neutrality. The model also describes different strategies of assessing these criteria in each type of research. For the purpose of this study, truth value, consistency and neutrality were established as the three
criteria applicable to the present study. Applicability, as a criterion for establishing trustworthiness was not considered for this study since it refers to the degree to which findings can be transferred to contexts outside of the study. As this is an exploratory study, it is not concerned with the ability to generalize the findings to the larger populations. However, Guba’s (Krefting, 1991) perspective on applicability includes the criteria of fittingness, or transferability in determining the applicability of qualitative data. Thus the applicability of the findings to another situation is not the responsibility of the researcher but that of the person wanting to apply the findings.

Truth value refers to the confidence of the researcher in his findings and the context in which the study was undertaken. The subjective presentation of the human experiences by the subjects and not that of the researcher, determine truth-value. In order to test the credibility of such representations the researcher will do well to measure this against the experiences of various groups familiar with the phenomenon being studied. The truth value, or credibility, of the qualitative findings were established using the strategy of peer examination. Peer examination took the form of employing a co-reviewer and independent coder, who had experience in qualitative methods. Discussion with this impartial colleague concerned the research process and findings and allowed for the discussion of insights and problems. The independent coder for this study also contributed to the truth value of the study by checking the substantive statements found in the recordings of the focus groups and by checking the thematic categories developed from this data (Krefting, 1991).

The reliability of qualitative research measures is dependent on meeting the criteria of consistency. However, in qualitative research, variability is expected and emphasis is
placed on the uniqueness of human experiences (Krefting, 1991). Peer examination was once again a useful strategy with which to establish this criterion. The use of colleagues, such as the independent coder and research supervisors for this study, to check the research plans and their implementation also helped to ensure consistency. In addition, a dense description of the research methodology and techniques increases the likelihood of consistency. A comprehensive description of research methodology and techniques provides information that affects how repeatable the study might be (Denscombe, 1998; Krefting, 1991).

The criterion of neutrality in any research attempts to free findings from any biases, motivation and perspectives. In quantitative research approaches, neutrality is ensured through objectivity by maintaining distance between the researcher and the research subjects. The trustworthiness of qualitative research findings is increased by reducing the distance between the researcher and the subjects. In this study the confirmability of the findings was determined by the use of a confirmability audit. The latter strategy is described in the paragraph above. However, in order to investigate the neutrality of the study, external auditors, in the persons of two research supervisors, followed the progression of the research to understand how and why decisions were made. This audit was valuable in ensuring that another researcher could arrive at comparable conclusions given the same data and research context (Krefting, 1991).

The criteria for trustworthiness, as outlined by Guba (Krefting, 1991) was constantly reviewed and determined the use of a variety of strategies. It is thus believed that this study possesses the truth value, consistency and neutrality. It is hoped that the objectivity,
reliability and validity of the qualitative research had been outlined by justifying the research methods chosen by the researcher.

**Conclusion**

For the present study a qualitative approach was chosen to deviate from and complement quantitative approaches because the latter tends to objectify or externalise participants’ experiences (Kazdin, 1998). Quantitative approaches reduce the ability to capture the internal, emotional processes related to the programme, which is the very focus of this study. Focus groups were conducted with the chosen sample and data was analysed using Tesch’s approach. The findings of the focus groups may not be generalisable to the entire population because of the nature of the research design. However, there are some interesting findings that emerge from the current research which warrant some attention. These findings are presented in the next chapter.
CHAPTER SEVEN
RESULTS AND DISCUSSION

Introduction
The empirical findings of this study are presented in this chapter. The purpose of the present study was to assess the perceptions of grade six and seven learners with regards to a HIV/AIDS Life Skills education programme. A semi-structured interview was employed to gather subjective, rich, experiential data. Thereafter, Tesch’s approach to data analysis (De Vos, 1998) was used. Seven general themes emerged from the responses of the groups to the semi-structured interview. These themes are introduced in Tables 7.3 to 7.8. Both the sub-themes and the specific aspects related to these sub-themes are included in the tabular presentations. Thereafter, the results are discussed according to the structure provided by these themes identified. For further information regarding the themes, sub-themes and coding, refer to Appendix B.

Learners’ perception of the questionnaire
Table 7.3 introduces this general theme, that is, the learners’ perception of the questionnaire, by presenting the sub-themes as well as specific aspects related to these sub-themes, that emerged when learners were asked to discuss their perceptions of the pre-test and post-test questionnaires.
Table 7.3

Main theme: Learners’ perception of completing the questionnaires

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Specific aspects of sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The questionnaire itself</td>
<td>1. Easily understood</td>
</tr>
<tr>
<td></td>
<td>2. Difficult language</td>
</tr>
<tr>
<td></td>
<td>3. Difficult to answer</td>
</tr>
<tr>
<td></td>
<td>4. Length was too long</td>
</tr>
<tr>
<td></td>
<td>5. Confusion with regards to repetition</td>
</tr>
<tr>
<td></td>
<td>6. Too little space for answers</td>
</tr>
<tr>
<td></td>
<td>7. No recommendations</td>
</tr>
<tr>
<td>2. Content of the questionnaire</td>
<td>1. Lacking in areas (no suggestions)</td>
</tr>
<tr>
<td></td>
<td>2. Comfortable</td>
</tr>
<tr>
<td></td>
<td>3. Scary, strange</td>
</tr>
<tr>
<td></td>
<td>4. Relevant</td>
</tr>
<tr>
<td>3. Anonymity</td>
<td>1. Positive perception of anonymity</td>
</tr>
<tr>
<td></td>
<td>2. Negative perception of anonymity</td>
</tr>
<tr>
<td>4. Procedure</td>
<td>1. Administration time of the questionnaire</td>
</tr>
<tr>
<td></td>
<td>2. Administration was rushed</td>
</tr>
<tr>
<td>5. Feelings</td>
<td>1. Nervousness</td>
</tr>
<tr>
<td>6. Pre-test to post-test</td>
<td>1. Knowledge acquisition</td>
</tr>
</tbody>
</table>

The learners reported both positive and negative perceptions related to the questionnaire. Generally the positive perceptions of the questionnaire included that it was understandable and the questions were relevant to the programme as a whole. Verbatim responses included: “Dit was nie baie moelik nie” (It wasn’t very difficult), “Ons het verstaan” (We did understand), “We understood the questions”, and all the questions were perceived as relevant. Negative perceptions of the questionnaire included the fact that some learners felt that the questionnaire was difficult in terms of the questions asked and the language used. Others felt that the questionnaire was too long, with confusion regarding the repetition of questions. Some said that the space provided to answer the questions was insufficient. Responses included: “Bietjie moelik” (A little difficult), “Ja (Yes) they asked me questions that I didn’t even know what they meant”, “It was quite
difficult”, “I got confused they were repeating questions”, “Te lank” (Too long), and “Die plekkies was te klein om in te vul” (The places were too small to complete).

Some learners felt that their names should have been asked for in the questionnaire. However, other learners understood the need for anonymity. Responses included: “Hulle het nie my naam gevra nie” (They didn’t ask my name), and “Dit is nie belangrik om jou naam te weet nie so lank hulle weet uhmm sommige van die kinders in die skool verstaan wat hulle skryf hier- dat hulle weet- dit is belangrik” (It is not important to know your name as long as they know uhmm that some of the children in the school understand what they wrote here- that they know- that is important).

Suggestions were also provided from the learners regarding the administration of the questionnaire, especially related to the time of administration and the length of the questionnaire, which caused a rush in answering the questions in order to complete them in time. Responses included: “Dit is beter om in die oggend te doen as die middag want jou verstand is weg daai tyd van die dag” (It is better to do it in the morning than in the afternoon because your understanding is gone that time of the day), “It was long”, and “I rushed through it”.

Differences were also noted between completing the first and the second questionnaire. The learners felt more comfortable completing the second questionnaire, and found that it was easier to complete because they had been through the programme and had acquired knowledge related to HIV/AIDS. Responses included: “Vir my was daar nie eintlik vrae wat ek wou beantwoord nie- want agterna het ek meer geleer oor die virus” (For me there weren’t actually any questions that I didn’t want to answer- because afterwards I learnt more about the virus) and “To see if you have learnt more- you see for
instance they asked you do you think that HIV spreads by cutlery- and the first time I did not know- and the next time after we learnt about it we knew”.

The pre- and post-test questionnaire formed an integral part of the larger project. Its aim was to measure the extent to which the programme intervention has brought about change in knowledge, perceptions, and to some extent, behaviour relating to HIV/AIDS. Based on the aims of the programme, and through discussions with the trainers, the Department of Education and with the assistance of the Nelson Mandela Metropolitan Municipality Health Department, the content of the focus group was structured to cover the aspects related to this particular theme. The reason for this was to determine the perceptions of the learners regarding the questionnaire and whether any necessary changes could be made based on their feedback. As can be seen from the results obtained above, the feedback received was generally positive. Some issues, which warrant attention, include revising the questionnaire in terms of language usage. This issue is being addressed and the questionnaire is presently undergoing reliability and validity studies (De la Harpe, Elkonin, Seymour, Venter, in process). The more practical issues that need to be addressed included the fact that there wasn’t enough space to write answers in. The learners’ ability for logical concrete thinking at this particular stage of cognitive development, made it possible for the learners to be included in the evaluation of the questionnaire, by expressing their perceptions of the questionnaire. This stage of development gives them the ability to make logical decisions and to contemplate different possibilities (Newcombe, 1996; Van Dyk, 2001).
Learners’ perception of the programme

Table 7.4 introduces this general theme, that is, the learners’ perception of the programme, by presenting the related sub-themes as well as specific aspects related to the sub-themes that emerged when learners were asked to discuss their perceptions of the HIV/AIDS Life Skills programmes.

Table 7.4

Main theme: Learners’ perception of the programme

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Specific aspects of sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Positive attitudes towards the programme</td>
<td>1. User friendly</td>
</tr>
<tr>
<td></td>
<td>2. Interaction/groupwork/sharing</td>
</tr>
<tr>
<td></td>
<td>3. Enjoyment</td>
</tr>
<tr>
<td></td>
<td>4. Learning process</td>
</tr>
<tr>
<td></td>
<td>5. Relevant content</td>
</tr>
<tr>
<td></td>
<td>6. Valuable</td>
</tr>
<tr>
<td></td>
<td>7. Preventative</td>
</tr>
<tr>
<td></td>
<td>8. Interesting</td>
</tr>
<tr>
<td></td>
<td>9. Material</td>
</tr>
<tr>
<td></td>
<td>10. Stimulating</td>
</tr>
<tr>
<td></td>
<td>11. Enhance education and positive view of sufferers</td>
</tr>
<tr>
<td></td>
<td>12. Programme had an impact on own behaviour/future behaviour</td>
</tr>
<tr>
<td>2. Negative aspects of the programme</td>
<td>1. Practical issues related to loss of books</td>
</tr>
<tr>
<td></td>
<td>2. Disruption in flow due to loss of books</td>
</tr>
<tr>
<td></td>
<td>3. Shyness</td>
</tr>
<tr>
<td></td>
<td>4. Sensitive topics</td>
</tr>
<tr>
<td></td>
<td>5. Difficult language</td>
</tr>
<tr>
<td></td>
<td>6. Unco-operative learners</td>
</tr>
<tr>
<td>3. Completed the programme</td>
<td></td>
</tr>
<tr>
<td>4. Should continue the programme in the future</td>
<td></td>
</tr>
<tr>
<td>5. Implementation of the programme</td>
<td>1. Should be interactive</td>
</tr>
<tr>
<td></td>
<td>2. Teacher as facilitator</td>
</tr>
<tr>
<td></td>
<td>3. Preference for same sex facilitator</td>
</tr>
<tr>
<td></td>
<td>4. Preference related to sensitive issue</td>
</tr>
<tr>
<td></td>
<td>5. Gender not important for males</td>
</tr>
<tr>
<td></td>
<td>6. Preference for non-familiar facilitator</td>
</tr>
<tr>
<td></td>
<td>7. Preference for familiar facilitator</td>
</tr>
<tr>
<td></td>
<td>8. Use of external speakers</td>
</tr>
</tbody>
</table>
Perceptions regarding the programme were generally positive in nature. Verbatim responses included: “I enjoyed it”, “It was enjoyable”, “It was fun and interesting”, “And it was better that schoolwork”, and “Dit was interessant” (It was interesting). Some of these positive feelings stem from the experience of two schools where workbooks were lost, and learners were asked to share their books. This led to greater interaction, group-work and sharing. Responses included the following: “Like we were all having discussions… and it was so funny we had a… we had a… And it was better than school work” and “Almal sit hulle idees by mekaar” (Everyone put their ideas together).

The positive feelings expressed by learners with regards to a more interactive approach is not surprising since research shows that participatory methods work best with young people (Mugabe, 2001). Participatory methods such as group work, exercises and role plays facilitate a more interactive approach (Aggleton & Rivers, 1993), which this particular age group enjoys.

Most of the learners felt that they had learnt something from the programme. The learners felt that they learnt more about the virus, to be more careful and to be more aware of risky behaviours. Verbatim responses included: “Om meer versigtiger te wees” (To be safer), “Niemand ander se bloed met joune meng nie” (Not mix anyone else’s blood with yours), “Ons het geleer hoe kry jy dit” (We learnt how you get it) and “There were things that I didn’t know that I know now”.

<table>
<thead>
<tr>
<th>6. Previous education</th>
<th>1. Programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Literature</td>
<td></td>
</tr>
<tr>
<td>3. Mother</td>
<td></td>
</tr>
<tr>
<td>4. Doctor</td>
<td></td>
</tr>
<tr>
<td>5. Television</td>
<td></td>
</tr>
</tbody>
</table>
Other positive feelings towards the programme were that the learners agreed with the facilitator that the content was relevant, valuable, stimulating and preventative. Responses related to prevention included the following: “I do think it will help people to know what goes on in your bodies” and “People will be more aware”.

The positive feeling expressed by learners towards the programme as well as the general feeling that the programme had increased their previous knowledge regarding HIV/AIDS can be explained in terms of the social cognitive theory as outlined in Chapter five. As mentioned, prevention programmes that aim to enhance motivation, reinforce risk reduction and self-efficacy should integrate information and attitudinal change (King, 1999) as this programme has clearly done with learners expressing a positive attitude towards, and acquired knowledge of, the information presented in the programme.

Regarding the gender of the presenter, all of the female learners felt that they would be more comfortable with a female presenter. This they attributed to their experience of hearing a male talking about the female parts of the body and their discomfort in this regard. They felt that females were easier to talk to. In response to the facilitators question regarding their need for a female presenter, female learners responded by saying: “Omdat ons oor vroudele praat” (Because we talk about women’s body parts). Their response to having a male presenter included: “Embarrassment, it was like- okay. It was like weird cause they were talking about us females and..”. Other verbatim responses included: “Dit sou makliker wees as dit ‘n vrou was” (It would be easier if it was a woman). The male learners felt that they would have preferred a male presenter for the same reasons. Responses included: “Want as mens daai snaakse woorde
met die juffrou moet praat en …”. (Because if people use those strange words with a
teacher and…). However, there were a few male learners who felt that having a male or
female presenter didn’t make any difference to them.

Most of the learners felt that having a presenter that was known to them,
especially a teacher would be a better choice since they are more comfortable with their
teachers. Responses included: “Because we are comfortable- we are with her everyday
basically and we know her- I don’t know we feel more comfortable I guess- otherwise if
with a stranger we will be all shy”, “Ja (Yes) and we would not want to ask any
questions- anything” and “Ja- ek sal ongemaklik voel om met die persoon te praat
daaroor- dit sal ongemaklik wees om met die persoon te praat oor die virus want ons is
nou gewoond om met die Juffrou te praat oor die virus” (Yes- I will feel uncomfortable to
speak to the person about it- it will be uncomfortable to speak to the person about the
virus because we are now used to speaking to the teacher about the virus). The
participants did however, feel that in order to combat the lack of seriousness by some of
their classmates regarding the programme and its content, a non-familiar presenter should
be used. One participant said that: “Ek sal miskien luister na die persoon (unfamiliar
person) wat ons kan vertel, want daar is kinders wat nie wil luister in die klas nie dan sal
hulle meer luister” (Maybe I will listen to the person that can tell us, because there are
children that won’t listen in the class then they will listen more). In addition, to this there
were learners who felt that they may have been more comfortable with an unfamiliar
presenter with one learner reporting that: “jy voel meer gemaklik as jy daai een nie ken
nie” (You feel more comfortable if you don’t know that person).
The interest expressed by the learners in whether the presenter of the programme is known or unknown, male or female, can be explained in terms of their particular age of sexual development as outlined in Chapter four. According to Van Dyk (2001), this stage of development is characterised by an increased interest in sex and sexual relations. Therefore, the emphasis placed on the kind of presenter by the learners indicates their eagerness in wanting to discuss this topic under the best of conditions where no barriers exist. For example, for the female learners a male presenter presents a barrier to open discussions and the same applies to the male learners.

Learners reported that their initial sources of information or education regarding HIV/AIDS included: programmes presented by guidance teachers; literature; their mothers or both their parents; the doctor; or the television. Verbatim responses included: “Met my ouers gepraat maar ek het ook baie boek gelees oor dit” (Spoke to my parents but I also read a lot of books about it); and “Last year we had…guidance or something but we did not have a booklet or anything”.

During this stage of social development learners readily acquire prejudice through modelling and imitation especially from their parents and teachers (Lievegoed, 1997; Van Dyk, 2001). Therefore, because information obtained from these previous sources could be laden with stereotypes and prejudice, prevention programmes should aim to reduce prejudice towards HIV/AIDS and HIV+ people. The implications for parents and teachers are that they should be more aware of their own behaviours and attitudes since they convey prejudice which children easily acquire through learning.
Learners’ discussions with others regarding HIV/AIDS

Table 7.5 introduces this general theme that is discussion of HIV/AIDS with others, by presenting the related sub-themes as well as specific aspects related to these sub-themes that emerged when learners were asked whom they had discussed HIV/AIDS with.

Table 7.5

Main theme: Learners’ discussions with others regarding HIV/AIDS

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Specific aspects of sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Parents (yes)</td>
<td>1. Mother</td>
</tr>
<tr>
<td></td>
<td>2. Father</td>
</tr>
<tr>
<td>2. No-one</td>
<td>1. Embarrassed</td>
</tr>
<tr>
<td></td>
<td>2. Shy</td>
</tr>
<tr>
<td>3. Teachers</td>
<td>1. Facilitators</td>
</tr>
<tr>
<td></td>
<td>2. Other teachers</td>
</tr>
<tr>
<td>4. Friends</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>5. Siblings</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>6. Reasons for discussions</td>
<td>1. Material stimulates discussions</td>
</tr>
<tr>
<td></td>
<td>2. Urge to learn</td>
</tr>
<tr>
<td></td>
<td>3. Shared experience</td>
</tr>
<tr>
<td></td>
<td>4. Discussions important in prevention</td>
</tr>
<tr>
<td></td>
<td>5. Discussion important for better treatment of HIV+ people</td>
</tr>
<tr>
<td></td>
<td>6. Responsibility</td>
</tr>
<tr>
<td></td>
<td>7. Teaching friends</td>
</tr>
<tr>
<td></td>
<td>8. Discussions easier after programme</td>
</tr>
<tr>
<td>7. Reasons for not discussing</td>
<td>1. No need</td>
</tr>
<tr>
<td></td>
<td>2. Taboo topic</td>
</tr>
<tr>
<td></td>
<td>3. Fear of idea/topic</td>
</tr>
<tr>
<td></td>
<td>4. Discussion easier after programme</td>
</tr>
<tr>
<td></td>
<td>5. Questions vs. discussions</td>
</tr>
<tr>
<td></td>
<td>6. Regarding transmissions</td>
</tr>
<tr>
<td></td>
<td>7. Parents not able to give answers</td>
</tr>
<tr>
<td></td>
<td>8. Teaching role of students</td>
</tr>
<tr>
<td></td>
<td>9. Parents able to give answers</td>
</tr>
</tbody>
</table>
Most of the learners have held discussions regarding HIV/AIDS with their parents or their teachers, which included both the teachers who facilitated the programme and other teachers. They reported that these were the people they had grown accustomed to talking to about HIV/AIDS. A verbatim response included: “Nie eintlik nie, maar ek het gewoond geraak daaraan”. Some learners could discuss HIV/AIDS with their brothers and sisters, although there were those who felt that this was a remote possibility. The same conflicting feelings were expressed with regards to having discussions with their friends. Some learners reported that they had held discussions with their friends and a larger majority felt that they couldn’t talk about HIV/AIDS to their friends.

It is interesting to note from the results above that most participants felt that they would or have approached their parents and teachers with regards to obtaining information regarding HIV and AIDS. This is contrary to research, which shows that during this stage of social development, peer groups are an important feature (Van Dyk, 2001). Therefore, because this particular age group is characterised by an interest in sex, and because the participants reported being most comfortable talking to their parents, it reinforces the suggestion made by Van Dyk (2001) that parents should be careful with regards to their reaction when children approach them for information. A negative response from their parents could lead children of this age to look to their peer group who, despite some advantages, are also a source of misinformation and myths (Van Dyk, 2001).

Many of the learners felt that having discussions about HIV and AIDS was important for prevention. Verbatim responses included: “I do think that it will help
people to know what goes on in your body”; “People will be more aware”; and “It
must make a difference”. There is also the belief among learners that relaying
information about HIV/AIDS could lead to the better treatment of HIV + people. One
learner responded by saying: “Baie mense- hulle werk nou reg met HIV-met mense
wat HIV het nie- hulle is soort van bangerig vir die mense. En nou dat hulle weet hoe
kry- hoe kan jy dit kry sal hulle meer vriendeliker wees teenoor die mense wat HIV
het” (Many people- they are now working right with HIV- with people that don’t
have HIV- they are kind of scared of these people. And now that they know how you
get it- how you get it they will be friendlier towards people that have HIV).

The concern for the better treatment of HIV + people can be explained in terms of
the learners’ stage of cognitive development which is characterised by a move away
from an egocentric way of thinking, as they begin to grasp the concept of treating
others the way that you would like to be treated (Van Dyk, 2001). In addition,
according to the HBM, this concern for HIV + people forms an important part of
“cues to action”, a health belief necessary to bring about changes in behaviour
(Perloff, 2001).

Learners felt that the materials in the programme stimulated discussions, urged
them to learn and led to a shared experience between learners which facilitated
discussions. They also felt that as a result of being in the programme, they had a
teaching role to play and that they would now teach their parents and their friends
about HIV/AIDS, because they found it much easier after having been through the
programme. One learners responded by saying that: “Dit is baie maklik nou om te
praat van die Life Skills wat ons geleer het met my vriende- dan verstaan- ons wil vir
hulle ook sê wat ons geleer het dan kan hulle ook leer- dan verstaan hulle ook meer” (It is very easy to talk about the Life Skills that we learnt with our friends- then understand- we want to tell them as well what we learnt then they can also learn- then they understand more). The responses above can be viewed as a significant positive outcome of the HIV/AIDS programme, in that according to the social cognitive theory, the programme has clearly enhanced motivation as a result of an integration of information and attitude change (Perloff, 2001).

Learners reported that some of the obstacles that they experienced in speaking to others (especially their parents) about HIV/AIDS were that they weren’t allowed to use the words sex and HIV/AIDS because it was a taboo subject. Verbatim responses included: “Jy mag nie dit sê nie- soos seks” (You cannot say it- like sex) and “We hardly ever talk about HIV and AIDS”. Other obstacles included the fact that participants felt that they were just too embarrassed and shy to ask any questions about HIV/AIDS; or because they feared the topic of HIV/AIDS. However, the programme seemed to have spurred them on in terms of approaching people especially their parents since discussions seemed easier to them after the programme. One learner responded by saying: “Ja, dit was makliker vir my- ek weet nou nie van die anders nie- vir my was dit beter” (Yes, it was easier for me- I am not so sure about the others- It was better for me). When approaching their parents many felt that their parents were able to provide them with answers, whereas some learners felt that their parents were unable to provide them with answers.

The reluctance to talk about HIV and AIDS can be explained in terms of available research. Research shows that because HIV and AIDS are the result of acts which
include sex and drug use, and because adults find it difficult to believe that young people are capable of engaging in these activities, they refuse to talk to young people about sex and drugs (AIDSAction, 2001). Therefore, it can be assumed that the inability of parents to answer questions related to HIV/AIDS could either be related to that they just don’t know or because of their reluctance to talk about it. Both these possibilities are barriers for young people in terms of preventative HIV/AIDS education and access to information and advice regarding sex (UNAIDS, 2002).

**Learners’ knowledge of HIV/AIDS**

Table 7.6 outlines this general theme, that is knowledge regarding HIV/AIDS, as well as the related sub-themes that emerged when learners were asked to discuss the high-risk behaviours that place people at risk of HIV infection and how one could protect oneself from it.

Table 7.6

**Main theme: Learners’ knowledge of HIV/AIDS**

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Specific aspects of sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Causes</td>
<td>1. Unprotected sex</td>
</tr>
<tr>
<td></td>
<td>2. Expired condom</td>
</tr>
<tr>
<td></td>
<td>3. Sleep with HIV+ person</td>
</tr>
<tr>
<td></td>
<td>4. Blood transfusions</td>
</tr>
<tr>
<td></td>
<td>5. Contact with infected blood</td>
</tr>
<tr>
<td></td>
<td>6. Promiscuity</td>
</tr>
<tr>
<td></td>
<td>7. Sharing needles</td>
</tr>
<tr>
<td></td>
<td>8. Mother to child</td>
</tr>
<tr>
<td></td>
<td>9. Rape victims</td>
</tr>
<tr>
<td></td>
<td>10. Drink saliva</td>
</tr>
<tr>
<td>2. Non-causes</td>
<td>1. Sharing cups</td>
</tr>
<tr>
<td></td>
<td>2. Living with HIV+ person</td>
</tr>
<tr>
<td></td>
<td>3. Kissing</td>
</tr>
</tbody>
</table>
The learners appeared to be quite knowledgeable regarding the causes of HIV/AIDS and how the disease cannot be spread. Knowledge of known causes included: unprotected sex; using an expired condoms; sleeping with HIV+ person; blood transfusions; having contact with infected blood; promiscuity; sharing needles; mother to child transmission; through rape; drinking large quantities of saliva.

It was clear from their responses that most of the learners had acquired sufficient knowledge about the disease to identify risky behaviour. According to the ARRM as outlined in Chapter five, people change behaviour according to three stages, that is behaviour labelling; commitment to change; and taking action (King, 1999; Perloff, 2001). Learners through their acquisition of knowledge are able to identify risk behaviours. The programme also takes the learners through the second stage of behaviour change by influencing their decisions to reduce risk in the course of the teaching module, which looks at decision-making.

The ability to identify high-risk behaviours coupled with the learners’ stage of cognitive development, sees them moving towards the ability for logical thinking. This works well with the TRA, which postulates that people think through the consequences of their behaviour reasonably (logical) before action is taken (King, 1999; Perloff, 2001). Therefore, the programme has equipped learners’ in terms of providing relevant
information about high-risk behaviours which they could apply when making decisions to reduce risk.

The participant’s knowledge of the myths regarding HIV included: sharing cups; living with an HIV+ person; kissing; using the same bathwater; using the same toilets as someone who is HIV+ positive.

The learners’ responses regarding the myths about HIV, reveals that they are knowledgeable in this regard. As mentioned in Chapter four, people in this stage of cognitive development are susceptible to the acquisition of myths. Therefore, their knowledge of what does not put people at risk of HIV infection can be viewed as a positive outcome of the HIV/AIDS programme since it was able to eradicate existing myths regarding HIV transmission (Van Dyk, 2001). In addition, sexual development in this particular age group is characterised by the ability to understand the transmission of HIV. Therefore, their knowledge of transmission confirms existing research regarding this ability (Van Dyk, 2001). According to Svenson, et al (1997) and UNAIDS (2002), children who engage in sex at this age do so without the necessary information to protect themselves. Therefore, the programme has hopefully countered this fact by providing them with the necessary information to reduce high-risk behaviours.

**Learners’ contact with HIV+ people and perceptions of their own risk of HIV infection**

The learners were asked to discuss whether they knew anyone who was HIV+ and whether it was possible for people their own age to get infected with HIV. Table 7.7 outlines their responses in terms of the related sub-themes as well as the specific aspects related to the sub-themes that emerged.
Table 7.7

Main theme: Learners’ contact with HIV+ people and perceptions of their own risk of HIV infection

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Specific aspects of sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Contact with HIV+ person</td>
<td>1. Knows someone</td>
</tr>
<tr>
<td></td>
<td>2. Doesn’t know someone</td>
</tr>
<tr>
<td>2. Physical evidence of being HIV+ or having AIDS</td>
<td>1. None</td>
</tr>
<tr>
<td></td>
<td>2. Later with other diseases</td>
</tr>
<tr>
<td></td>
<td>3. Death from diseases</td>
</tr>
<tr>
<td></td>
<td>4. Signs of AIDS include weight loss and sores</td>
</tr>
<tr>
<td>3. Learners own infection possible</td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td>2. Yes</td>
</tr>
<tr>
<td>4. Supportive attitude towards HIV+ people</td>
<td></td>
</tr>
<tr>
<td>5. Lack of knowledge of difference between HIV and AIDS</td>
<td></td>
</tr>
<tr>
<td>6. Feelings related to HIV infection</td>
<td>1. Fear of having contracted HIV already</td>
</tr>
<tr>
<td></td>
<td>2. No fear for family</td>
</tr>
</tbody>
</table>

Most of the learners in the focus groups did not have contact with HIV + people. Some learners, however, did report that they had contact with someone they suspected of being HIV +. One learner responded by saying: “I don’t know somebody but I know of someone”.

Research indicates that the learners’ stage of cognitive development is characterised by a greater compassion for HIV + people, which is largely due to their contact with HIV + people (Van Dyk, 2001). However, the learners of this particular study reported having no contact with HIV + people. Therefore, their compassion could be due to their stage of moral development, which includes knowing how they themselves would like to be treated.
The learners seemed to be well educated, realising that there are very little visible signs to suggest that someone is HIV+. Verbatim response included: “Ja (Yes), so you won’t know exactly when they have AIDS”; and “Jy kan nie sien wanneer iemand die siekte het nie-wanneer jy die siekte optel gaan jy nie sommer onmiddelik sien jy het hom nie-die mense gaan nie sien nie” (You cannot see when someone has the virus-when you get infected you cannot see immediately that you have it-people cannot see). They are also aware that these individuals do become very ill after a while and that they do not die from AIDS but from other diseases. Responses included: “Jy sien eers later” (You only see it later) and “Oor ‘n paar jaar wanneer jy ouer word” (In a few years when you are older). Learners were also knowledgeable about the visible signs that do exist of full blown AIDS, such as: weight loss and sores.

The fact that the learners are able to understand that there is a time lapse between HIV infection and AIDS, is characteristic of this age group’s stage of cognitive development, which includes the ability for abstract thinking (Gerdes, 1998; Van Dyk; 2001). In addition, the ability for abstract thinking enables them to understand that even though there are no visible signs of HIV, a person can still be infectious. This is due in part to the fact that learners are able to make judgements that are not based on what they see but on the consequences of their own reasoning. This reasoning involves the understanding that people engage in high-risk behaviours and therefore place themselves at risk of HIV infection (Gerdes, 1998; Van Dyk, 2001).

The programme appeared to generate a supportive attitude towards HIV+ people, with some learners having an existing positive view of HIV+ people due to previous sources of information. Verbatim responses included: “They should just try to support
them” and “Ek was nog altyd positief want ek het baie gelees oor mense wat die virus opgetel het” (I was always positive because I read a lot about people that were infected with the virus).

The concern of learners regarding the treatment of HIV + people and their support for the use of prevention programmes to reduce the maltreatment of HIV + people, is expected of their particular stage of moral and cognitive development. During this stage of development, learner’s judge behaviour on the basis of whether it is right or wrong, good or bad, and are more aware of the way that they themselves would like to be treated (Van Dyk, 2001). In other words, learners have begun to realise that the way that HIV+ people are treated is wrong and that prevention could help in terms of decreasing the existing negative treatment of, and negative attitude exist towards HIV + people. In addition, the concern of learners for HIV + people can be explained in terms of the HBM. According to this model changes in behaviour require beliefs, i.e., a belief in the perceived severity and consequences of the health threat (Perloff, 2001). The learners, through their expression of concern, demonstrated their understanding of the perceived severity in terms of the fact that one’s AIDS status results in ostracism from society, an idea that they do not condone. As a result of this ostracism they are able to see the hardship of someone who is diagnosed with HIV. Therefore, learners do possess the belief of perceived severity, which is important for behaviour change.

Learners did express a fear regarding the possibility that they could have contracted HIV already (“n bietjie bang want miskien het jy dit lankal”) (A little scared because maybe you have contracted it already), but no fear existed for family members. The fear of HIV/AIDS as expressed by the learners is characteristic of their particular stage of
emotional development in that fears, which were vague and imagined, become more concrete. These fears, which they acquire through the media and discussions, tend to be relevant to the times in which young people live (Van Dyk, 2001). Therefore, it is not surprising that the learners have expressed a fear of HIV/AIDS. Although this fear existed it was interesting to note that the topic related to the learners’ own risk of infection was hardly mentioned with just one yes and one no related to this topic. Besides these two instances, participants from the focus groups did not reveal this as a sub-theme of concern. Therefore, it appears that learners did not feel that their age group was susceptible to HIV infection.

This inability of learners to see their own vulnerability to HIV infection, can be explained in terms of their emotional development. Although fears at this stage become more concrete, young people at this stage of development still have difficulty with distinguishing between fact and reality. Learners are aware that people in the 15-25 year age are particularly vulnerable to HIV infection. They also see AIDS as something concrete which they fear, but they do not accept it as a part of their own subjective reality as yet. In addition, research shows that the adolescent stage is characterised by a sense of invincibility, which together with their misconception and misinformation about AIDS, explains their risk to HIV infection (Livingston, 1992 in Umeh, 1997). Therefore, learners pass from a stage where they are unable to see their own risk of infection to a stage of invincibility. So, young people still present the best option to encourage a belief of perceived susceptibility amongst their peers, (a belief which according to the HBM is necessary for behavioural change) (King, 1999; Perloff, 2001). This finding is consistent with the findings of Flischer’s (2001) findings, which revealed that these prevention
programmes had no effects in terms of enhancing perceived susceptibility in participants. Flischer’s findings were however, not clear as to why this phenomenon existed. However, this is an interesting finding which requires further investigation.

**Learners’ perceptions of the role of adults for future and recommendations regarding future prevention**

Table 7.8 below introduces this general theme, that is, the role of adults in the future and recommendations, by presenting the related sub-themes as well as specific aspects related to the sub-themes that emerged when learners were asked to discuss what others, especially adults, can do that would work better at reducing the spread of HIV.

Table 7.8

**Main theme: Learners’ perceptions of the role of adults in future prevention and recommendations regarding future prevention**

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Specific aspects of sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Schools educational role</td>
<td>1. Sharing information</td>
</tr>
<tr>
<td></td>
<td>2. Through workshops</td>
</tr>
<tr>
<td>2. Church educational role</td>
<td></td>
</tr>
<tr>
<td>3. Treatment of HIV+ people</td>
<td>1. Send them away</td>
</tr>
<tr>
<td></td>
<td>2. Accept them</td>
</tr>
<tr>
<td>4. Ages to educate</td>
<td>1. Younger ones not preferable</td>
</tr>
<tr>
<td></td>
<td>2. Adapt for younger learners</td>
</tr>
<tr>
<td></td>
<td>3. High school learners should be educated</td>
</tr>
<tr>
<td>5. Parents should be more open</td>
<td></td>
</tr>
<tr>
<td>6. Recommendations</td>
<td>1. Education at hospitals</td>
</tr>
<tr>
<td></td>
<td>2. Contact with HIV+ people</td>
</tr>
<tr>
<td></td>
<td>3. HIV+ people as speakers</td>
</tr>
<tr>
<td></td>
<td>4. Person who cut himself should be sent to</td>
</tr>
<tr>
<td></td>
<td>the office and teacher should wear gloves</td>
</tr>
</tbody>
</table>
The general feeling was that schools could play a role in reducing the spread of HIV/AIDS by sharing information and holding workshops. Verbatim responses included: “Tell all the people about it” and “Workshop with people”. It was also felt that the church could play a role in prevention: “Praat van die pulpit en ook om mense meer in te lig” (Talk from the pulpit and also to inform people more).

The perception of learners regarding the role of schools in prevention is consistent with research which suggests that schools present the best setting for reaching millions of school children worldwide (Bunde-Birouste & Jones, 1993; Dunn, Ross, Caines, & Howorth, 1998). In addition, the perception of learners regarding the role of schools could be related to their earlier responses regarding whom they have had discussions with regarding HIV/AIDS. Next to their parents, participants felt most comfortable talking to their own teachers regarding this sensitive topic and preferred them to unknown presenters. Research indicates that since children have little or no access to primary health care, schools can provide this service (Dick, et al., 1993). It is clear that next to their own parents, young people see their teachers and the school as their source of information regarding HIV/AIDS and sex.

Some learners reported that their parents could be more open in discussing HIV/AIDS as well as sex and that their role in HIV/AIDS prevention should be, “Talking about it”. Learners also felt that their parents were “too protective” when it came to the subject of sex and HIV and AIDS. This phenomenon was explained earlier in terms of the difficulty that adults have in accepting that children have sex and use drugs, and therefore, explains their lack of openness with regards to these topics (Svenson, et al., 1997).
Regarding the recommendations about the age of the target group in prevention programmes, many learners felt that younger children should not be exposed to the programme since they “wouldn’t understand”, that “they must be mature enough to understand” or they would just become “worried”. There were those however, who felt that if they were to target these age groups that changes should be made in the programme since younger children wouldn’t understand some of the content. Verbatim responses included: “Kinders van voorskool moet ook eintlik al meer ingelig word van die virus” (Children in pre-primary school must actually already be more informed about the virus); “Die kinders van standerd een sal nie als verstaan nie-waaroor die onderwyser praat nie-dan moet hulle-die program sal moet makliker wees vir hulle om te verstaan” (The children in standard one will not understand everything-that the teacher talks about-then they must-the program must be made easier for them to understand). The learners seemed to have reached a consensus on the fact that older children should be targeted (high school). Their reason was that learners’ belief that the older age group are most at risk of contracting the virus. One participant said that: “Hoërskool, want die kinders van 15 jaar en ouer hulle is die kinders wat nog ingelig moet word oor hoe jy die virus kry want hulle is meestal kinders van 15 jaar en ouer wat die virus optel” (High school, because children 15 years and older are the children that must be more informed about how you can be infected because they are mostly the children 15 years and older who are infected). This reconfirms the fact that the learners do not see AIDS as part of their reality, but view it as part of the reality of older children. In addition, they do not see AIDS as part of the reality of younger children who they fear might be harmed by this
information because they wouldn’t understand it, or because they would become upset.

After experiencing the HIV/AIDS Life Skills programme, learners were in a position to make suggestions and recommendations to enhance the success of the programme in schools. Suggestions for possible improvement for the presentation of the programme included the use of an HIV+ person to present the programme to them or allowing learners to have contact with HIV+ people. Verbatim responses included: “I think they should bring people that is infected with AIDS to tell us more about it” and “Take you to the hospice so that you can learn about this stuff”. In addition, responses from the learners indicated that they enjoyed small group discussions, as this fostered better group interaction and discussions. These recommendations for small group discussions and making use of HIV+ people are consistent with this age group’s interest in learning through participatory methods, as mentioned earlier (Aggleton & River, 1993).

**Summary of research findings**

An analysis of the qualitative data regarding the HIV/AIDS Life Skills programme, as gathered from the focus groups held with grade six and seven learners, revealed six themes. These themes were: learners’ experience of the pre- and post-test questionnaires; learners’ experience of the programme; learners’ discussions with others regarding HIV and AIDS; learners’ knowledge of HIV and AIDS; learners’ contact with HIV+ people and perceptions of their own risk of HIV infection; learners’ perceptions of the role of adults in future prevention and recommendations regarding future prevention.
These themes were consistent across all six focus groups and are therefore all considered relevant for grade six and seven learners although the results cannot be generalised due to methodological limitations. The major research findings of the present study based on the six general themes included the following:

7. Learners’ perceptions of completing the questionnaire were generally positive in nature. Negative perceptions related to practical issues such as the length of the questionnaire and the time of administration.

8. Learner’s perceptions of the programme were generally positive.

9. Learners’ felt more comfortable discussing HIV/AIDS with parents and teachers as opposed to their peers.

10. Learners’ appeared to be well informed about high-risk behaviour related to HIV/AIDS and existing myths.

11. Contact with HIV+ people is non-existent. However, learner’s felt that the programme had fostered positive attitudes towards HIV+ people.

12. Learner’s felt that schools had an important role to play in sharing information about HIV/AIDS.

**Conclusion**

The findings of the data collected from the focus groups were presented in this chapter. The results were important in determining the perceptions of the grade six and seven learners with regards to the HIV/AIDS Life Skills programme.
The last chapter focuses on the conclusions reached about this study, which are based on the results presented in this chapter. The limitations of the study are discussed and recommendations are made based on the major findings of this study.
CHAPTER EIGHT
CONCLUSION AND RECOMMENDATIONS

Introduction
HIV and AIDS continue to have devastating effects on countries worldwide, affecting people from all walks of life. The need for effective prevention programmes aimed at young people, as outlined in Chapter four and five, are seen as the only means by which to curtail its growing impact. The present investigation into the perceptions of grade six and seven learners with regards to an HIV/AIDS Life Skills programme, forms part of the pilot phase of a larger project, which aims to present an HIV/AIDS Life Skills programme to young people in South Africa.

This final chapter of the present study firstly outlines the conclusions based upon the research findings of Chapter seven. Certain limitations in conducting the present study and the interpretation of the data must also be documented, as they influence suggestions for future studies. These limitations are therefore included and is followed by the recommendations for future research.

Research findings and conclusions
It must be noted that the results of this study are exploratory in nature, and not conclusive, and should be regarded as such throughout the following discussion. The conclusions are based on the research findings of the present study and include the applicability of the theories mentioned in Chapter four and five to the findings.
The theories as outlined in Chapter four and five were useful in providing a framework for analysing the focus group data. Due to this framework, meaningful data analysis was possible. The developmental theories provided the means for conceptualising the responses of the learners as they relate to their specific developmental age. The social cognitive and TRA together with the HBM and the ARRM were useful in conceptualising the learners’ statements as it relates to whether the programme had covered all the necessary aspects to bring about behavioural change in this particular age group. Most of the findings confirm the applicability of the developmental theories mentioned in Chapter four in understanding the learners’ perceptions as they relate to the HIV/AIDS Life Skills programme. The theories and models as outlined in Chapter five, coupled with the learners’ responses to the focus group interview questions indicate that a few aspects were lacking in this programme to bring about the required behavioural change. Learners’ responses regarding anticipated behavioural change in the future were very limited. However, aspects necessary to construct a foundation for behavioural change were present.

**Main themes and conclusions**

Some prominent themes emerged from this investigation. It seems as though the learners’ perception of the questionnaire was generally positive in nature. Negative perceptions related to practical issues such as the length of the questionnaire, time of administration and not having enough space to write answers. However, an important issue related to the questionnaire that warrants attention, included the language usage in the questionnaire which learners perceived as being difficult to understand. A positive outcome for the
HIV/AIDS Life Skills programme was that learners found it easier to complete the second questionnaire because they had learnt from the HIV/AIDS Life Skills programme.

The general perceptions regarding the HIV/AIDS education programme were positive. Of particular interest was the fact that learners felt that they had acquired knowledge regarding HIV/AIDS, that the programme had enhanced a positive view of HIV + people, and that they believed that it would impact their behaviour or lead to future changes in their behaviours.

Learners felt more comfortable discussing HIV/AIDS with their parents and their teachers. Friends and siblings received ambiguous responses when the same questions were addressed to learners.

Learners appeared to be well-informed regarding the causes and non-causes of HIV. This information in turn has provided insight into their ability to identify high-risk behaviours and their knowledge of existing myths regarding HIV transmission.

Learners appeared to have limited contact with HIV+ people. However, a positive outcome of the programme is the generally positive attitude that learners have towards HIV+ people as well as their perception that prevention programmes are the means by which to facilitate this positive attitude in others.

Most learners felt that the school had an important role to play in the presentation of the programme. The role of schools included sharing information regarding the disease and providing opportunities to hold workshops at the school to discuss HIV/AIDS.
Conclusions about the developmental theories

The developmental theories provided a useful framework, to contextualise the responses of learners in the focus groups. According to Piaget’s cognitive development theory (1971, in Gerdes, 1988), learners’ concern for HIV+ people, their knowledge of myths and their understanding of the time lapse between HIV infection and full blown AIDS can be understood in terms of their cognitive development. These findings also present important conclusions for prevention programmes. Learners at this stage of development are susceptible to myths and their concern for HIV+ people presents a starting point for prevention programmes in terms of reducing or eliminating the development of myths and reducing the prevalence of high-risk behaviours. In addition, the learners’ concern for HIV+ people could be explained in terms of their moral development, which involves an awareness of treating others the way they would like to be treated.

The social development of the learners made it possible to contextualise their responses to previous sources of information. Learners’ responses highlighted a concern for the development of prejudice. Prejudice is generally learnt through the sources stated by the learners, which included the media and discussions (Van Dyk, 2001). Therefore, prevention programmes have an important role to play in terms of reducing these prejudice, especially those towards HIV+ people. The key people that learners felt most comfortable asking about HIV/AIDS were their parents and their teachers. This, as mentioned, runs contrary to theory related to the social development of this particular age group, which states that the peers play an important role (Van Dyk, 2001). This finding could be used to encourage prevention programmes at schools run by teachers.
The theory of sexual development was used to explain learners’ recommendations regarding the use of known, gender specific presenters. This was explained in terms of their growing interest in sex and a need to ensure the best conditions for them to comfortably discuss this topic. Therefore, these recommendations need to be considered for future implementation of the programme.

The theory of emotional development as it relates to the learners was used to explain their fear of HIV/AIDS and the denial of their own susceptibility to HIV infection. Prevention programmes should therefore capitalize on their fear of potential HIV transmission and eradicating irrational fears that exist about HIV/AIDS.

**Conclusions about the theories and models used in prevention programmes**

The models and theories that were introduced in Chapter five presented a useful framework for understanding the impact of the programme on the learners on the basis of the learners’ responses in the focus groups. The social cognitive theory was useful in understanding the learners’ positive perception of the programme and the increase in knowledge they perceived. According to this theory the integration of knowledge and a change in attitude is necessary for behaviour change (King, 1999; Perloff, 2001).

The learners’ concern for HIV+ people plays an important role in the HBM. According to this theory behaviour change depends on a number of beliefs. Two beliefs which emerged from the concern express by learners include: the cue to action, which is brought about by contact with someone ill or seeing someone die; and the belief of perceived severity, which involves the perceived seriousness of the disease and the impact on one’s life (King, 1999; Perloff, 2001). Therefore, prevention programmes can do well to reinforce
the positive attitude towards HIV + people by using them as speakers. However, an important belief in this model, that is perceived susceptibility to the disease, which leads to behaviour change was not expressed by the learners.

According to the ARRM, an important stage leading to behavioural change involves labelling high-risk behaviours. Therefore, this model was used to explain learners’ knowledge of high-risk behaviours.

**Limitations of the study**

Certain limitations were noted in conducting the present study and must be documented in order to critically evaluate the study’s conclusions and the research findings on which they are based. These limitations were related to the research approach and methodology.

The disadvantages of the various research methods employed in the present study were discussed in some detail in Chapter six and are therefore not repeated here. However, limitations as a result of the research approach, which were not noted earlier, include:

1. The qualitative research approach only allowed for tentative conclusions, therefore future research may be needed before basing decisions on these conclusions.

2. As the approach is exploratory in nature, there is limited external validity and the findings are thus not generalisable to other populations.

3. There was also no control of extraneous variables within the qualitative research approach. For example, potentially confounding variable such as the backgrounds
of the focus group participants could influence the interpretation of the data gathered from these groups.

4. The use of the conveniently sampled six schools in the focus groups raises a question regarding whether data generation had reached saturation point.

**Recommendations for future research**

It is very difficult to make recommendations based on the qualitative nature of the study since the strengths of a qualitative study are also the weaknesses of that study. The major strength of this study is in its qualitative nature. In utilising a small-scale exploratory qualitative approach it is possible to obtain an in-depth view into the internal, emotional processes of the learners as it relates to the programme. Ironically, the major weaknesses of this study also lies in its qualitative nature as outlined above. However, recommendations can be made that the selection of participants for the focus groups be done according to random sample selection, thus making it possible to generalise the findings obtained. In addition, the number of focus groups utilised should not be limited and should instead be guided by the theoretical concept of data saturation (De Vos, 1998).

**Recommendation made by learners for the HIV/AIDS Life Skills programme**

The learners made some important recommendations that should be considered for the future implementation of the HIV/AIDS Life Skills programme. These included: revising the language usage in the questionnaires; the use of gender specific presenters; using presenters that are known to the learners, consider using HIV+ people as speakers during
the programme and the use of more interactive methods in presenting the programme such as role-plays and group-work activities.
REFERENCES


http://www.thebody.com/aac/youth_prev/chapter1.htm


De la Harpe, Elkonin, Seymour, Venter. In process.


Morgan, D. (2002). HIV-1 infection in rural Africa: is there a difference in median time to AIDS and survival compared with that in industrial countries? AIDS, 16 (4), 597-603.


National Institutes of Health, National Institute for Allergy and Infectious Disease (NIAID). (September 1995). A brief history of the emergence of AIDS: the relationship


BIBLIOGRAPHY


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APPENDIX A

FOCUS GROUP INTERVIEW SCHEDULE

Briefly explain purpose of interview.

Ask permission to make recording.

Emphasise confidentiality.

Ask permission to continue.

**Question 1:** Could you share with the group what you thought about filling out the questionnaire both the first and the second times?

**Question 2:** How did you experience the HIV/AIDS education intervention and education programmes as run by the teachers?

**Question 3:** Should teachers tell you about HIV/AIDS or someone else?

**Question 4:** How old do you think children should be they are taught about HIV/AIDS?

**Question 5:** With who have you discussed HIV/AIDS?

**Question 6:** Do you know anyone who has HIV/AIDS?

**Question 7:** Do you know what puts people at risk for HIV/AIDS?

**Question 8:** What are your attitudes now towards HIV/AIDS issues after having been through the programme?

**Question 9:** Do you have any suggestions for making the programme better?

Thank learners for their co-operation.
## THEMES, SUB-THEMES AND CODING UNITS

Main theme: Learner’s experience of completing the questionnaires

<table>
<thead>
<tr>
<th>Theme and sub-themes</th>
<th>Coding unit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The questionnaire itself</strong></td>
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</tr>
<tr>
<td>Easily understood</td>
<td>#B1, 2, 3; #C1; #E1, 39; #F1, 1b, 7</td>
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<tr>
<td>Difficult</td>
<td></td>
</tr>
<tr>
<td>Language</td>
<td>#D3; #E33, 36; #F3</td>
</tr>
<tr>
<td>To answer</td>
<td>#A1; #D6; #F37</td>
</tr>
<tr>
<td>Length was too long</td>
<td></td>
</tr>
<tr>
<td>Confusion with regards to repetition</td>
<td>#C68; #D11, 12; #F8, 8a, 8b</td>
</tr>
<tr>
<td>Too little space for answers</td>
<td>#C6</td>
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<tr>
<td>No recommendations</td>
<td>#B4</td>
</tr>
<tr>
<td><strong>Content of the questionnaire</strong></td>
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<tr>
<td>Lacking in areas (no suggestions)</td>
<td>#F24</td>
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<tr>
<td>Comfortable</td>
<td>#E2, 3</td>
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<tr>
<td>Scary, strange</td>
<td>#A2, 3</td>
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<tr>
<td>Relevant</td>
<td>#F23, 25</td>
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<td><strong>Anonymity</strong></td>
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<td>Positive</td>
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<tr>
<td>Negative</td>
<td>#F4b</td>
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<tr>
<td><strong>Procedure</strong></td>
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</tr>
<tr>
<td>Administration time (in morning)</td>
<td>#F9</td>
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<tr>
<td>Rushed</td>
<td>#D11, 12</td>
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<tr>
<td><strong>Feelings</strong></td>
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</tr>
<tr>
<td>Nervousness</td>
<td>#D1</td>
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<tr>
<td><strong>Pre-test to post-test</strong></td>
<td></td>
</tr>
<tr>
<td>Knowledge acquisition</td>
<td>#C70; #D7; #E38</td>
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Main theme: Learner’s experience of the programme

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<td>Positive attitudes</td>
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<tr>
<td>User friendly</td>
<td>#F12</td>
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<tr>
<td>Interaction/groupwork/sharing</td>
<td>#A8, 9, 10, 44, 45; #D24</td>
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<td>Enjoyment</td>
<td>#A11; #D21, 22, 23, 24; #E29, 31, 34, 42</td>
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<td>Learning process</td>
<td>#A12, 13; #B5; #C3, 49; #E6b, 28, 30, 32, 35, 40, 41; #F11</td>
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<td>Relevant content</td>
<td>#D26, 40; #E8</td>
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<td>Valuable</td>
<td>#B7a, 8, 28; #F7</td>
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<tr>
<td>Preventative</td>
<td>#C48, 49</td>
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<td>Interesting</td>
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<tr>
<td>Material</td>
<td>#B10; #D38, 39</td>
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<tr>
<td>Stimulating</td>
<td>#D34</td>
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<tr>
<td>Enhance education and positive view of sufferers</td>
<td>#C57, 58</td>
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<tr>
<td>Programme had an impact on own behaviour/future behaviour</td>
<td>#A31; #E26</td>
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<tr>
<td>Negative aspects</td>
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<tr>
<td>Practical issues</td>
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</tr>
<tr>
<td>Loss of books</td>
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<td>Disruption in flow</td>
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<td>Shyness</td>
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<td>Sensitive topics (body parts)</td>
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<tr>
<td>Difficult language</td>
<td>#D25, 27</td>
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<tr>
<td>Unco-operative learners</td>
<td>#C59</td>
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<tr>
<td>Completed the programme</td>
<td>#B9; #E5</td>
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<td>Should continue in the future</td>
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<td>Implementation of the programme</td>
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<td>Interactive</td>
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<tr>
<td>Facilitator</td>
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<tr>
<td>Teacher</td>
<td>#C70, 73; #F14</td>
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<tr>
<td>Preference for same sex</td>
<td>#C74; #D16, 17; #F15, 16, 21, 22</td>
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<td>Sensitive issue</td>
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<td>Gender not important for males</td>
<td>#F75,77</td>
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<td>Preference for non-familiar facilitator</td>
<td>#C69, 71; #F18, 19</td>
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<td>Preference for familiar facilitator</td>
<td>#C72; #D18, 19, 20</td>
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<tr>
<td>External speakers</td>
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<td>Previous education</td>
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<td>Programmes</td>
<td>#D37</td>
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<tr>
<td>Literature</td>
<td>#C8</td>
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<tr>
<td>Mother</td>
<td>#B26</td>
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<td>Doctor</td>
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<td>Television</td>
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Main theme: Learners’ discussions with others regarding HIV/AIDS

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<td>Mother</td>
<td>#A19; #D28; #F27</td>
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<tr>
<td>Father</td>
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<tr>
<td>No-one</td>
<td>#D30; #E18</td>
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<td>Embarrassed</td>
<td>#E19</td>
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<td>Shy</td>
<td>#C15</td>
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<tr>
<td>Grow accustomed</td>
<td>#C13, 14</td>
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<tr>
<td>Teachers</td>
<td></td>
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<tr>
<td>Facilitators</td>
<td>#A14b; #E10</td>
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<tr>
<td>Other teachers</td>
<td>#A14c</td>
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<tr>
<td>Friends</td>
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<td>#A18; #B11; #F32</td>
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<td>No</td>
<td>#B14a, 14b, 15; #D41, 42; #E13</td>
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<td>Siblings</td>
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<td>Yes</td>
<td>#A8; #B19, 20, 23</td>
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<td>No</td>
<td>#C65; #D45; #E13</td>
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<td>Material stimulate discussions</td>
<td>#A15</td>
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<td>Urge to learn</td>
<td>#A16</td>
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<td>Shared experience</td>
<td>#A17</td>
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<td>Discussions important in prevention</td>
<td>#A21, 22; #B20, 21; #C17, 19, 37; #D46, 48; #E16</td>
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<td>Discussion important for better treatment of sufferers</td>
<td>#C18; #D47</td>
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<td>Responsibility</td>
<td>#E17</td>
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<td>Teaching friends</td>
<td>#F33, 48, 49</td>
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<td>Discussion easier after programme</td>
<td>#C67; #F26, 30</td>
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<td>Reasons not discussing</td>
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<tr>
<td>No need</td>
<td>#A20</td>
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<td>Taboo topic</td>
<td>#C16; #D43, 44; #F34</td>
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<td>Fear of idea/topic</td>
<td>#B43</td>
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<td>Questions vs. discussions</td>
<td>#B16</td>
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<tr>
<td>Regarding transmissions</td>
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<tr>
<td>Parents not able to give answers</td>
<td>#E12</td>
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<tr>
<td>Teaching role of students</td>
<td>#B17; #E15; #F47, 50</td>
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<td>Parents able to give answers</td>
<td>#D32, 33; #C11, 12</td>
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Main theme: Learner’s knowledge of HIV/AIDS

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<tr>
<td><strong>Causes</strong></td>
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<td>Unprotected sex</td>
<td>#A25,26; #C20; #D63; #E23</td>
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<tr>
<td>Expired condom</td>
<td>#C40, 41</td>
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<td>Sleep with HIV+ person</td>
<td>#E24</td>
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<td>Blood transfusions</td>
<td>#D58; #E22</td>
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<td>Contact with infected blood</td>
<td>#A24; #B6, 7, 39; #C21; #D60; #E25;#F44</td>
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<td>Promiscuity</td>
<td>#B24; #F13</td>
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<td>Sharing needles</td>
<td>#C22; #D57, 61; #F43</td>
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<td>Mother to child</td>
<td>#C23; #D59</td>
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<tr>
<td>Rape victims</td>
<td>#C36</td>
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<tr>
<td>Drink saliva</td>
<td>#B36</td>
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<tr>
<td><strong>Non-causes</strong></td>
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<tr>
<td>Sharing cups</td>
<td>#C26; #F45</td>
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<td>Living with HIV+ person</td>
<td>#F46</td>
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<td>Kissing</td>
<td>#B37; #C24; #D63</td>
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<td>Same bathwater</td>
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<td>Using the same toilets</td>
<td>#C25</td>
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<td>Prevented by wearing gloves</td>
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<tr>
<td>Ability to say no to unprotected sex in important</td>
<td>#C38</td>
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Main theme: Learners’ contact with HIV+ people and perceptions of their own risk of HIV infection

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<tr>
<td>Knows someone</td>
<td>#B34; 35; #D51, 52; 53</td>
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<tr>
<td>Doesn’t know someone</td>
<td>#A23; #C27, 35; #D49; #E20, 21; #F36</td>
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<td>Physical evidence of being HIV+ or having AIDS</td>
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<tr>
<td>None</td>
<td>#C28; #D55; #F37</td>
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<tr>
<td>Later with other diseases</td>
<td>#C29; #D56; #F38</td>
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<tr>
<td>Death from diseases</td>
<td>#C33</td>
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<td>Signs:</td>
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<tr>
<td>Weight loss</td>
<td>#C30, 32; #F39</td>
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<td>Sores</td>
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<td>Learners own infection possible</td>
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<td>No</td>
<td>#F40</td>
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<tr>
<td>Yes</td>
<td>#C34</td>
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<td>Supportive attitude towards HIV+ people</td>
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<tr>
<td>Lack of knowledge of difference between HIV and AIDS</td>
<td>#C55, 56, 62, 63; #D50</td>
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<td>Fear of having contracted HIV already</td>
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<td>No fear for family</td>
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Main theme: Learners’ perceptions of the role of adults in future prevention/recommendations regarding future prevention

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<td>Schools educational role</td>
<td>#C42, 43; #D66</td>
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<tr>
<td>Sharing information</td>
<td>#D67</td>
</tr>
<tr>
<td>Through workshops</td>
<td>#D68</td>
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<tr>
<td>Church educational role</td>
<td>#C47</td>
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<td>Recommendations</td>
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<tr>
<td>Treatment of sufferers</td>
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<tr>
<td>Send them away</td>
<td>#C45, 46</td>
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<tr>
<td>Accept them</td>
<td>#C44</td>
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<tr>
<td>Ages to educate</td>
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<tr>
<td>Younger ones not preferable</td>
<td>#D69, 70, 71, 72</td>
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<tr>
<td>Adapt for younger learners</td>
<td>#C52, 53, 54</td>
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<tr>
<td>High school learners should be educated</td>
<td>#C51</td>
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<tr>
<td>Parents should be more open</td>
<td>#D73, 74</td>
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<tr>
<td>Education at hospitals</td>
<td>#A27</td>
</tr>
<tr>
<td>Contact with HIV+ people</td>
<td>#A28</td>
</tr>
<tr>
<td>HIV+ people as speakers</td>
<td>#A29, 30</td>
</tr>
<tr>
<td>Person who cut himself should be sent to the office and teacher should wear gloves</td>
<td>#D65</td>
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APPENDIX D

COVERING LETTER EXPLAINING THE PROPOSED RESEARCH STUDY SENT TO SCHOOLS

20 November 2001

The Principal

Dear Sir/Madam

Re: PEM Health/ Department of Education- Lifeskills, AIDS/HIV Pilot Project

As you are aware the above pilot project is in the final stage of this year, with much of the research testing being completed. However, there is still one task remaining.

This task involves running one focus group per school in 12 randomly selected schools. The schools and the pupils have been randomly selected from the total sample and a list of these selected pupils is attached, as is a list of the dates and times for the focus groups. Each group will consist of 12 learners, an intern/psychologist and a co-facilitator, thus a suitable quiet venue would be required for this small group to meet. If possible this should be private and allow for no interruptions.

The purpose of the focus group is to gather information from the pupils themselves in a confidential group setting. We are fortunate to have registered psychologists or intern psychologists who are trained in group interviewing skills assisting us on the project. Three of these are Xhosa speaking. The information gained from these groups will add valuable information to the research data.

These schedules have been discussed with Mr. Spies. Should you require any additional information please contact Mr. Spies at the Department of Education on 5023041, for any issues relating to process of testing. For any issues relating to the scheduling of testing times, please contact Mrs. Marian Neale-Shutte (Research Coordinator) on 5042833, or Mr. Francois Potgieter (Senior Researcher with the Health and Development Research Institute at UPE) on 5042344.

Thank you for your cooperation in this valuable and exciting venture.

Yours sincerely

Mrs. Marian Neale-Shutte    Mr. Francois Potgieter
Research Coordinator    Senior Researcher- Health and Development Research Institute
Dear Mrs. de la Harpe/ Ms. T. Kemp

RE: Coding

Herewith please find the attached transcriptions of focus groups conducted in November 2001. The focus groups were arranged to explore the perceptions of grade six and seven learners with regards to the HIV/AIDS Life Skills Education Programme.

The data analysis is being conducted using Tesch’s approach. It would be greatly appreciated if you would act as my independent coder in this regard, as you are yourself a research psychologist familiar with qualitative research.

I am available at Cell: 083 979 5911 should you have any further queries.

Thank you for your time.

Kind Regards,

Ms. Z. Julies
Intern Counselling Psychologist
APPENDIX F

HIV/AIDS LIFESKILLS PROJECT FOCUS GROUP SCHEDULE 8-9

NOVEMBER

<table>
<thead>
<tr>
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<td>11am</td>
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