THE PERCEPTIONS OF GRADE EIGHT AND NINE LEARNERS OF A LIFE SKILLS PROGRAMME ON HIV/AIDS, SEXUALLY TRANSMITTED INFECTIONS, RAPE AND CHILD ABUSE

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Co-supervisor: Mr F. Potgieter
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To my parents and grandmother for their support, encouragement, guidance and security needed to complete my studies.
DEDICATION

I dedicate this study to my exemplary mother, Marie Lambert, whose love and support has given me the courage to follow my dreams.
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ABSTRACT

Worldwide millions of children are victims of neglect and physical and mental harm, including sexual abuse and exploitation. South Africa, however, is widely believed to have not only one of the highest incidences of rape in the world, but also one of the highest levels of Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) transmission. With research findings showing that HIV and other Sexually Transmitted Infections (STIs) are rapidly increasing globally, young people are, and continue to be, at the forefront of the AIDS pandemic. Therefore, it is suggested that prevention programmes should be aimed particularly at the young. Schools have specifically been recognized as the setting for preventative Life Skills Programmes, having the potential to reach billions of children worldwide. The aim of this study is to explore and describe the perceptions of grade eight and nine learners with regard to the Life Skills Programme that focuses on HIV/AIDS and STI's, rape and child abuse 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 sample of four schools was selected. Focus groups, utilising an unstructured interview, were used to gather qualitative data on the learners' perceptions of the Life Skills Programme. The focus groups consisted of 10 - 12 grade eight and nine learners who were selected using simple random sampling. The data was thematically analysed using Tesch's approach.
The major findings of the present study, based on the six general themes, include the following:

1. Most of the learners perceived the educators, as well as the teaching methods utilised by the educators, positively.

2. Although the learners perceived the presenters of the Life Skills Programme positively, it was suggested that teachers, health care professionals, family members and peers should be involved in presenting the Life Skills Programme.

3. Learners reported various levels of comfort discussing different topics presented in the Life Skills Programme.

4. Learners of all the schools perceived the Life Skills Programme to be very relevant.

5. Learners recommended that more children, especially children from deprived communities, should be included in the programme. In addition, learners felt that counselling services should be available in conjunction with the Life Skills Programme.

6. Differences were noted in completing the first and the second questionnaire. Learners reported that they felt more comfortable completing the second questionnaire. They perceived the interviewing process positively.

**Keywords:** HIV/AIDS, STIs, Rape, Child Abuse, Life Skills Programmes
CHAPTER ONE

INTRODUCTION

1.1 General Overview

In 1979, the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) arrived on the world scene without any warning (Van Dyk, 2001). Never before, in the history of the human race, has one disease presented so many challenges to the world's scientists and health care professionals. In the past twenty years more people have died from AIDS, than from any other disease in history (Barks-Ruggles, 2001). To date, 25 years after the onset of HIV/AIDS, there is still no cure.

Although there are many means of contracting HIV/AIDS, the predominant method is that of sexual intercourse. HIV and other Sexually Transmitted Infections (STIs) are rapidly spreading around the world (AVERT, 2003). The African continent, its Sub-Saharan region in particular, is identified as having the highest incidence of HIV/AIDS and other STIs in the world (UNAIDS, 2003; Van Dyk, 2001; Whiteside & Sunter, 2001).

Research has indicated that the subgroup of the population at greatest risk of contracting HIV/AIDS and other STIs, are young people. Between 70 and 80% of new infections occur among people aged 15 to 25 years. This group's vulnerability is partly due to their developmental stage, which is characterized by a sexual awakening, a heightened sensitivity to peer relations and a sense of invincibility (Hall, 2001). These characteristics and other reasons affecting the vulnerability of this group, will be developed in later chapters. Other factors, such as the cleansing myth belief that sex with
a virgin cures HIV/AIDS and other STIs, not only places young people at risk of infection, but is a powerful factor contributing to the high incidence of child abuse in South Africa (Earl–Taylor, 2004; Italo, 2003; Simmons, 2001; Sylvester, 2003).

Although child abuse is a worldwide phenomenon, South Africa has been identified as the country with the highest incidence of child abuse in the world (Bower, 2002). In addition to the cleansing myth, the dominant forces of poverty, patriarchy, racism and a culture of violence, together with the disempowerment of children in South Africa, create a fertile ground for all types of abuse to flourish (De Grandpre, 1997). Like HIV/AIDS and other STIs, rape and child abuse is a reality for many South African children.

Education has been identified as one of the primary means of prevention (Asmal, 2001; Baldo, Metcalfe & Barttes, 1993; Van Dyk, 2001) and plays an integral part in the campaign to combat HIV/AIDS/STIs, rape and child abuse. Schools have been identified as an ideal way to reach young people in implementing education programmes (Dunn, Ross, Caines, & Howorth, 1998). South Africa has approximately 28 000 schools and 12 million learners making this environment an ideal one for educational programmes (Garson, 2004). Although various school-based intervention programmes have been implemented in South Africa, little is known about the effectiveness of child abuse prevention initiatives (James, 1994; Melton & Flood, 1994; Chalk & King, 1998) or HIV/AIDS prevention initiatives (The World Bank, 2002). Therefore, programme evaluation is an important area for preventative campaigns to address.
1.2 Problem Formulation

Ubuntu Education Fund is an international organisation which aims at uplifting impoverished communities and underprivileged children. One of their projects involves educating children about HIV/AIDS/STIs, rape and child abuse. In order to reach this objective, Ubuntu Education Fund developed a Life Skills Programme, trained health educators and implemented this programme in five primary and five secondary schools in Port Elizabeth.

This study forms part of a bigger research project, which aimed to evaluate the Ubuntu Education Fund's Life Skills Programme on HIV/AIDS/STIs, rape and child abuse. It consisted of assessing the knowledge of the learners prior to the learning intervention (pre-test) and a follow up assessment of the acquired knowledge (post-test). In addition, it qualitatively explored the learner's perceptions of the syllabus and the method utilized by the facilitators to convey the knowledge.

The aim of the present study was to explore and describe the perceptions of learners from the secondary schools specifically the grade eight and nine learners, of a Life Skills Project on HIV/AIDS/STIs, child abuse and rape education.

1.3 Outline of Chapters

Chapter Two provides definitions and descriptions of Sexually Transmitted Infections (STIs), the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS). In addition, it develops an understanding of these diseases, by providing global statistical information, with specific focus on the situation in Sub-Saharan Africa, narrowing the attention to South Africa, the Eastern Cape, and finally,
Port Elizabeth. The impact of these diseases at various levels is briefly discussed. Finally, it will be explained why adolescents are identified as one of the sub groups in the population, with the highest risk of infection.

Chapter Three focuses on child abuse and rape. Definitions of these concepts are provided, and the incidence of child abuse and rape are briefly shown in the global, and highlighted in the South African context. Furthermore, an understanding of the aetiology of child abuse, focusing on the macrosystemic, microsystemic and personal levels, are provided. The chapter is concluded by examining the effects of child abuse on the abused.

Chapter Four focuses on education aiming towards the prevention of HIV/AIDS/STIs, rape and child abuse. Theories related to designing an educational programme are presented. Life Skills programmes within the school context are discussed, and the importance of programme evaluation is established.

Chapter Five outlines the methodology followed for the present study. The research methodology has been divided into the following categories; the research design, participants and the sampling procedure employed, the data gathering method used, the research procedure followed, and the data analysis, to present a more thorough overview of the employed methodology.

The results of the data collected in this study are presented and discussed in Chapter Six.

Finally, Chapter Seven contains the conclusion and evaluation of the present study as well as recommendations for future research.
CHAPTER TWO
HIV/AIDS/STIs

2.1 Introduction
This chapter focuses on definitions and descriptions of the Human Immunodeficiency Virus (HIV), the Acquired Immune Deficiency Syndrome (AIDS) and other Sexually Transmitted Infections (STIs). Although these three medical conditions appear to be separate, they are in fact intimately entwined and collectively present one of the greatest medical threats known to humankind. In addition, this chapter will highlight the incidences of these diseases globally, with a specific focus on the situation in Sub-Saharan Africa and South Africa. Finally, adolescents will be identified as one of the populations with the highest risk of infection.

2.2 Sexual Transmitted Infections (STIs)
Sexually Transmitted Infections (STIs), otherwise known as Sexually Transmitted Diseases (STDs), or by their old name, Venereal Diseases (VDs), are transmitted through body contact during sex, and are caused by viruses, bacteria and parasites. There are at least 25 different sexually transmitted diseases, which are spread by sexual contact, namely vaginal, anal and oral sex. Therefore, anyone who is sexually active, is at risk of contracting STIs (Hills-Jones & Fredriksson-Bass, 2004; WHO, 2004).

Some STIs can have symptoms, such as a genital discharge, pain when urinating and genital swelling and inflammation. However, many STIs, such as Chlamydia, can sometimes be symptomless for long periods of time. During this time a person may pass on infections to sexual partners (Hills-Jones & Fredriksson-Bass, 2004; WHO, 2004).
Table 1 provides a comparison of the most prevalent STIs, illustrating the symptoms, modes of transmission and possible effects of each.

**Sexually Transmitted Infections (Sexual Health, 2004).**

<table>
<thead>
<tr>
<th>SEXUALLY TRANSMITTED INFECTIONS</th>
<th>STI</th>
<th>Symptoms</th>
<th>Transmission</th>
<th>Concerns</th>
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</thead>
<tbody>
<tr>
<td><strong>AIDS</strong>&lt;br&gt;(Acquired Immune Deficiency Syndrome)</td>
<td>• Several months or years after contact with HIV:&lt;br&gt;• Chronic flu-like feelings.&lt;br&gt;• Unexplained weight loss.&lt;br&gt;• Diarrhoea.&lt;br&gt;• White spots in mouth (thrush).&lt;br&gt;• Opportunistic infections leading to death.</td>
<td>• Sharing intravenous needles.&lt;br&gt;• Anal sex, sexual intercourse and possibly oral sex with someone who has AIDS or is carrying the AIDS virus, known as Human Immunodeficiency Virus (HIV).&lt;br&gt;• Exchange of body fluids.</td>
<td>• AIDS can be passed on to the sexual partner(s) or someone who shares an IV needle.&lt;br&gt;• AIDS can not be cured. Even if treated it is still fatal.&lt;br&gt;• Mother with HIV can infect her baby peri-natally and peri-natally.</td>
<td></td>
</tr>
<tr>
<td><strong>Chlamydia</strong></td>
<td>• Seven to 21 days after sex with infected partner:&lt;br&gt;• Most women and some men have no symptoms.&lt;br&gt;• Discharge from vagina; or watery, white drip from penis.&lt;br&gt;• Bleeding from vagina between periods; or burning pain upon urination.</td>
<td>• Sexual intercourse, oral sex, or anal sex with someone who has chlamydia.</td>
<td>• Chlamydia can be given to a sexual partner(s).&lt;br&gt;• Can lead to more serious infection.&lt;br&gt;• Reproductive organs can be damaged.&lt;br&gt;• Both women and men may become infertile.&lt;br&gt;• Mother with chlamydia can infect her baby peri-natally.</td>
<td></td>
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</table>
| **Genital Warts**  
(venereal warts) | **Pain in abdomen, sometimes with fever and nausea.** | **One to 6 months after sex with infected partner:**  
- Small, bumpy warts on sex organs and anus.  
- The warts do not go away.  
- Itching or burning around sex organs. | **Sexual intercourse, oral sex and anal sex with someone who has genital warts.** | **Genital warts can be given to a sexual partner(s).**  
- More warts grow and are harder to eradicate.  
- Mother with warts can give them to her baby peri-natally.  
- May lead to pre-cancerous conditions. |
|---|---|---|---|---|
| **Gonorrhea** | **About 21 days after sex with infected partner:**  
- Most women, and many men, have no symptoms.  
- Thick yellow or white discharge from vagina; or drip from penis.  
- Burning or pain upon urination or bowel movement.  
- More pain than usual during menstruation.  
- Cramps and pain in lower | **Sexual intercourse, oral sex or anal sex with someone who has gonorrhoea.** | **Gonorrhoea can be given to a sexual partner(s).**  
- Can lead to more serious infection.  
- Reproductive organs can be damaged.  
- Both men and women may become infertile.  
- Mother with gonorrhoea can infect her baby peri-natally.  
- Can cause heart problems, skin disease, arthritis, blindness. |
<table>
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<tr>
<th><strong>Herpes</strong></th>
<th></th>
<th><strong>Herpes</strong> can be given to a sexual partner(s).</th>
<th><strong>Herpes can not be cured.</strong></th>
<th><strong>Mother with herpes can infect her baby peri-natally.</strong></th>
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<tr>
<td></td>
<td></td>
<td>Sexual intercourse, oral sex, or anal sex with someone who has herpes.</td>
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<td></td>
<td></td>
<td>Sexual intercourse, oral sex, or anal sex with someone who has herpes.</td>
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<tr>
<td></td>
<td></td>
<td>Both men and women are effected by NGU.</td>
<td></td>
<td>NGU can be given to a sexual partner(s).</td>
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<td></td>
<td></td>
<td>Up to 1 to 3 weeks after sex with an infected partner:</td>
<td></td>
<td>Can lead to more serious infections.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Most women, and some men, have no symptoms.</td>
<td></td>
<td>Reproductive organs can be damaged</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yellow or white drip from penis; discharge or burning in vagina.</td>
<td></td>
<td>Both men and women may be rendered infertile.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Burning or pain upon</td>
<td></td>
<td>Mother with NGU infection can infect peri-natally.</td>
</tr>
</tbody>
</table>

**Herpes**

- Two to 30 days after sex with infected partner:
  - Some people have no symptoms.
  - Flu-like feelings.
  - Small, painful blisters on sex organs or mouth.
  - Itching or burning before the blisters appear.
  - Blisters last 1 to 3 weeks.
  - Blisters go away, but can recur. Herpes remains present but inactive.

---

**NGU (nongonococcal or nonspecific urethritis, NSU)**

- Both men and women are effected by NGU.
- Up to 1 to 3 weeks after sex with an infected partner:
  - Most women, and some men, have no symptoms.
  - Yellow or white drip from penis; discharge or burning in vagina.
  - Burning or pain upon

---

**Herpes**

- Sexual intercourse, oral sex, or anal sex with someone who has herpes.
- Sexual intercourse, oral sex, or anal sex with someone who has NGU infection.

---

**Herpes**

- NGU can be given to a sexual partner(s).
<table>
<thead>
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<th><strong>Syphilis</strong></th>
<th>1st STAGE:</th>
<th>2nd STAGE:</th>
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<tr>
<td>• Urination.</td>
<td>• One to 12 weeks after sex with an infected partner:</td>
<td>• Six weeks to 6 months after sore appears:</td>
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<td></td>
<td>• Painless, reddish-brown sore on mouth or sex organs.</td>
<td>• Rash appears anywhere on the body.</td>
</tr>
<tr>
<td></td>
<td>• Sore lasts 1 to 5 weeks.</td>
<td>• Flu-like feelings.</td>
</tr>
<tr>
<td></td>
<td>• Sore heals, but syphilis virus remains dormant.</td>
<td>• Rash and flu-like feelings go away, but you still have syphilis.</td>
</tr>
<tr>
<td></td>
<td>• Sexual intercourse, oral sex, or anal sex with someone who has syphilis.</td>
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<tr>
<td></td>
<td>• Syphilis can be given to a sexual partner(s).</td>
<td>• Pregnancy, antibiotics, birth control pills, menstruation, diabetes, can lead to vaginitis.</td>
</tr>
<tr>
<td></td>
<td>• Mother with syphilis can infect her baby peri-natally.</td>
<td>• Can be spread during sexual intercourse, oral or anal sex.</td>
</tr>
<tr>
<td></td>
<td>• Can cause heart disease, brain damage, blindness, and death.</td>
<td>• Vaginitis infections can be given to a sexual partner(s).</td>
</tr>
<tr>
<td></td>
<td>• Vaginitis infections can be given to a sexual partner(s).</td>
<td>• Uncomfortable symptoms will continue.</td>
</tr>
<tr>
<td></td>
<td>• Men can get infections in the prostate gland.</td>
<td>• Men can get infections in the prostate gland.</td>
</tr>
</tbody>
</table>
2.2.1 Incidence of Curable STIs

With no single body collating worldwide STI data, the exact magnitude of infections globally is unknown. However, it is thought that countries tend to underestimate the total number of new cases substantially because many people are thought to avoid health care systems due to the social stigma that can surround infection. Furthermore, many cases are not reported, either because they are asymptomatic or have nonspecific symptoms (WHO, 2004).

Infection rates can vary enormously between countries in the same region, and between urban and rural population. The World Health Organisation (WHO) has released documents stating estimated prevalence rates of STIs across global regions. It is estimated that 340 million new cases of STIs occurred worldwide in 2000 (WHO, 2004). Furthermore, it is estimated that the largest number of new infections occurred in the region of South and Southeast Asia, followed by Sub-Saharan Africa, Latin America and the Caribbean. The highest rate of new cases per 1000 population occurred in Sub-Saharan Africa (WHO, 2004).

2.2.2 Impact of STIs

The effects of the most common STIs were summarised in Table 1. As STIs are often untreated and unrecognised, they can result in adverse consequences, ranging from stigmatisation, to infertility, and death. In particular:

- STIs disproportionately affect women, having symptoms that are either less noticeable or non-existent, while their complications can be more severe. The
complications that women with STIs, can incur, include chronic pelvic pain, ectopic pregnancies and cervical cancer.

- STIs are associated with 40% of global infertility. In some cultures and societies, infertile women are divorced or even forced into commercial sex work.
- Left untreated, STIs can be transmitted to infants, causing death or serious health conditions such as blindness or pneumonia.
- STIs increase three to six times the risk of HIV transmission through sex.

(Frahn, 2004).

STIs are a major public health problem, not only because of the morbidity of acute illness, but because they have serious consequences and facilitate the transmission of HIV (WHO, 2004). The next section of this chapter will focus on HIV, being the most well-known STI.

2.3 Human Immunodeficiency Virus (HIV)

HIV stands for Human Immunodeficiency Virus. It is a retrovirus related to the human T-cell viruses (HTLV) and to retroviruses that infect animals (Kaplan & Sadock, 1998). 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 illnesses (Crewe, 1992).

The Human Immuno Deficiency virus (HIV) uses the genetic material (DNA) of other cells to replicate. In doing so, HIV breaks down the body’s ability to defend itself against infectious diseases, by the destruction of the body's T4 cells, cells that are vital to the body's immune system (Crewe, 1992; NIAID, 2001).
HIV disease progression is lengthy, as HIV is a slow acting virus with a long incubation period (Belman, 1992). Usually, only after three to seven years, enough HIV is produced to destroy immunity cells to the degree that immune-deficiency occurs (Evian, 1993). The infected person moves through the following stages:

Initially HIV is drawn to the tissue of the lymphatic system, where T4 cells are most prevalent. There is an increase in viral components in the body, and a decrease in T4 cells. Although infected individuals may not present any symptoms immediately after infection, they are infectious to others (NIAID, 1998). However, during this stage some individuals may begin to experience some flu-like symptoms a month or two after infection. These symptoms include fever, headaches, and enlarged lymph nodes.

As the immune system becomes more compromised, the symptoms begin to accumulate. These symptoms include a lack of energy, weight loss, frequent fevers, sweating, short-term memory loss and persistent skin rashes. Some individuals may develop persistent or frequent oral or vaginal infections, as well as herpes (NIAID, 1998).

The final stage of HIV infection is marked by more severe illnesses and eventually death (CDC, 2002).

2.4 Acquired Immune Deficiency Syndrome (AIDS)

AIDS stands for Acquired Immune Deficiency Syndrome. Van Dyk (2001) explained 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 infections; and syndrome refers to a collection of symptoms that make up a particular condition. Although the term disease is used when referring to AIDS, it is
not a specific illness, but rather a collection of many different conditions that manifest in the body, because the HI virus has weakened the body's immune system. AIDS is, therefore, more accurately defined as a syndrome of opportunistic diseases, infections and certain cancers.

Major symptoms and opportunistic diseases begin to appear as the immune system continues to deteriorate and individuals become AIDS symptomatic. Symptoms include persistent diarrhoea; purple or brown spots on the skin and nervous system impairment, including dementia and memory loss (Cusack & Singh, 1994; Van Dyk, 2001). These symptoms are often accompanied by other opportunistic infections including cancer, pneumonia, myobacteria tuberculosis, recurrent herpes, shingles, thrush and Cytomegalovirus (CMV), to name just a few (Cusack & Singh, 1994; Kaplan & Sadock, 1998; Van Dyk, 2001).

An individual may live for years with HIV and its associated symptoms, but once they become AIDS symptomatic, they usually die within two years from any one of the opportunistic diseases to which they are susceptible (Gilbert, 2001; Van Dyk, 2001).

2.5 HIV Transmission

Although research has shown that HIV is carried in bodily fluids, it has been ascertained that only certain body fluids carry the virus. These body fluids include blood, semen, and cervical and vaginal secretions, and the HIV concentration in these fluids is very high (Kalra, Kohli & Datta, 2000; Van Dyk, 2001). In order for a person to become infected, the virus has to pass, in sufficient quantities, from one person's bloodstream to another (Whiteside & Sunter, 2000).
Transmission of HIV from one person to another occurs in a number of different ways. The virus is primarily transmitted through unprotected vaginal or anal intercourse. Research indicates that about 75 percent of global infections involve heterosexual contact and 25 percent involve homosexual relations between men. The increase in heterosexual transmission has resulted in a sharp increase in infection amongst women. This has resulted in an increase in mother to child transmission pre-, or peri-natally or during breastfeeding (Lachman, 1991; Quinn, 1996; Van Dyk, 2001). In consensual sex in the western world, the average risk of transmission per contact of unprotected receptive anal intercourse with an HIV-positive man is approximately 5%; with unprotected receptive vaginal intercourse this risk is less than 1%. The risk after rape is much greater, especially in the case of multiple penetrations by multiple perpetrators. Dry sex and the presence of other sexually transmitted infections also increases the risk factor, as the occurrence of perineal injury increases (Van As, Withers, Du Toit, Millar & Rode, 2001).

Another main mode of HIV transmission occurs through the inoculation of blood as a means of HIV transmission, including receiving a blood transfusion of infected blood. Sharing a needle with an infected individual and transmission through sharp instruments (eg. body piercing, tattooing, circumcision, or sharing a toothbrush with a person with bleeding gums) is considered to be high risk behaviour. Contact with blood at an accident scene is also considered to be high risk behaviour (Cusack & Singh, 1994).

There are many myths with regards to HIV transmission. HIV cannot be contracted by every day contact with people and is not transmitted through touching, hugging, coughing or sneezing. It is not spread in water, air, or in food, or by sharing cutlery, clothing and toilet seats (Cusack & Singh, 1994; Lachman, 1991; Van Dyk, 2001).
2.6 Incidence of HIV/AIDS

2.6.1 World-Wide Impact

Research findings show that HIV and other STIs are rapidly increasing around the world (AVERT, 2003). In the last twenty years more people have died from AIDS than from any other disease in history (Barks-Ruggles, 2001). The number of people living with HIV/AIDS world-wide is approximately 42 million and AIDS has already killed more than 21 million people worldwide (AVERT, 2003). During 2003, some 5 million people became infected with HIV. It is estimated that about 95% of the global total of people with HIV, live in the developing world. The proportion is set to grow even further as the infection rates continue to rise in countries where poverty, poor health care systems and limited resources for prevention and care, fuel the spread of the virus. The following table illustrates the HIV prevalence rates in 2003.

Table 2


<table>
<thead>
<tr>
<th>Region</th>
<th>Adult Prevalence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>7.5-8.5%</td>
</tr>
<tr>
<td>North Africa &amp; Middle East</td>
<td>0.2-0.4%</td>
</tr>
<tr>
<td>South &amp; South East Asia</td>
<td>0.4-0.8%</td>
</tr>
<tr>
<td>Latin America</td>
<td>0.5-0.7%</td>
</tr>
<tr>
<td>Caribbean</td>
<td>1.9-3.1%</td>
</tr>
</tbody>
</table>
What has further become evident is the prevalence of HIV among younger individuals, with 30% of infected individuals being under the age of 24, and the majority of new infections occurring in individuals between 15 and 24 years of age.

Although it is evident that the disease is progressing rapidly, it is still in its early stages. It is estimated that only 10 percent of the illness and death that this epidemic will bring, has been seen (The World Bank, 2000).

2.6.2 Sub-Saharan Africa

Sub-Saharan Africa is the region of the world that is most affected by HIV/AIDS. An estimated 26.6 million people are living with HIV/AIDS in this region and approximately 3.2 million new infections occurred in Sub-Saharan Africa in 2003. Ten million young people (aged 15-24) and almost 3 million children under 15 are living with HIV. An estimated eleven million children have been orphaned by AIDS in Sub-Saharan Africa (AVERT, 2003).

More than 95 percent of all HIV infected people live in developing countries, which, according to WHO, equates to about 36 million people (WHO, 2002). Almost nine tenths of new infections occur in Sub-Saharan Africa (NIAID, 2004), which hosts around 70% of the global total of HIV infected adults and 80% of the infected children.
2.6.3 South Africa

In South Africa, HIV infection has increased significantly over the past few years. There are approximately 5.3 million South Africans living with HIV. An estimated 1,800 people are infected with HIV and 600 die from HIV/AIDS in the country each day (Defending Human Rights Worldwide, 2004). It is estimated that by the year 2005, there will be six million South Africans infected with HIV, and almost one million children under the age of 15 in 2005, will have lost their mothers to AIDS. Currently 250,000 children (aged 0 – 14) in South Africa are infected with HIV (AVERT, 2003). It is estimated that the total South African population in the absence of HIV/AIDS would have numbered about 61 million by 2015, the total population is now expected to grow to only about 49 million (Health Systems Trust, 2004).

With regard to the provinces, it should be noted that HIV/AIDS will have a differential demographic impact on the various provinces. KwaZulu-Natal, the province with the highest provincial HIV prevalence, is expected to experience the highest number of annual AIDS-related deaths. The provinces with the largest populations, namely Gauteng and the Eastern Cape, will follow KwaZulu-Natal with the number of AIDS related deaths. The impact of HIV/AIDS will be particularly high in the age groups between 15 and 49 years. In KwaZulu-Natal approximately 350 000, and in Gauteng about 500 000 people, in the 15 to 49 year age group, will have died of AIDS-related diseases by 2006 (Health Systems Trust, 2004).

In the Eastern Cape, the prevalence rate of HIV infection has progressively increased, and is now at 29.9% (Defending Human Rights World Wide, 2004). Although, when compared to other provinces in the country, the HIV rates are not as high, the Eastern
Cape is the poorest province and access to health care is the most inefficient. This factor is further complicated by an inadequate welfare system and the lack of social security safety nets (Dispelling the AIDS myths, 2002).

In Port Elizabeth, HIV infection is growing exponentially. A comparison has been made, illustrating that in 2000, Port Elizabeth already had more HIV positive, laboratory confirmed cases than the whole of Australia and New Zealand combined (Pailman, 2001).

From these statistics it is evident that the HIV positive population is continuing to increase, as is the number of AIDS related deaths and these are expected to rise substantially for many more years. This will inevitably impact on the economic and social development of the country (Whiteside & Sunter, 2000). The impact of HIV/AIDS will be discussed briefly.

### 2.7 The Impact of HIV/AIDS

Since its first appearance, the accumulative effect of HIV/AIDS has grown steadily more severe. At a macro level, this impact is slower in surfacing. Inevitably the cumulative weight of death and illness, will lead to long-term social and economic consequences which are becoming, or will, in the near future, become more evident.

#### 2.7.1 Economy

Any increase in death and illness will inevitably have an impact on the economic development of the country (Whiteside & Sunter, 2000). The severity of the impact on the economy of the country will depend on how much money is diverted from savings to
care, and on how important the infected people are, in terms of national production. Half of all new infections are in individuals under 25 years of age (Meldrum, 2002). This implicates a large portion of the active work force, rendering them incapable of contributing productively to the economy. According to Whiteside and Sunter (2000), if the infection rate becomes higher among the economically active part of the population, the economy could be affected in the several ways, such as:

- A loss of skills.
- An increase in training and replacement costs.
- A loss of productivity due to absenteeism, illness and funerals.
- An increase in payments by medical schemes, resulting in a unit labour cost increase.
- An increase in remuneration and replacement costs.
- A low tax income for the government, which is worsened by an increase in health care spending.
- Smaller savings, resulting in a higher inflation rate.
- A loss of income to families, leading to more poverty.

AIDS is draining human resources at an increasing rate, and in the process, ruining the capacities on which the future of sustainable development depends (Meldrum, 2002).

2.7.2 Health

Research indicates that the health sector will be more severely impacted than any other sector of the economy (Kinghorn & Steinberg, 1999). Health care for HIV/AIDS patients includes basic treatment for managing quality of life as well as hospitalisation for
acute and terminal cases. With more people requiring hospitalisation, the quality of care provided by health systems is reduced. Some developing countries have 50-80% of their hospital beds in urban areas occupied by HIV patients (The World Bank, 2000). Often there may be a shortage of beds, and consequently people are admitted to hospitals only in the later stages of the disease, which then reduces the effectiveness of the treatment. The result is that individuals with HIV/AIDS need to be cared for at home, which places pressure on the family systems and on the community. It is clear that the health care system lacks the infrastructure to deal with the consequences of the disease on such a large scale.

Health care systems have become stretched to capacity, as they not only have to deal with an increase in the numbers of HIV patients, but also with the rising cases of the most common opportunistic infections associated with AIDS, and the effect of the disease on their own system, in the form of the loss of health personnel to death and illness (The World Bank, 2000).

2.7.3 Education

Education is also affected by the HIV/AIDS pandemic. There is a decrease in formal education due to the increasing dual pressures on children to financially provide for the family, particularly in child headed families, as well as to care for sick individuals. The education system is further compromised by a loss of educators to AIDS related illnesses, as many educators are themselves ill or caring for affected family members. This results in a decrease in the quality of education provided, as educators are unable to function optimally. According to Coombe (2000), unless preventative measures succeed, school
effectiveness will decline to a point where 30% to 40% of teachers and school officials will be ill, demoralised and unable to concentrate on teaching and learning. The general decline in the quality of education is particularly concerning, as education effects the way communities respond to HIV/AIDS.

2.7.4 Effect on the Family

There has been insufficient research on the impact of HIV/AIDS on households in South Africa (Kelly, Parker & Gelb, 2002; Whiteside & Sunter, 2000), but it is presumed that HIV/AIDS will impact on families at various levels.

After diagnosis with HIV, individuals have to deal with the psychological distress of dealing with chronic illness, not only personally, but for their partner, and perhaps their children too. Adjustment to the HIV diagnosis is wrought with the guilt, anger, fear and self-blame of spreading the illness to another, feelings of isolation and discrimination, and feelings of the loss of normality (Belman, Ultmann, Hhoroupian, Novick, Spiro, Rubinstein, Kurtzberg, & Cone-Wesson, 1985).

Problems within the individual and family systems range from medical conditions to psycho-social problems. Following the initial emotional trauma experienced after diagnosis with HIV/AIDS, the infected individual begins to suffer on a physical level, as his/her body is weakened in its ability to fight off opportunistic diseases. As they weaken, damage also extends to neurological and neuropsychological impairment. The infected individual's family is then impacted financially, as it often loses its primary income earner. In addition, the earning capacities of the caretakers are reduced, as they spend time caring for the affected individuals, instead of working (Moore, 2001).
As individuals become more ill, the structure and behaviour of the family system changes, as it is placed under pressure to take over the roles usually undertaken by the sick individual. The increase in the number of orphans may cause more children to leave school in order to survive financially, usually by way of child labour or commercial sex work (Whiteside & Sunter, 2000).

In addition, high levels of fear and prejudice cause family systems to be excommunicated from their communities, when it becomes known that a family member has been diagnosed with or has died of an AIDS related illness. The prejudice, discrimination and rejection associated with the disease, are sometimes even more difficult to cope with than the disease itself (Evian, 1993).

2.8 High – Risk Groups for HIV/AIDS/STIs

Although anyone can contract HIV/AIDS/STIs, irrespective of race, age, gender or class, research indicates that certain groups are more affected than others and can therefore be identified as high-risk groups. Women, low-income earners, homosexuals, intravenous drug users, sexual abuse survivors, babies born from mothers who are HIV-positive, and promiscuous heterosexual individuals, are all classified as high risk groups. According to various authors, young people are also regarded as a high risk group for HIV/AIDS/STIs (Halperin, 1999; Mati, 1996, Whitside & Sunter, 2000).

As HIV infection rates rise in the general population, new infections are increasingly concentrating in younger age groups. Young people are, and continue to be, at the forefront of the AIDS pandemic (Clark, 2002; Marcus, 2001) as half of new, daily infections are among this group (UNAIDS, 2003). When considering the incubation period between HIV infection and the onset of AIDS, i.e., nearly 10 years, the high
incidence of AIDS in 20-29 year olds can be attributed to infection during their adolescent years (Svenson, Carmel & Varnhagen, 1997).

2.8.1 The Vulnerability of Adolescents to HIV/AIDS/STIs

Adolescence begins with the onset of puberty and roughly ends with graduation from high school or approximately 18 years of age. According to Gerdes (1998), adolescence falls within the age range of 13 and 18 years. However, the term "young people" is often used when referring to people between the ages 10 and 24 (WHO, 2002).

Adolescents between the age of 12 and 18, are the group most vulnerable to HIV/AIDS/STIs (Swartz, 2000). Increased sexual activity among adolescents is one of the most significant reasons for the high rate of STIs among this developmental group. It is estimated that about 50% of young people in South Africa are sexually active by the age of sixteen years (Alan & Leif, 2003). Furthermore, because of the early age which young people become sexually active (Svenson, et al., 1997) they are even less likely to engage in safer sexual activities. About 25% of sexually active adolescents contract a sexually transmitted disease each year (Newman & Newman, 2003).

Various factors might contribute to the vulnerability of the youth to HIV and other STIs. According to Hall (2001), adolescents are vulnerable to STIs due to their particular developmental stage. This stage is characterized by sexual awakening, a heightened sensitivity to peer relations and a sense of invincibility.

2.8.1.1 Sexual Awakening

During adolescence, sexual interests and behaviours increase partly as a result of biological changes and partly as a result of social, cultural and historical context. The
adrenal gland produces a sex hormone that is the same in both males and females. The amount of this hormone produced reaches a peak between ten and 12 years of age, a time when both girls and boys begin to become aware of sexual feelings (LaFreniere, 2000).

This developmental stage is characterised by an interest in, and curiosity about, sexual relations (Papalia & Olds, 1998), and adolescents are found to be particularly aware of their own sexual feelings (Van Dyk, 2001). Unfortunately, sex during this developmental stage tends to be unplanned and frequently coerced through sexual abuse, incest, rape or forced prostitution (UNAIDS, 2003).

2.8.1.2 Peer Pressure

Peer pressure refers to demands for conformity to group norms, and a demonstration of commitment and loyalty to group members. The term peer pressure is often used with a negative connotation, suggesting that young people behave in a way that goes against their values and beliefs, due to the fear of rejection by their peers. (Newman & Newman, 2003). An unhealthy attachment to, and conformity with the peer group, results in undesirable behaviours, such as experimenting with drugs and sex (Erwin, 1993; Mussen, Conger & Kagan, 1990).

Although both male and female adolescents are exposed to peer pressure, adolescent boys, especially, often face tremendous pressures to be sexually active. Therefore, adolescent boys are less likely to seek information about how to protect themselves and their partners, for fear of appearing inexperienced (Engender Health, 2004).

Peer pressure may be exerted in a variety of ways, and should not necessarily imply negative behaviour. Peer pressure is important to adolescents and young adults (Fowler, 2002; Santrock, 2002), and it can have a positive effect on sexual behaviour. By
becoming aware of peers abstaining from sex or using condoms if they are sexually active, peer pressure can motivate others to engage in similar behaviour.

2.8.1.3 Drug and Alcohol Abuse

Other factors contributing to adolescents' vulnerability to HIV/AIDS is substance misuse. Many adolescents take drugs, mainly out of curiosity or due to negative peer pressure (Papalia & Olds, 1998). Alcohol and drug use are linked with risky sexual behaviour, and may impair adolescents' ability to make judgments about partaking in sexual activities and using contraception. Studies show that adolescents are less likely to use condoms when having sex after drinking alcohol, than when sober. There is also considerable evidence that alcohol and other drugs weaken the immune system, thereby increasing susceptibility to infection and disease (Witmer, 2004).

Furthermore, the perception of adolescents with regards to drug use and sexual consent is disturbing. For example, a survey of high school students found that 18 percent of females and 39 percent of males said that it is acceptable for a boy to force sex if the girl is under the influence of alcohol or drugs (Witmer, 2004).

2.8.1.4 Sense of Invincibility

Adolescents typically understand death as the irreversible cessation of biological processes and are able to think in more abstract ways about it. However, they do not necessarily face up to the fact that they too will die, and therefore take risks that they would not take if they truly believed that death is final and irreversible (Newman & Newman, 2003).

Adolescents tend to be overwhelmed by their emotions and are inclined to focus on themselves. This egocentric state creates a sense of invulnerability, which leads to
adolescents often perceiving themselves as immune to injury and disease. The "typical" adolescent egocentricity becomes evident, for example, when sexually active adolescents refuse to use a condom because they believe that they cannot be infected even if other people can. This delusion of invincibility and immortality therefore, makes adolescents more willing to engage in risky experimental behaviour, especially sexual behaviour (Van Dyk, 2001).

2.8.1.5 Other Factors

Literature suggests that older men may be seeking younger women and girls for sexual relations, believing that they are less likely to be infected with STIs. Wide age disparities in infection rates substantiate these social patterns, with young women in many places having infection rates equal to men 10 years older. Research results from the Human Science Research Foundation (HRSC) (2002) indicate that 8 % of women aged between 15 and 24 years, have partners who are 11 to 25 years older than they are, while a further 22.4 % of women have sexual partners who are six to ten years older than they are. Adolescent girls often lack negotiating power which increases their vulnerability (Engender Health, 2004). Furthermore, many African men believe that sex with a virgin, even a child or baby, can cure HIV/AIDS. This so called cleansing myth contributes to the increase of rape in South Africa (LoBaido, 2001), placing the victims at risk of being infected with HIV/AIDS. Biological factors also increase this group's vulnerability to infection, for example, less mature genital tissues may be more readily permeated or damaged and the likelihood of contracting a STI will increase.

Another major factor contributing to the youth's vulnerability is the lack of knowledge about HIV/AIDS/STI transmission and, as a result, they are less likely to recognize
potentially risky situations or negotiate safer sexual behaviour. Although knowledge in itself is not enough to change behaviour, an increase in knowledge may provide the necessary motivation for people to identify their own risky behaviour. Knowledge will therefore be the first step in the process of behaviour change. A household survey in South Africa (HSRC, 2002) found that while knowledge of HIV/AIDS appears to have no direct bearing on sexual activity, it corresponds with preventative behaviour.

2.9 Conclusion

The vulnerability of adolescents to HIV/AIDS/STIs has been discussed, from both a statistical point of view as well as from a developmental point of view. Adolescents and children have been identified as the group most in need of education with regards to HIV/AIDS (Aggleton & Rivers, 1993; Clark, 2002; Mati, 1996). The role of education in the prevention of HIV/AIDS/STI will be discussed in Chapter Four.

In the next chapter an equally disturbing phenomenon, namely child abuse and rape, will be discussed as South Africa is a country with not only the highest levels of reported abuse in the world, but also with the highest levels of rape and HIV/AIDS transmission, with the most vulnerable group being girls aged 15 to 19 years (Bower, 2002).
CHAPTER THREE
RAPE AND CHILD ABUSE

3.1 Introduction

According to the constitution of South Africa, children should have the right to be protected from maltreatment, neglect, abuse and degradation. Furthermore, the Convention on the Rights of the Child reflects that states shall protect children from physical and mental harm, neglect, sexual abuse and exploitation (De Grandpre, 1997). Unfortunately, the dominant forces of poverty, patriarchy, racism, a culture of violence and the disempowerment of children, help create a fertile ground for all types of abuse to flourish.

This chapter focuses on child abuse and rape, primarily in the South African context. As child abuse and rape are difficult to define, definitions of these concepts are provided. The incidence of child abuse and rape, globally and in South Africa, are highlighted. Furthermore, an understanding of the aetiology of child abuse, focusing on the macro-, micro-, and personal level is provided. The chapter is concluded by examining the effects of child abuse.

3.2 Defining Child Abuse and Rape

Definitions are important as they affect the reporting of incidents and inform subsequent actions. There is a considerable debate, both in South Africa and at an international level, over the definition of child abuse. There is also dispute over the age
group considered as "children". According to Section 28 (3) of the South African Constitution, a child is any person under the age of eighteen.

3.2.1 Definition of Child Abuse:

Literature suggests numerous definitions of abuse. Consider the following definitions of abuse (Stratton, 1988) and child abuse (Hlungwani, 1998):

Stratton (1988) proposed a heuristic definition of abuse: "Abuse occurs whenever there is a substantial failure of any person to act towards another person with care appropriate to their relationship" (Stratton, 1988, p.194).

The World Health Organization defines child abuse as: "Any interaction or lack of interaction by a parent or caretaker which results in the non-accidental harm to the child's physical and/or emotional well-being" (Hlungwani 1998, p.3). However, this definition of abuse is too narrow as literature describes abuse in broader terms. Child abuse not only includes the physical, non-accidental injury of children, but also emotional abuse, sexual abuse and neglect. Therefore, abuse can range from habitually humiliating a child, to neglecting to give necessary care, and from excessively shaking of a child to rape. It is often assumed that children are only abused by strangers, but frequently the perpetrator is a friend of the child's parents, a family member, or one or both of the parents. According to Hlungwani (1998), there are 4 different kinds of child abuse. They are as follows:

**Child Sexual Abuse** involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. It comprises the following actions:

- exposure of one's private parts to a child;
• forcing a child to expose his/her private parts;
• touching a child's private parts, either with hands, mouth or the adult's private parts or if the adult has sexual intercourse with the child;
• masturbating in front of the child;
• forcing the child to masturbate;
• showing a child pornographic material and;
• taking photographs or videos of the child's private parts.

Physical Abuse can be illustrated in the following ways:
• Beating or hitting a child with any object for example: a stick, a belt, or by using a fist;
• burning the child with, for example, a cigarette or hot iron;
• strangling a child;
• suffocating a child and;
• locking a child up.

Emotional Abuse occurs when parents or caregivers withhold warmth and affection from a child. Other examples of emotional abuse are:
• using derogating language and expletives towards a child;
• parental indifference (uncaring attitude);
• humiliating a child;
• speaking or behaving in a way that causes a child to feel unworthy;
• threatening a child;

• manipulating a child and;

• disciplining a child in an inconsistent manner.

**Neglect** is the constant failure to meet a child's basic physical and/or psychological needs, which is likely to result in the serious impairment of the child's health and development. Neglect is illustrated in the following actions:

• failure to provide proper supervision;

• failure to provide sufficient clothing;

• failure to provide medical or dental care;

• failure to provide educational opportunities;

• failure to provide proper hygiene to a child.

### 3.2.2 Definition of Rape

Statutory rape is an important category of child abuse. In South Africa, anyone who has intercourse with a child, under the age of sixteen, is guilty of 'statutory rape.' The South African law states that children younger than 16, are not yet mature enough to make responsible decisions to participate in sexual intercourse or not (Heinemann Educational Publishers, 2004).

According to the South African Law Commission (2002), rape occurs when a person intentionally commits an act of sexual penetration with another person, against that person's will. Sexual penetration includes the penetration of genital organs into the anus,
mouth or genital organs of another person, or the penetration of an object into the anus or genital organs of a person, to simulate sexual intercourse.

Various types of rape are:

- **Stranger Rape** is defined as rape by a random person who the victim doesn’t know.
- **Acquaintance Rape** happens when the victim knows the person who rapes them, and may see the rapist as a peer or colleague.
- **Date Rape** occurs when the victim is raped by someone he/she has dated, or currently is dating.
- **Multiple/Group/Gang Rape** is when the victim is raped by multiple people (Heinemann Educational Publishers, 2004).

### 3.3 Incidence of Child Abuse and Rape

Evidence from many countries illustrates that child abuse is a world-wide phenomenon (McGregor, 1999). Of these countries, South Africa has been identified as the country with the highest incidence of child abuse (Bower, 2002). The incidence of child abuse and rape in South Africa will be discussed.

#### 3.3.1 Incidence in South Africa

• The monthly average of the number of physically abused children on Child Welfare caseloads, increased from 8,763 for the period 1997-1999, to 11,124 for the period 2000 - 2002.


• Sexual abuse constituted 57% of the total child abuse figure, physical abuse 34%, emotional abuse 9%, and sexual commercial exploitation of children constituted approximately 5% of the total figure.

• About 72% of all abuse cases are against females, with 69% of these cases falling into the category of sexual abuse.

• In 50% of these cases, family members were responsible for the abuse. In 12% of the cases, the extended family (grandparent/s, uncle/s, aunt/s etc.) was responsible for the abuse. In 11% of the cases, neighbours and friends were responsible. The majority of these cases were comprised of sexual abuse.

• The age group with the highest incidence of physical and sexual abuse, are between the ages of 10 and 15 years. Only 2% of sexually abused children were younger than two years.

Furthermore, South Africa is widely believed to have one of the highest incidences of rape in the world (Italo, 2003; Simmons, 2001). Figure 2 illustrates the incidence of rape and attempted rape in South Africa for the period 2001 to 2003.
Rape and Attempted Rape Statistics in South Africa

As illustrated in the graph above, approximately 50 000 rapes were reported in 2001, although women's groups say this is just a small percentage of the total number. According to police statistics, 52 107 rapes and attempted rapes were reported to the South African Police Service (SAPS) in 2002 (Defending human rights worldwide, 2004). Approximately 21 000 child rapes, and some 37 000 adult rapes, were reported in South Africa in 2003 (Earl-Taylor, 2004).

Nationally, more than 40% of the cases of sexual offences are against children (Simmons, 2001) and about 40% of rape survivors, who reported their cases to the police between February 2002 and March 2003, were girls under the age of eighteen. Although reliable numbers are hard to obtain, there is evidence that child rape has become more common in recent years (Defending human rights worldwide, 2004). It is estimated by
the South African Police Service that in South Africa a female is raped every 36 seconds (Earl-Taylor, 2004).

According to the South African Police Service only one in 35 rapes are actually reported (Earl-Taylor, 2004). When this fact is coupled with the current, narrow definition of the crime, a conservative estimate of the true situation is probably around 20 times higher (Bower, 2002). In other words, there are in excess of 400,000 child rapes (where rape is more broadly defined) in South Africa each year.

It can be extrapolated then that the actual incidence of child/infant rape has reached alarming and phenomenal proportions that should signal urgent intervention at all levels of society (Earl-Taylor, 2004).

3.3.2 Incidence in Eastern Cape

In the Eastern Cape, child abuse numbers for the period of April 2001 to March 2002, increased from 278 to 502. These abuse statistics are a conservative estimate, as they are comprised only of the cases reported to the SAPS (LoBaido, 2001).

According to statistical information gathered by the SAPS the incidence of crimes against children (aged 0 – 15 years) in Port Elizabeth is very high. In 2003, 452 rape cases, 185 cases of indecent assault and 79 cases of child neglect, were reported in this area, according to the Child Care Act (23/1987). The abuse statistics for children (aged 0 – 17 years) in 2004, in Port Elizabeth, are equally disturbing: during the period of January 2004 to 30 June 2004, 259 rape cases, 80 indecent assault cases, and 31 cases of child neglect were reported.
3.4 Aetiology of Rape and Child Abuse

Child abuse is not caused by a single factor, but rather a multitude of factors. To explore the phenomenon of child abuse, a multi-level approach, influenced by Tolan and Guerra (1998), will be followed. The model suggests that the multiple influences in child abuse, can be understood as levels of influence, each nested within the less proximal level.

![Multi-level Model of Risk Factors that influence Child Abuse (Tolan & Guerra, 1998).](image)

The concentric circles suggest that individual characteristics are nested within the contexts of interpersonal relationships, which in turn, are nested within the economic and socio-cultural macrosystems. Many of these influences overlap between the various levels. It is within the wider macrosystemic context that the subsequent influences arise.
3.4.1 The Macrosystemic Context

The socio-political/cultural context is crucial in understanding child abuse. The role that economic circumstances, cultural values and practices play in the aetiology of child abuse, will be discussed briefly.

Research indicates that there is a strong correlation between poverty-related stressors and child abuse. These stressors include unemployment, overcrowded housing, geographical mobility, large family size and inadequate child spacing (Bittner & Newberger, 1982; Wilson & Saft, 1993).

Unemployment creates a greater opportunity for abuse to occur since the abuser has more time at hand. The resultant economic hardship usually creates stressful family relationships.

According to Dawes (2002), overcrowding is a pertinent feature of poverty, and raises the risk of sexual abuse. He suggests that overcrowding limits the separation of sexualised adults or teenagers and children. Co-sleeping occurs frequently under these circumstances providing additional opportunity for sexual abuse.

With regards to the ecological perspectives on child abuse, societal willingness to tolerate high levels of violence, sets the stage for the occurrence of family violence, and physical child abuse (Belsky, 1980; Gelles & Cornell, 1997). Research shows that, when cultures where physical punishment is tolerated, are compared to cultures where physical punishment is rare, child abuse is quite uncommon (Zigel & Hall, 1989). Also implicated in a cultural analysis of the aetiology of child maltreatment, is the society's general attitude towards children. Particularly important may be the belief that children are property, to be handled as parents choose (Garbarino, 1977).
According to McGregor (1999), the feminist approach to sexual abuse, which focuses on power, has made an enormous contribution to understanding some of the dynamics of the problem. It is argued that the patriarchal family system and societal structures, support men's power over women and children. Sexual abuse is thus seen as an abuse of power. Arguments from different sources of literature support this, illustrating that the acts of sexual abuse and rape are seen as acts of enforcing one's power and not of sexual satisfaction (Lisak, 1995; Vogelman, 1990; Wyre & Swift, 1990).

3.4.2 Microsystemic Level
At the microsystemic level, the focus is on interpersonal relationships in the context of the abusive parental and parent-child interactions. What is difficult to determine is whether the findings generated, reflect proximal causes of child abuse and neglect, or whether they define the event.

Literature reveals that living in conditions of economic hardship, often predisposes the abuser to perpetration. Past history of intra-familial abusive relationships, often has the same effect. Furthermore, the impact of poverty on the family and the neighbourhood may increase the risk of children's vulnerability to abuse. According to Pelton (1994), research indicates that there is no single fact about child abuse and neglect that has better been documented and established, than their strong relationship to poverty and low income. Many poor parents experience overburdening stresses associated with being financially unstable (Dawes, 2002; McNeill, 1994). Lack of supervision and monitoring of children in these conditions, make children especially vulnerable to sexual abuse. Children may be left alone at home for long periods of time, while adults try to secure an
income. In addition, conditions in the home might be so difficult that children tend to spend much time away from home, increasing the risk of abuse (Dawes, 2002).

These harsh circumstances can also result in parents being overly punitive and abusive, and distant and emotionally barren parenting is common. Literature states that abusive parents are more likely to rely on physical punishment and negative acts of control (Gelles & Cornell, 1997). In addition, physically abusive parents are less likely to vary the harshness of their discipline in response to different types of misbehaviour (Trickett & Kuczynski, 1986).

3.4.3 The Individual Level

At the individual level, examples of possible characteristics of both the abuser and the victim will be discussed.

3.4.3.1 The Abuser

Child abusers come from all walks of life, and are not particularly represented in any one group. However, it is well established in literature that the majority of sexual offenders are men (McGregor, 1999). Furthermore, although perpetrators are from all age groups, over 60% of adult sex offenders commit their first sexual crime as adolescents (Bower, 2002).

Research has not found consistent patterns of personality attributes that characterise parents who abuse children. However, when compared to control groups, physical abusers are more immature, demanding, rigid, depressed, irritable, fearful of external threat, hyper-reactive to negative stimuli, less empathetic and less sensitive (Baumrind, 1995; Eth, 1996). In addition, abusive parents in general, appear to have poor impulse
control, low self-esteem, and low ego strength (Baumrind, 1995). These characteristics can cause the parents to be less sensitive to their children's needs and increase the parent's probability to react impulsively and negatively to the demands of their children.

Research suggests that a variety of negative emotional states, such as depression and anxiety may contribute to abusive behaviour (Eth, 1996; Whipple & Webster-Stratton, 1991). There is evidence that depression is associated with intrusive, hostile and rejecting care and abuse (Gelfrand & Teti, 1990).

Due to the fact that sex offenders form a heterogeneous group, it is very difficult to pinpoint a specific profile of sex offenders. Theories suggest that multiple factors influence the individual's personality and functioning, and in the recent years multifactorial models have been proposed. One such a model is suggested by Marshall and Marshall (2000). It explains the aetiology of sex offenders by stating that, the root of the offender's problem is in the poor quality of the relationship during childhood with primary caregivers, which may be due to a number of reasons. These reasons include sexual, emotional, or physical abuse, rejection, lack of support and disruptive experiences. These factors may leave the individual feeling more sensitive to suffer abuse from others and/or to lack the self-confidence to engage in intimate relationships with appropriate others. Furthermore, Marshall and Marshall (2000) suggest that the lack of self-confidence combined with high levels of masturbation in adolescents, may lead to fantasies incorporating elements of power. These fantasies become more deviant over time. Such fantasies and low levels of social competence lead to the disposition for abuse. When the right circumstances to offend occur, in combination with disinhibiting factors, such as cognitive distortions, this pre-disposition may be acted upon.
3.4.3.2 The Victim

Although all children are at risk of child abuse and cannot be characterised by any single factor, some factors can differentiate between larger subsets.

According to McGregor (1999) the strongest differentiating factor is gender, as almost every study indicates that girls are more at risk than boys. However, there are other authors that believe that boys are just as likely as girls to be abused, but are more reluctant to report the abuse (Kempe & Kempe, 1984).

Another differentiating factor is age. Research indicates that younger children and pre-adolescents are at a particularly vulnerable age for abuse, owing to a number of factors. Younger children spend more time with caregivers, and are more physically and psychologically dependent on them, than older children, and are more susceptible to injury as result of their physical vulnerability (Straus & Steward, 1999). Children’s vulnerability is also largely due to their limited intellectual and emotional capacity, based in their still immature, developmental levels. Although, research indicates that younger children are more vulnerable to abuse, most studies show that abuse continues into early adolescence (Finkelhor, Hotaling, Lewis, & Smith, 1990; Flemming, Mullen, & Bammer, 1997). Adolescent girls are often coerced into sexual relationships or are otherwise subjected to sexual harassment and violence by male relatives, boyfriends, schoolteachers and male classmates.

A bi-directional perspective on the parent-child relationship suggests that children's behaviour may function to bring forth or maintain the maltreatment (Eth, 1996). Although parents play a larger role in the aetiology equation than children do, there is no disputing that children may inadvertently contribute to abusive situations. Such outcomes
seem likely to occur when the age, health and behavioural aspects of certain children combine to make them more challenging to a parent, than others.

In addition to the above-mentioned factors, various other scenarios have been identified which place children at risk. An unhappy family life, living without a natural parent, living with stepparents, not having someone to confide in, social isolation and inadequate sex education, have all been shown to increase the risk of sexual abuse (Flemming et al., 1997)

3.5 Child Abuse in the South African Context

All of the above-mentioned factors are applicable in explaining child abuse in the South African context. However, other factors on the aetiology of child abuse might create a better understanding of the extremely high incidence of child abuse in South Africa.

Many South Africans are exposed to extensive poverty conditions. According to Whiteside and Sunter (2000) approximately 50 per cent of South Africa's population earn less than R355 per adult per month. Another 27 per cent of the population earn less than R195 per adult per month. It is estimated that 70 per cent of South African children live in poverty.

Increasing poverty, especially among vulnerable families and communities affected by HIV/AIDS, is creating potentially dangerous situations for children. Under these circumstances children engage in livelihood activities prematurely, of these, the most in demand and most profitable, is sex. In South Africa, both the commercial and the sexual exploitation of children and trafficking in children, are growing significantly. Children
whose family networks are already burdened with taking care of extended family members, who have lost their care-giver/s to AIDS, are easy targets for exploitation and trafficking (Higon-Smith & Richter, 2004).

Literature indicates that other reasons for the high incidence of rape and child abuse in South Africa, are linked to our very high rates of interpersonal violence, community violence and violence against women. These rates are fuelled by the ongoing crises of poverty, unemployment and powerlessness experienced by many South Africans. In South Africa because of the deeply patriarchal nature of many of our communities, together with religious traditions and cultural practices, women and children are often viewed as property whose status is determined in terms of their relationship to men (Bower, 2002).

Furthermore, it is suggested that South Africa's human rights record, and the systematic oppression and dehumanisation of huge numbers of the population through several decades of apartheid might have contributed to the high levels of child abuse (Bower, 2002). Some observers claim that apartheid took away the feeling of power from black men, who in turn began taking out their feelings of disempowerment on the only people less powerful than themselves, women and children (Italo, 2004).

Another factor that places young girls at risk for sexual abuse is the practise of virginity testing, prominent in Zulu and Xhosa cultures (Jewkes, 2004). Virginity testing is currently a hugely sensitive issue as highlighted by a recent article (Virginity testing leaves medical experts uneasy, 3 December, 2004, p.2), where reference was made about the widespread adoption of virginity testing in the Eastern Cape and the personal endorsement of the practise by Premier Nosimo Balindlela. In the same article reference
was made concerning a mass virginity testing session for 600 girls organised by The Rharhabe Royal House of Xhosa King Maxhoba Sandile, 13 km outside King Williams Town. The Royal House and the Health Department insisted that all girls participated voluntarily.

People in favour of virginity testing argue that this procedure should be encouraged as a way to curb the spread of HIV/AIDS and that the practise will help to identify abused children (Virginity testing leaves medical experts uneasy, 3 December, 2004, p.2). In reality, however, this practise is often misused and places many girls at risk for sexual abuse.

Being declared a virgin may also convey an additional risk of rape as the myth exists that sex with a virgin cures HIV/AIDS (Jewkes, 2004). Literature states that this myth may be a powerful factor contributing to the high incidence of child abuse in South Africa (Earl–Taylor, 2004; Italo, 2003; Simmons, 2001; Sylvester, 2003). The idea that sex, with a virgin, will cure men of a sexually transmitted infections is not new, nor is it exclusively African. In Renaissance Europe, it was widely believed that syphilis could be cured by having intercourse with a virgin, and that contact with an immature vulva would cure venereal disease (Davidson, 2001). Studies on the subject have yielded mixed results, as some have found that only a very small number of South Africans actually believe that myth, while others, conducted in different parts of the country by different researchers, have found that the view is widely believed (Italo, 2003). It seems apparent that perceptions regarding this belief are difficult to change. In a South African sexual health workshop, held in 2000, 32.7% of the participants believed that sex with a virgin
could cure HIV infection. After 14 sessions of 2-3 hours each, this myth was still believed by 20% of the participants (Van As et al., 2001).

### 3.6 Effects of Child Abuse

The effects of child abuse and rape have been well documented and most of the studies have reported similar results (McGregor, 1999). Some effects of child abuse are very obvious, for example the bruises on children who have been physically abused. Many other symptoms and effects of child abuse, though, go undetected. These effects will briefly be discussed.

#### 3.6.1 Fear

The single most common, immediate effect is fear. The child may fear a number of things, such as the danger of being alone with the abuser, the consequences to the child and/or the family if the abuse becomes known, and fear of the reactions of others who become aware of the situation (Beitchman, Zucker, Hood, Da Costa, Akman, & Cassavia, 1991; German, Habernicht, & Fitcher, 1990). Fear, nervousness and worry may manifest as feelings of anxiety, restlessness, agitation and/or irritability (Stroud & Cloete, 2003).

#### 3.6.2 Behavioural Disturbances

The internal conflict of an abused child manifests in behavioural disturbances. The child may experience sleep disturbances, and eating patterns can be effected. Neglecting self and others, for example by losing interest in his/her own physical appearance, home and family is common (Merry & Andrews, 1994; Muenzenmaier, Meuer, Struening, &
Feber, 1999). Furthermore, victims of abuse may display poor concentration levels and a weak memory (Stroud & Cloete, 2003). Speech problems, such as stuttering, stammering more than usual, or not speaking at all may also occur. Abused adolescents are also more likely to use or abuse substances such as drugs and/or alcohol (Stoud & Cloete, 2003).

3.6.3 Loss of Trust in people

Trust is often lost, not only towards the abuser, who might have been a trusted adult, but in older people in general. The child may feel that the parent should protect them, even without possibly knowing the about the abuse, and this can result in a deteriorating parent-child relationship (Beitchman, et al., 1991; Muenzenmaier, et al., 1999). Global distrust in people, and often in men in particular, may further negatively impact other relationships. Some abuse victims may thus become housebound, venturing out only if accompanied (Stroud & Cloete, 2003).

3.6.4 Guilt

A very common, immediate effect of sexual abuse, is guilt. Younger children often do not always have the capacity to distinguish between being a victim or a participant (Beitchman, et al., 1991; German, et al., 1990; Stoud & Cloete, 2003). Even adolescents, who have a greater cognitive capacity, struggle with this concept. Adolescents might feel that they acted in a provocative manner, which caused the abuse. Therefore, feelings of guilt might develop, as the victim often feels somewhat responsible for the abuse (Stroud & Cloete, 2003).
3.6.5 Loneliness

A very powerful effect of abuse, especially with regards to sexual abuse, is the feeling of being isolated (Beitchman, et al., 1991; Muenzenmaier, et al., 1999). The child often feels that he/she cannot talk to anyone about the abuse that is happening, and as a result, becomes isolated. This can be experienced as a feeling of loneliness and the child may consequently withdraw from all social contact (Stroud & Cloete, 2003).

3.6.6 Ambivalence

Another common effect of abuse is the development of feelings of ambivalence in the child. The child often has a good relationship with the abuser, who may be the parent, a relation or an older friend of the family. When the aspect of abuse is introduced into the relationship, confusion and ambivalence towards the abuser is common. Most abused children hate the abuse, but still love the person who abuses them (Search, 1988).

3.6.7 Low Self-Esteem

According to Briere (1992), abused children may have distorted images of the self and they may overestimate the amount of danger in the world and underestimate their own self worth. Low self-esteem is likely to continue well into adulthood (Gold, 1986) and may cause interpersonal difficulties.

3.6.8 Psychiatric Illnesses

Psychiatric illnesses have been found as one of the most common long term effects of sexual abuse. Psychiatric illnesses associated with sexual abuse include mood disorders,
such as anxiety and depressive disorders (Beitchman et al., 1991; Murrey, Bolen, Millar, Simensted, Robins, & Truskowski, 1993), post traumatic stress disorder (Jehu, 1991; Rodriguez, Ryan, Rowan, & Fox, 1996), substance abuse disorders (Mullen, 1993; Roesler & Dafler, 1994), eating disorders (Mullen, 1993), personality disorders (Coons & Milstein, 1986) and dissociative disorders (Schulte, Dinwiddie, Pribor, & Yutzy, 1995).

3.6.9 Sexual Reactions

Childhood survivors of sexual abuse, are likely to suffer from sexual problems and dissatisfaction (Dent-Brown, 1993). The issue of sex, may therefore play an important role, in the disturbance or dissolution of relationships (Stroud & Cloete, 2003).

In addition, survivors of sexual abuse, especially rape, are at risk of being infected with sexually transmitted infections, including HIV/AIDS. Adolescent girls are also at risk of being impregnated (Heinemann Educational Publishers, 2004; Simmons, 2001).

3.6.10 Coping Mechanisms

Not all children react immediately or outwardly to these symptoms, as various coping mechanisms, namely avoidant coping, internalised coping and angry coping may be employed. This may give the impression that sexual abuse does not necessarily cause harm. However, Chaffin, Wherry, and Dykman (1997) found that the above-mentioned coping mechanisms were directly associated with the symptoms.
3.7 Myths concerning the Effects of Child Abuse

A common myth is that the sexually molested boys will grow up being homosexual. Despite some higher rates of abuse found in the childhoods of homosexual men, there is no consistent evidence for this belief (Schulze & Van Rooyen, 1990), and studies exist which contradict this belief (Isaacs & McKendrick, 1992).

Another myth is that adults, who have been abused, will go on to abuse others. Literature provides contradictory results concerning this issue. Veneziano (2000) studied a group of 74 adolescent offenders aged between 10 and 17 years, and concluded that child sexual offenders are likely to have a history of both sexual and physical abuse. Although a fairly high incidence of childhood abuse has been found in the childhoods of adult abusers, this does not suggest that the majority of children who are abused will grow up to abuse others. In fact, many abused children grow up to be sensitive to the needs of children, as a result of their own victimization (Hooper, 1995).

It can be seen from the above discussion that a wide range of symptoms result from abuse, but not all the symptoms apply to every child. The severity of symptoms may also differ from one victim to another.

Considering the effects of child abuse, it is devastating that most cases of child abuse are unreported, allowing the vicious cycle to continue. In the following section some the reasons for not reporting child abuse in the South African context will be discussed.

3.8 Why Child Abuse is not reported

Research in South Africa has shown that schoolteachers, relatives and people otherwise known to victims, constitute a significant percentage of perpetrators of
childhood rapes, and that fear of revenge by the perpetrator, is among the barriers of reporting these crimes to police (Human Rights Watch, 2001). Many women and girls do not report rape or sexual coercion by intimate partners, because they believe that their partner has a right to demand sex, or because they have low expectations of their right to control the terms of their sexual interactions. Studies have documented a range of obstacles to reporting, which include the fear of not being believed; problems of physical access to the police; and fear of the legal processes involved, including poor treatment by police (Kim, 2000).

Many rape survivors, in South Africa, choose not to go to the police, because they lack confidence in the criminal justice system, and believe that perpetrators will not be punished for their acts. These concerns appear justified, since approximately 63% of traced sexual offenders are not tried for their crimes in South Africa, and only seven percent of offenders receive a prison sentence. (Van As et al., 2001). Police have identified corrupt practices that undermine successful prosecution of rape cases, including the acceptance of money or bribes by certain police officers, prosecutors, and other court officials, to destroy cases, the dockets being either lost, stolen, or destroyed (Andersson, 2000). Furthermore, there are numerous problems encountered by children at the court case stage, which frequently results in the case being withdrawn. These problems include the following: the cost of travelling to court may be beyond the means of the victim; there are often no interpreters available; insufficient evidence is given by prosecutors; and the lack of training and sensitisation of court personnel (Bower, 2002).
Finally, women who are abused, or whose children are abused by the breadwinner of the family, often worry that if the perpetrator goes to jail, the family will be forced to go without food or housing.

3.9 Prevention of Child Abuse

The prevention of child abuse can only occur with the corresponding development of public awareness, legal reform, refocused health services and social services. It is reported that in countries where these areas of activity were developed in a co-ordinated way, significant advances in child protection had been made over the past decade (Bower, 2002).

With regards to prevention of rape and child abuse in South Africa, a holistic approach should be adopted. Parents, health workers, educators and community organizations need to develop a response, which attempts to prevent abuse from happening.

According to Bower (2002), this strategy should encompass a greater commitment to ensure that the life-skills component of the school curriculum challenges the development of rigid and defined gender roles for girls and boys, and assists with the development of an understanding of the inappropriateness of sex-role stereotyping. Furthermore, people of all ages need to be educated about the rights of children.

3.10 Conclusion

Child abuse is not caused by a single factor, but rather through a combination of various factors which could be explained at the macrosystemic, microsystemic and individual levels. It is evident that many of these influences overlap between the various
levels. In South Africa various factors have been identified which impact on the increase of abuse in this country. These factors include extreme poverty, a high incidence of community violence, dehumanisation of huge numbers of the population through several decades of apartheid, virginity testing and the myth that sex with a virgin cures HIV/AIDS.

Prevention of child abuse is complicated by the complexity of the aetiology of the phenomenon. Therefore, a holistic approach should be adopted which should include interventions at various levels.

The next chapter focuses on education aiming at prevention of HIV/AIDS/STIs, rape and child abuse.
CHAPTER FOUR
EDUCATION PROGRAMMES

4.1 Introduction

This chapter focuses on education, aimed at the prevention of HIV/AIDS/STIs, rape and child abuse, within a school context. Since almost all children worldwide attend school, it creates a unique opportunity and context to influence children's ideas about sex and relationships (Ross, Nelson & Kolbe, 1991). As theories form the basis of all preventative programmes, an outline of some psychological theories relevant to the research topic is provided. Life Skills Programmes within the school context are discussed and the importance of programme evaluation is illustrated. In addition, the Life Skills Programme focusing on HIV/AIDS/STIs, rape and child abuse education in the Port Elizabeth region, which forms the basis of the present study, will be introduced.

4.2 Theories on Prevention

Scientifically proven theories form the basis for developing effective prevention campaigns, providing guidelines with regard to designing prevention campaigns, and defining important terms and concepts (Perloff, 2001). These give programme planners a framework for the goals of an intervention and are also useful in explaining aspects of behaviour when working with new populations. In addition, the use of theories to design prevention interventions can help improve the programmes (Valdiserri, 1989).

One of the most difficult tasks for health educators is changing individual or group behaviour. It is even more difficult to help individuals or groups maintain that behaviour
once it has changed (Bensley & Brookins-Fisher, 2003). Although each behaviour is
unique, there are limited numbers of theoretical variables that serve as determinants of a
given behaviour. Understanding these variables and their role in behaviour prediction can
guide the development of effective behavioural change interventions (Fishbein, 2000).
Health education professionals have subscribed to a number of theories that take into
consideration variables that influence behaviour (Bensley & Brookins-Fisher, 2003).
Occasionally, however, it can be challenging to decide which theory is the best for a
specific intervention programme.

Research indicates that the most effective educational programmes are based upon
theoretical approaches derived from behavioural change models (Coyle & Basen-
Engquist, 1995). Optimally, status assessment of the target population, involving several
of the model constructs, should occur before constructing the intervention. Programme
designers consider the fundamental concepts of the models and the research on their
effectiveness, and then design interventions based on their best judgement. This process
can involve several steps including:

1. specifying the specific target audience and the context in which the intervention will
   be administered;

2. identifying the desired behavioural outcome expected from the educational
   programme;

3. examining how the constructs of the various models are related to the expected
   outcome and the target audience;

4. developing the intervention strategies and programme based on the findings. (Coyle
   & Basen-Engquist, 1995; Perry, Baranowski, & Parcel, 1990).
4.2.1 Application of Health Education Theories

A discussion of four, commonly used theories, with a description of each theory, and its application to child abuse or HIV/AIDS education, will follow.

4.2.1.1 The Social Cognition Theory

The social cognition theory is one of the most popular theories of health educators, and has been used to study a wide variety of problems, from medical therapy compliance, to alcohol abuse and immunizations (King, 1999; Perloff, 2001). According to the social cognition theory, all behaviour is learned either through modelling the behaviour of others or through direct experience. One particularly valuable area of investigation, to which this theory has been applied, is the study of moral and value internalisation among children. The social cognition theory helps in understanding how children are socialised to accept the standards and values of their society (Johnston, O’ Malley & Bachman, 1994). Six concepts are essential to this theory (Buckner, 1994). Each of these is defined below and then applied to child abuse education.

1. *Reciprocal Determination*. Reciprocal determination suggests that behavioural changes are determined by the interactions between a person and his/her environment. The environment can therefore influence or discourage a person in either a healthy or unhealthy way, as some environments are healthier than others. It is possible for people to influence an environment in such a way, that it is more conducive to a healthy lifestyle. For example, an adolescent girl attending a school in which there are caring and honourable teachers, should she be abused or sexually assaulted, will find her environment conducive to disclose abuse to a teacher.
2. *Behavioural Capability*. This concept is based on a person's capability to change behaviour, by having the knowledge and skills necessary to act in a desired way. For example, a girl has knowledge that sexual advances by an adult are not acceptable and she is assertive enough to convey this message to the perpetrator.

3. *Expectations*. Expectations are what a person anticipates as a result of modifying behaviour. For example, after talking to the perpetrator, the girl expects the advances to stop.

4. *Reinforcement*. Reinforcement refers to the response to a person's behaviour, that will increase the continuation of the behaviour. For example, when the sexual advances stop after talking to the perpetrator, the girl is likely to act in the same way if she is in a similar situation in the future.

5. *Self-efficacy*. Self-efficacy is the belief that one can bring about necessary changes. For example, being able to prevent abuse will increase self-efficacy.

6. *Observational Learning*: Observational learning is the ability to learn by observing others. For example, when the girl's friend is sexually assaulted, she mimics the girl's actions, changes her behaviour assertively, and informs the perpetrator that sexual advances by adults are not acceptable.

4.2.1.2 Trans-theoretical Stages of Change Model

The Stages of Change Model is based upon the assumption that behaviour change is a process. It suggests that people are at different levels of readiness for change, and that people at different stages of change, can benefit from different interventions. As a result, the methods used for desired outcomes are not generic, because individuals are not
always at the same level of readiness. Furthermore, the model suggests that people may relapse to a previous stage and that return to the initial stage can occur. The model identifies five stages of readiness that could be applied to any type of behaviour change (Prochaska, 1979). Each stage of readiness is defined below, and then applied to child abuse education.

1. **Pre-contemplation.** During this stage a person is not at all interested in changing his/her behaviour. For example, an adolescent boy who was raised to believe that females are the property of men, may force younger females to have sex. At this stage he does not want to change his behaviour.

2. **Contemplation.** At this level a person is considering changing his/her behaviour someday. For example, after being exposed to programmes that promote female equality, the same adolescent boy considers changing his behaviour in the future.

3. **Preparation.** During the preparation stage, a person is preparing for and experimenting with, behavioural change, but lacks self-efficacy to actively engage in the process.

4. **Action.** At this stage a person is actively engaging in the behaviour. For example, the above-mentioned adolescent boy does not force girls to have sex, but rather negotiates sexual relations.

5. **Maintenance.** During the maintenance stage the behavioural change is sustained over time. For example, the adolescent boy reaches adulthood and still continues to negotiate sexual relations with women.
4.2.1.3. The Health Belief Model (HBM)

As the name suggests, the Health Belief Model (HBM), is concerned with believing in health. The model emphasises the role of vulnerability to illness, and the potential effectiveness of treatment. It suggests that health educators should take into account individuals' perceptions that they are vulnerable to illnesses that threaten health, and examine the actions taken by individuals that could prevent this threat and eliminate possible illness (Rosenstock, 1966).

The HBM focuses on the belief held by the individual, how it is related to a particular disease, and how to cope with illness. This model postulates that an individual should hold the beliefs, listed below, in order to change behaviour.

1. *Perceived Susceptibility*. This refers to a person's perception of the chances of contracting a disease.

2. *Perceived Severity*. This refers to the assessment of the consequences of the health threat.

3. *Perceived Benefits*. These are beliefs about the effectiveness of various coping actions.

4. *Cues of Action*. For example, the boy witnesses the decline of a friend’s health as a result of AIDS. This encourages him to take steps so as not to contract the disease.

5. *Perceived Benefits of Prevention Action*. For example, the boy realises that if he continues to be faithful to his partner and use a condom, he can avoid infection from HIV.
6. **Perceived Barriers.** Perceived barriers refer to negative consequences of actions (King, 1999; Perloff, 2000).

The following table applies the six concepts to two sexual health actions namely STI screening and HIV testing.

**Table 3**

**Application of the HBM to Sexual Health Actions (ReCAPP, 2003)**

<table>
<thead>
<tr>
<th>Concept</th>
<th>Condom Use Education Example</th>
<th>STI Screening or HIV Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perceived Susceptibility</td>
<td>Adolescents believe they can contract HIV or other STIs.</td>
<td>Adolescents believe they may have been exposed to STIs or HIV.</td>
</tr>
<tr>
<td>2. Perceived Severity</td>
<td>Adolescents believe that the consequences of contacting HIV or other STIs are significant enough to try to avoid.</td>
<td>Adolescents believe the consequences of having STIs or HIV without knowledge or treatment is significant enough to try to avoid.</td>
</tr>
<tr>
<td>3. Perceived Benefits</td>
<td>Adolescents believe that the recommended action of using condoms would protect them from contracting HIV or other STIs.</td>
<td>Adolescents believe that the recommended action of getting tested for STIs and HIV would benefit them — possibly by allowing them to get early treatment or preventing them from infecting others.</td>
</tr>
<tr>
<td>4. Perceived Barriers</td>
<td>Adolescents identify their personal barriers to using condoms (i.e., they are too embarrassed to talk to their partner about it) and explore ways to eliminate or reduce these barriers (i.e., have them practise condom communication skills to decrease their embarrassment level).</td>
<td>Adolescents identify their personal barriers to getting tested (i.e., getting to the clinic or being seen at the clinic by someone they know) and explore ways to eliminate or reduce these barriers (i.e., brainstorm transportation and disguise options).</td>
</tr>
<tr>
<td>5. Cues to Action</td>
<td>Adolescents receive reminder cues for action in the form of incentives (such as pencils with the printed message &quot;no glove, no love&quot;) or reminder messages (such as messages in the school newsletter).</td>
<td>Adolescents receive reminder cues for action in the form of incentives (such as a key chain that says, &quot;Got sex? Get tested!&quot;) or reminder messages (such as posters that say, &quot;25% of sexually active teens contract an STI. Are you one of them? Find out now&quot;).</td>
</tr>
<tr>
<td>6. Self-Efficacy</td>
<td>Adolescents receive training in using a condom correctly.</td>
<td>Adolescents receive guidance (such as information on where to get tested) or training (such as practice in making an appointment).</td>
</tr>
</tbody>
</table>
This model postulates that behavioural change requires beliefs leading to change. Using this model, prevention programmes focus on the perception of risk, the beliefs of the severity of AIDS, and the benefits of using a condom, or delaying the onset of sexual activity (King, 1999).

4.2.1.4 Information-Motivation-Behavioural Skills (IMB) Model.

The IMB model identifies important components of HIV/AIDS behavioural change, namely, information, motivation and behaviour skills (Perloff, 2001). It is essential to link these three components in a coherent manner if attitude and behavioural changes are to take place. Furthermore, it is imperative that motivation and information are treated as separate entities. For example, a well-informed individual may not possess the motivation to practise safe sex, while a well-motivated individual may not possess the information to protect him/herself from high risk situations (Perloff, 2001).

Information provision, through education and other modalities, is critical to the IMB model. Without information a person cannot perform HIV/AIDS preventative behaviour. A person needs to be informed accurately as to how HIV/AIDS/STIs are transmitted. However, knowledge is not enough. For example, a person can know how the disease is spread, and still not believe this threat applies to him/her personally (Perloff, 2001).

The second component to the IMB model is motivation. This component refers to an individual's attitude towards AIDS precautionary behaviours. The model stipulates that individuals must be highly motivated to initiate and sustain HIV/AIDS behavioural changes.
The core component of the model is behavioural skills, and according to the IMB model, information about AIDS risk reduction and motivation, activates behavioural changes (Perloff, 2001).

Figure 3. The Information-Motivation-Behavioural Skills (IMB) Model (Perloff, 2001).

Five skills are identified as necessary for the practice of AIDS prevention behaviour:

1. self-acceptance of sexuality;
2. acquisition of behaviourally relevant information;
3. negotiation of preventive behaviour with partners;
4. performance of public prevention acts such as condom purchase and;
According to literature, interventions focusing on the three components of the IMB model, namely information, motivation and behavioural skills, have the most impact (Fisher & Fisher, 1992).

4.3 Implementation of Preventative Programmes in the School Setting

Schools and youth centres have been identified as two vehicles to reach young people in implementing HIV/AIDS education programmes (Aggleton & Rivers, 1993). Since many children 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 have especially been identified as the setting for preventative programmes (Dunn, Ross, Caines, & Howorth, 1998), having the potential to reach billions of children world-wide (Ross et al., 1991). South Africa has 12 million learners, 366 000 teachers and around 28 000 schools, including 390 special needs schools and 1 000 registered private schools (Garson, 2004). The school setting in South Africa therefore provides an ideal setting for preventative programmes.

Gilligan (1998) lists various ways in which teachers and schools may serve children:

1. Schools can offer children access to caring adults who can serve as confidants, instructors and positive role models.

2. Schools can provide a day by day monitoring of children's emotional and physical health and behaviour (which can be important in detecting abuse or HIV/AIDS-related health problems).
3. Schools have the possibility of building capacity in the community, including raising awareness of issues such as abuse and HIV/AIDS among learners, parents and the community in general.

4. Schools can provide a safe area for the vulnerable.

5. Schools serve as a place where relationships can be built with adults, as well as other children.

6. Schools can be a source of resources for parents and provide hubs for the delivery of service to children.

4.3.1 Life Skills Programmes

Over the past decade, approaches to health education have moved away from just conveying knowledge. These approaches, often referred to as Life Skills Programmes, also focus on building skills and value systems. Life Skills Programmes place a definite emphasis on an individual’s ability to identify options and to make alternative choices. They aim at directing each learner to a point in their development where they are able to make decisions about their behaviour and their future (Futrell, 1992).

A fundamental assumption underlying Life Skills Programmes is that learners must be given the opportunity to identify their own concerns, rather than having an agenda imposed on them. Experiential learning is, therefore, encouraged. Experiential learning is participatory, and is a shared activity where everybody has something to teach and something to learn (Rooth, 1995).
As shown above, the experiential learning cycle consists of the following four stages:

1. **Concrete experience.** The learner experiences a concrete activity, such as a role play or group discussion.

2. **Reflection.** After the learner has experienced the concrete activity, time is allowed to reflect on his/her thoughts and feelings of the concrete experience.

3. **Wisdom.** During this stage the learner gains insight and draws conclusions about his/her learning experience.
4. **Doing.** The learner starts experimenting with behavioural change and the implementation thereof.

The focus of this type of learning method is on developing existing strengths and the life experience of the participants, acknowledging values; and uses the existing knowledge and competence of every person in the group (Rooth, 1995). Life Skills Programmes aimed at HIV/AIDS/STI, child abuse and rape, should thus allow learners the opportunity to explore their own attitudes and feelings towards these issues.

4.3.2 School-Based Intervention in South Africa

In South Africa, various school-based intervention programmes, focusing on HIV/AIDS/STIs, and to a lesser degree, rape and child abuse, have been introduced. The following section gives a brief overview of such programmes.

4.3.2.1 HIV/AIDS/STI Education Programmes

The National Department of Education enacted legislation as the National Education Policy Act, No. 27 of 1996. The Act states that learners should receive HIV/AIDS education in the context of life skills education on an ongoing basis, and that HIV/AIDS education should not be presented as isolated learning content, but should be developed within the whole curriculum (Pailman, 2001). Consequently various HIV/AIDS/STI preventative programmes in South Africa, have been developed and introduced over the past few years (Swartz, 2000).

In 1998 a learning programme was developed by the National Departments of Health and Education, Provincial Coordinating Committees and NGOs implemented in
secondary schools, incorporating Life Skills Training into the curriculum. The project is aimed at:

- increasing learners’ knowledge about HIV/AIDS/STIs;
- developing skills to prevent HIV/AIDS/STIs transference;
- promoting positive and responsible attitudes and behaviour and;
- providing motivational support regarding HIV/AIDS/STI related issues.

The Life Skills Programme also emphasises the importance of a holistic approach in addressing HIV/AIDS, while learner-centeredness and participatory methodology are strongly recommended. A total of 9,034 teachers and 840 master trainers were trained by the end of 1998 and the programme was implemented in most secondary schools in South Africa. Although the target population project was initially secondary school children (grades 8-12), it extended to primary school children (grades 1-7) and to children who are out of school (Magome, 2002).

As stated before, HIV/AIDS/STI education should be implemented, while considering other factors, such as sexual harassment and sexual abuse in schools. According to the Ministry of Education (2001) the incidence of both coercive and transactive sex are high in South African schools. For any HIV/AIDS/STI education campaign to be successful, the problem of sexual abuse and harassment must be eradicated from the schools system.

4.3.2.2 Child Abuse and Rape Education Programmes

The development of school-based programmes, by and for teachers, has been an integral part of child abuse prevention efforts in other countries. The situation in South Africa, however, is quite different, where only a few school-based intervention
programmes aiming at the prevention of child abuse have been introduced (McGreggor, 1999).

In 1991, the then Eastern Cape Education Department developed a programme for primary school teachers to combat child abuse (Hughes & Pretorius, 1991). A number of teachers, at various schools in the Eastern Cape, were trained in its use, although it was not widely implemented.

A programme developed by McGregor (1993) focused on the prevention of sexual abuse. This programme was directed at secondary schools and concentrated not so much at teaching adolescents self-protecting skills, although that was a component, but rather on preventing the development of a disposition for abuse.

According to Skeweyiya (2003), the Department of Education has introduced a number of initiatives to combat abuse in schools, focusing primarily on abuse. A few of these initiatives will be discussed briefly.

In 1998 the Department of Education launched the Creative Arts Initiative as part of its Culture of Learning and Teaching Campaign, as a first effort aimed at providing learners with the opportunity to speak about sexual abuse and related issues. This provided learners with a non-threatening forum to talk about what they experience as barriers to learning and teaching. High on the list of learners' concerns has been the issue of violence against girls, perpetrated by learners and teachers.

In an endeavour to manage sexual abuse in schools, the Department of Education, in November 2002, supported by the Canadian International Development Agency, completed the development of a school-based module on Managing Sexual Harassment and Gender-based Violence. This module was developed in consultation with education
district officials, teachers and schools in Gauteng, Free State and Mpumalanga. The model consists of eight workshops that raised awareness regarding gender-based violence. In addition, it provides institution-based policies and programmes, to deal with such.

In 2003, a handbook on gender equity in education was prepared for use by teachers in schools throughout South Africa. It highlighted the relationship between inequality in relations between males and females, in engendering sexual violence against women. The last section in this handbook was dedicated to the management of sexual violence in schools, and enabled educators to address this issue with learners.

The Life Skills component of Curriculum 2005 aims at equipping learners with skills, knowledge, values and attitudes that are essential for effective and responsible participation in a democratic society. The objectives of the programme are to enable learners to analyse the different types of relationships that exist between the sexes and to evaluate these relationships. It also aims at enabling learners to reflect on their behaviours and on those of others, and to critically evaluate human rights, values and practices.

4.4 Programme Evaluation

Intervention programmes, however well-intentioned, will not be successful without thorough well-designed evaluations and there is an increasing pressure on service providers, to produce evidence of their programme’s effectiveness, usually by means of an evaluation of the extent to which each programme reaches its objectives (Ainsworth, 1998). Programme evaluation provides:

1. a systematic method for the collection, analysis and use of information;
2. a determination of what is, and is not, working in a programme, enabling modifications to enhance effectiveness;

3. evidence for funding bodies and stakeholders as to what a programme does, its level of effectiveness and the benefits for participants;

4. new knowledge about the most beneficial approaches that can be used when adopting programmes of a similar type, and when dealing with similar participants (U.S. Department of Health and Human Services, 1995).

Furthermore, it can be argued that determining the effectiveness of a programme, and the areas for improvement, actually enhances the benefits for the participants. Although an evaluation is important to identify the positive aspects of a programme, it is equally important to discover whether a programme, or some of its elements, is not working, in order to learn how to improve the programme. The failure to evaluate a programme means that it operates without any clear evidence that it is working. In contradiction, it has also been suggested that, rather than focusing on whether such arbitrary standards are met, it is more useful to focus on the extent to which a programme is effective at creating changes in the participants’ knowledge, attitudes or behaviours; and which elements of the programme are more or less likely to result in positive change (U.S. Department of Health and Human Services, 1995).

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 preventative programmes (World Bank, 2002). However, some successful programme evaluation has been reported. The study conducted in Estonia during the period 1997-1999 is an example of a success story. Two school based education programmes were
implemented. The first from 1997 to 1999, labelled the Promotion of School-based Sexual Education and HIV/STD Prevention in Estonia and the second, from 1998 to 1999, labelled the Alternative Methods of Teaching Healthy Sexuality and Safer Sexual Behaviour. Kaldmae, Priimaji, Raudsepp, Grintchak, and Valjaots (2000) evaluated these programmes and amongst others, found the following:

- Interest, active participation, and satisfaction were demonstrated by teens.

- Interactive learning facilitates two way learning, allowing teachers to get a better impression about sexual development of young people, their risk behaviour and their problems.

- The adolescents’ perception of intimacy is important, as it offers a view of their knowledge, attitude and beliefs toward love and sex.

- Low self-esteem inhibits active participation and learning, and participants’ self-esteem was believed to be higher after the education programmes.

Other successful programme evaluations were conducted by Kinsmend and Harrison (1999), Makalima (2003) and Julies (2003). The latter two programme evaluations were based in Port Elizabeth.

In South Africa, some barriers to and limitations of preventative programmes have been documented. A summary of findings include:

1. Adult discomfort and misperceptions about the nature of modern sexuality education plays a significant role in limiting the development and implementation of effective programmes.
2. At times, cultural diversity is not taken in account when designing Life Skills Programmes. For example, within the African tradition, discussion of sexual matters between adolescents and older individuals, like teachers, is often an unwelcome intrusion.

3. Teachers and health administrators have expressed lack of confidence in teaching about topics of a sexual nature.

4. Language barriers may serve as a barrier to the implementation of education programmes as most programmes are designed in English which is not the first language of many learners.

5. Programme content has been cited as a problem resulting from a lack of considering the developmental stage and educational abilities of learners.

6. The presentation of Life Skills Programmes is a very extensive process that can consume much time, leading to incomplete coverage of the necessary material (Grier & Hodges, 1998; Harrison, Smith & Meyer, 2000; Planned Parenthood Association of South Africa, 2000).

In the context of the information presented above, a Life Skills Programme, focusing on HIV/AIDS/STIs, rape and child abuse education, which was presented to primary and secondary school learners in Port Elizabeth, will be discussed.

4.5 Life Skills Programme on HIV/AIDS/STI, Rape and Child Abuse Education

This study forms part of a larger research project composed of a partnership between Ubuntu Education Fund and The Health and Development Institute (HDRI) in the Faculty
of Health Sciences at the University of Port Elizabeth funded by UNAIDS. Ubuntu Education Fund is an international organization that focuses on the enrichment of the community, more specifically, the community of the previously disadvantaged youth of South Africa. The HDRI was approached by Ubuntu Education Fund to assist with the evaluation of the Mpilo-Lwazi Life Skills Programme on HIV/AIDS/STIs, as well as rape and child abuse which was implemented in five primary and five secondary schools in Port Elizabeth during 2004.

The HIV/AIDS/STI education programme encompassed the following aspects:

- conveying information on HIV/AIDS/STIs,
- the risks involved in contracting HIV/AIDS, STIs
- the modes of transmission of HIV/AIDS, STIs
- myths about HIV/AIDS and STIs
- the prevention of HIV/AIDS/STIs.

The purpose of rape and child abuse education was to:

- establish a common understanding of rape and child abuse;
- introduce steps the learner can take to reduce his/her risk and;
- to prevent different forms of rape and child abuse.

The Ubuntu Education Fund requested assessment pre- and post intervention in order that they might more successfully assess the success of their intervention. The larger project consists of assessing the knowledge of the learners prior to Ubuntu's facilitated learning intervention (pre-test) and a follow up assessment of the acquired knowledge (post-test). This area of research is not applicable to this study. At the conclusion of the programme, focus groups were conducted with randomly selected subjects from within
the larger sample, in order to qualitatively explore their perceptions of the syllabus and the method utilized by the facilitators to convey the knowledge. This latter aspect is the focus of this study.

4.5.1 The Aims of the Larger Project

The aims of the larger research project were to develop an evaluation procedure by which the effect of the HIV/AIDS/STIs, rape and child abuse programme, for grade six to nine learners, could be assessed. The research consisted of following aims:

1. To determine if there is a change in the pre-test and post-test information regarding the level of knowledge the learners gained regarding HIV/AIDS/STIs, rape and child abuse.

2. To explore and describe the perceptions of the learners about the Life Skills project.

The aims of the larger research project employed two methods, i.e., the experimental pre- and post test design and the focus group design. The research project was divided into four phases:

1. Content and editorial refinement of the pre- and post-test questionnaire administered to learners.

2. Administering the pre-test to the learners to establish a baseline of knowledge.

3. Administering the post-test to learners to determine possible changes from the baseline to determine whether, and to what extent, the programme intervention had brought about a change in knowledge with regards to HIV/AIDS/STIs, rape and child abuse.
4. Focus group sessions with learners to capture qualitative data with regards to the learners' perceptions of the programme.

The information gained from these focus groups, form the content of this study. Both the qualitative and quantitative information will be collated and given as feedback to Ubuntu and the facilitators, to assist them in improving the syllabus and the teaching.

4.5.2 Aim of the Study

This study aims to explore and describe the perceptions of grade eight and nine learners of a Life Skills Programme on HIV/AIDS/STIs, child abuse and rape education.

4.6 Conclusion

This chapter reviewed literature regarding some theories that are applicable to HIV/AIDS/STI, child abuse, and rape prevention as well as education within the school context. The larger project, of which the HIV/AIDS/STI, rape and child abuse Life Skills Programme forms part, together with the methodology, were outlined above.

The next chapter will outline the methodology followed for the present study.
CHAPTER FIVE
RESEARCH METHODOLOGY

5.1 Introduction

This chapter outlines the methodology followed for the present study. The research design, participants and sampling procedure employed, the data gathering method 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.

5.2 Problem Statement and Aim of Study

As stated in Chapter Three, children have the right to be protected from maltreatment, neglect, abuse or degradation. Worldwide, however, millions of children are victims of neglect and physical and mental harm, including sexual abuse and exploitation. In South Africa the picture is equally disturbing as the country is widely believed to have not only one of the highest incidences of rape in the world, (Italo, 2003; Simmons, 2001), but also one of the highest levels of HIV/AIDS transmission. With research findings showing that HIV and other STIs are rapidly increasing globally (AVERT, 2003), young people are, and continue to be, at the forefront of the AIDS pandemic (Clark, 2002; Marcus, 2001). Therefore, prevention programmes should be aimed particularly at the young (Perloff, 2001; Van Dyk, 2001).

Education has been identified as one of the primary means of prevention (Asmal, 2001; Baldo et al., 1993; Van Dyk, 2001). Although it is widely accepted that the success of preventative programmes should be thoroughly evaluated, little is known about the
effectiveness of prevention initiatives (James, 1994; Melton & Flood, 1994; Chalk & King, 1998; The World Bank, 2002)

The aim of this study therefore, was to explore and describe the perceptions of grade eight and nine learners of a Life Skills Programme on HIV/AIDS/STIs, child abuse and rape education.

5.3 Research Design

The decision to select a research approach demands a consideration of the differences between how either qualitative or quantitative approaches best answer questions regarding reality and human nature. 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. In contrast, qualitative research does not separate the individual from their reality, and the researcher interacts with the subjects. In this form of interaction, the researcher discovers the subject's world and personal interpretation (De Vos, 1998). The qualitative approach was selected here, as it complemented the aim of this study.

Qualitative research is defined as a multi-perspective approach (utilising different techniques and data collection methods) to social interaction in terms of the meaning the subjects attach to it (De Vos, 1998). According to Berg (1995) qualitative data research methodology focuses on the experiences of the participants, and the relationship between the researcher and the participants. It also allows the researcher to establish a rapport with the participants, to be flexible in the way that interviews or data gathering methods are conducted and to enable both verbal and non-verbal information to be collected. In addition, qualitative research is deemed advantageous for this study as it enables the
researcher to identify unanticipated outcomes and to explore emerging ideas, thus ensuring the quality, depth and richness of the study (Denscombe, 1998).

5.4 Participants and Sampling Procedure

Non-probability, convenience sampling was used to select the target population of the larger project and consisted of grade six, seven, eight and nine learners from five primary and five secondary schools in Port Elizabeth. These were selected by Ubuntu Education Fund according to their criteria, taking in consideration the geographical locations and the socio-economic levels which the schools serve. Non-probability sampling is defined as the unlikely possibility of any particular member of the population being chosen for the study (Cosby, 1993). An advantage of non-probability sampling is its convenience and cost effectiveness. A disadvantage of non-probability sampling, is that statistical theories of probability do not apply to non-random samples (Terre Blanche & Durrheim, 1999). Therefore, the results of the study cannot be generalised to all schools in Port Elizabeth.

Participants from each school were selected using simple random sampling. Simple random sampling is defined as a sample where each person in the sampling frame has an equal chance of being selected. An advantage of simple random sampling is that it permits the full use of conventional statistical techniques (Breakwell, Hammond & Fife-Shaw, 1998). Therefore, the results of the study can be generalised to grades in the specific schools selected. A disadvantage of simple random sampling is that this approach can be somewhat cumbersome if the sampling population is exceptionally large (Breakwell, Hammond & Fife-Shaw, 1998).
5.5 Data Collection Method

Focus groups were conducted with learners to capture qualitative data regarding the research objectives. The use of focus groups was considered for this study, since the goal of self-contained focus groups is to learn about participants’ attitudes and opinions on the topic under research (Morgan, 1997). The strengths of focus groups include the ability to collect concentrated amounts of data on the research topic, and the fact that they are quick and easy in that one can achieve the same number of ideas with one focus group session, consisting of eight to ten participants, as one would normally achieve with eight to ten interviews (Morgan, 1997).

On the negative side, focus groups are less controlled than individual interviews, and the presence of the researcher, acting as a moderator, might produce researcher directed data. To prevent this from occurring, a research assistant aided the researcher in remaining objective.

For this study, semi-structured interviews were used. The advantages of semi-structured interviews are related to the objectives of the qualitative methodology, in that the reality can be constructed from the world of the participant. The researcher obtains an "inside view" of the social phenomenon. Another advantage of this type of interview is that both socially, and personally sensitive topics can be more openly discussed (De Vos, 1998). The most important disadvantage of the semi-structured interview is that it is time-consuming, and the interpretation of the data can be difficult.

In the interviews, open-ended questions were used. Bailey (1997) highlights the following advantages of open-ended questions:
1. They can be used when 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 practical 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:

1. They may produce useless and irrelevant information.

2. Coding of information is very difficult and subjective, resulting in a lower inter-coder reliability.

3. Open-ended questions require superior verbal abilities, and a higher educational level than close-ended questions.

4. Open-ended questions that are designed to be general, may be too general for participants to understand what is being asked. This could lead to the interviewer needing to probe for answers.

5. Open-ended questions require much more of the participants’ time and effort, and may produce a higher refusal rate.
The advantages and disadvantages of open-ended questions were considered, and it was decided that the advantages exceeded the disadvantages.

For this study, focus group sessions were conducted, and data was gathered until a saturation point was attained. A focus group consisted of 10-12, grade eight and nine learners from each school. The learners (aged 14 to 18) were Xhosa speaking. The interviews were conducted by a trained, Xhosa speaking Psychology Intern, who was assisted by a scribe who monitored non-verbal communication and interaction. These interviews were recorded. The content of the interviews were translated from Xhosa into English by a Registered Counsellor Intern whose English language proficiency was deemed adequate for this study as her home-language is Xhosa and she is a fourth year Psychology student at an English tertiary institution. Care was taken that the meaning and subtle nuances were not lost in the process. In keeping with the aims of the larger project, the semi-structured interview with the focus groups consisted of the following open-ended questions:

1. Perceptions about the programme as presented by the educators:
   
   • What did you like about the way in which the educators presented the Life Skills Programme?
   
   • What did you dislike about the way in which the educators presented the Life Skills Programme?
   
   • Who should teach you the Life Skills Programme?

2. Perceptions about the content of the Life Skills Programme:

   • What was easy to talk about?

   • What was difficult to talk about?
• What in the Life Skills Programme was important to you to know?

3. Suggestions to improve the programme:
• What else must be included in the programme?
• What other suggestions do you have for making the programme better?

4. Perceptions about being part of the research project:
• How did you feel about filling out the questionnaire both the first and second time?
• How do you feel about being interviewed?

5.6 Research Procedure

Ethics form an integral part of the interview process, and this includes informed consent and confidentiality. The participants of any research programme must always be informed about the research procedure and purpose of the interview. This is often accomplished by having a written agreement that is signed by both the interviewer and the participants (Kvale, 1996).

The proposal for this research was developed by the Health and Development Research Institute (HDRI) and submitted to the UPE Human Ethics Committee. Permission for the study to be undertaken was granted. Informed consent for the participation in the research, was obtained from the parents of the identified learners and from the learners themselves, before pre-test information was gathered (See Appendix B). The issue of confidentiality was addressed by ensuring that all interviews remained anonymous. Only the name of the school appeared on the interview transcriptions.
The participating schools were informed about the current phase of the larger project and their co-operation was requested. Upon receiving confirmation from the participating schools, a list of the learners who had completed the pre- and post test questionnaires which forms part of the quantitative study, in grade eight and nine classes was requested. From these lists the researcher randomly selected 10-12 participants from each school. These lists were forwarded to the schools and times for the focus group sessions negotiated.

At the start of each focus group session, the participants were briefed regarding the purpose of the interview and asked for permission to make a recording. Confidentiality was emphasised. A tape recorder and a 90 minute cassette tape were utilised to make audiotapes of the interviews. The tapes were clearly labelled and numbered before the sessions started, to avoid confusion.

The Health and Development Research Institute (HDRI) transcribed the data obtained from the audiotape recordings into written verbatim English records. The researcher conducted the coding and an independent coder was utilised.

5.7 Data Analysis

A thematic content analysis of the data collected from each focus group was conducted. For the purpose of analysing the data collected, and to meet to aims of the research, Tesch's model of content analysis was utilised. Data analysis occurred up to the point at which saturation was accomplished. Tesch (1990, in De Vos, 1998) suggests eights steps to follow in analysing data. These steps include the following:
1. The researcher needs to acquire an intuitive and holistic sense of the protocol by reading it repeatedly. In order for the researcher to make meaningful explications he/she needs to continually draw from their own experiences and thus maintain an awareness of self throughout the process. Personal perceptions and judgements should be bracketed.

2. The researcher selects one interview and asks, "what is this about" in an attempt to grasp the underlying meaning in the information. Thoughts are written in the margin. This should be conducted with all the interviews.

3. After thorough examinations of all of the participants' interviews, the researcher lists the topics and similar themes are clustered together. Themes are then arranged into columns and they can be classified as major themes, unique themes and leftovers.

4. Once this list is compiled the researcher returns to the data. The themes are then abbreviated into codes and written next to the appropriate segments in the text. During this phase it is possible to detect new categories and codes.

5. The researcher names the themes in descriptive wording and the themes are then turned into categories. Grouping related themes reduces the greater list of themes. By drawing lines between themes the researcher can indicate interrelationships between them.

6. Once the researcher has finalised the abbreviation for each category it is alphabetised.

7. Related data is assembled in one place and a preliminary analysis is performed.

8. Should it be necessary, the researcher recodes the existing data.
In accordance with the guidelines for qualitative data analysis as provided by Tesch (1990, in De Vos, 1998), transcriptions were coded and analysed per school, to obtain information regarding the perceptions of the learners in each specific school. The general themes and sub themes that emerged over the four schools were coded using a specific coding unit.

Furthermore, Guba's model of trustworthiness was used to assess the trustworthiness of the findings. This model includes four aspects namely: truth value, applicability, consistency and neutrality. Guba's approach was used to account for the researcher's bias and subjectivity (Krefting, 1991).

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 the context outside of the study. This study is exploratory and it is therefore not concerned with the ability to generalise to larger populations.

Truth value determines whether the researcher has established confidence in the truth of the findings, based on the research design, participants and context. The truth value is determined by the subjective presentations of human experiences by the subjects and not that of the researcher. The truth value of the research was increased by using the method of peer examination. An independent coder and co-reviewer were employed. Discussions with these impartial colleagues involved the research process and findings made. The independent coder 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).
Consistency of data refers to whether the findings would be consistent if the enquiry were replicated with the same participants or in a similar context (Krefting, 1991). Peer examination was useful in establishing this criterion. The use of colleagues to check the research plans and their implementation helped ensure consistency. A dense description of research methodology and techniques increased the likelihood of consistency. A comprehensive description of research methodology and techniques provided information that effected how applicable the study might be (Denscombe, 1998; Krefting, 1991).

Neutrality refers to the degree to which the findings are a reflection solely of the participants and the conditions of the research, and not of other biases, motivations and perspectives. Guba shifted the emphasis of neutrality in qualitative research from the researcher to the data. Thus the neutrality of the data was considered rather than looking at the researcher (De Vos, 1998). In order to investigate the neutrality of the study, two research supervisors acting as external auditors, followed the progression of the research to understand how and why decisions were made.

5.8 Conclusion

Chapter Five provided an outline of the research methodology relating to this study. For the purpose of this study, a qualitative approach was chosen, as it does not separate the individual from their reality. With this form of interaction, the researcher discovers the subject's world and interpretation (De Vos, 1998). Qualitative approaches therefore capture the internal, emotional processes related to a programme. These results are the purpose of this study. Focus groups were conducted within the chosen sample, and data was analysed using Tesch's approach.
The next chapter is a presentation of the findings of the research. A discussion of the findings will show that the aims of the study have been achieved.
CHAPTER SIX
RESULTS AND DISCUSSION

6.1 Introduction
This chapter presents the results of the study drawn from the semi-structured focus group interviews. The aim of this was to determine the perceptions of grade eight and nine learners with regards to a Life Skills Programme focussing on HIV/AIDS/STIs, rape and child abuse. Tesh's model of data analysis (De Vos, 1998) was utilised. After analysing all the transcripts, six general themes emerged. These are:

1. Learners' perceptions of the Life Skills Programme as presented by the educators.
2. Learners' perceptions of who must present the Life Skills Programme.
3. Learners' perceptions of the degree of comfort in discussing various topics.
4. Learners' perceptions of the relevancy of the Life Skills Programme.
5. Learners' perceptions on recommendations regarding future prevention.
6. Learners' perceptions of being part of the research process.

The data is presented in themes, sub-themes and aspects to the themes in tabular form. Thereafter, the results are discussed according to the structure provided by these identified themes.

6.2 Themes, Sub-Themes and Specific Aspects of Themes that emerged from the Data
6.2.1 Learners' Perceptions of the Life Skills Programme as Presented by the Educators.
This general theme presents the learners' perceptions of the Life Skills Programme as
presented by the educators. Sub-themes and specific aspects relating to these sub-themes are presented in the table 4 below.

Table 4

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Specific aspects of sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Likes</td>
<td>1.1 Teaching methods</td>
</tr>
<tr>
<td></td>
<td>1.1.1 Provision of information</td>
</tr>
<tr>
<td></td>
<td>1.1.2 Explaining concepts</td>
</tr>
<tr>
<td></td>
<td>1.1.3 Clarifying concepts</td>
</tr>
<tr>
<td></td>
<td>1.1.4 Advising learners</td>
</tr>
<tr>
<td></td>
<td>1.1.5 Experiential learning</td>
</tr>
<tr>
<td></td>
<td>1.2 Educator qualities</td>
</tr>
<tr>
<td></td>
<td>1.2.1 Kind</td>
</tr>
<tr>
<td></td>
<td>1.2.2 Approachable</td>
</tr>
<tr>
<td></td>
<td>1.2.3 Patient</td>
</tr>
<tr>
<td></td>
<td>1.2.4 Trustworthy</td>
</tr>
<tr>
<td></td>
<td>1.2.5 Non-discriminatory</td>
</tr>
<tr>
<td>2. Dislikes</td>
<td>None</td>
</tr>
</tbody>
</table>

Different teaching methods were employed by the educators. These included the traditional teaching methods such as providing information and advising learners. Some educators utilised experiential learning exercises such as group discussions. Almost all of the learners perceived the teaching methods as very positive and noted some relevant
issues. None of the learners reported negative aspects of the teaching methods utilised by the educators.

Learners welcomed educators providing them with new information and knowledge. "I liked that they educated about things that we did not know", "They taught us and educated us so that we must also have knowledge", and "I learnt a lot about things I did not know before".

Learners reported that they liked that educators provided them with advice. Verbatim responses included: "What I also liked is that they also gave you advice in the problems that you had – they gave us advice on how to go about to do certain things", "They advised us the right way because we are still children", "I liked it that they sometimes advised us not to drink alcohol or use drugs" and "I liked that they gave us a lot of advice". These verbatim responses do not reflect traditional African custom in which the discussion of sexual matters between children and adults is perceived as an unwelcome intrusion (Schoef, 1999).

Learners liked that educators explained and clarified concepts. Verbatim responses included: "I liked that educators explained certain topics", "I liked that they explained the things thoroughly", "If you put up your hand they would come to you and actually explain to you", "If you were confused about certain things they will explain until you understand", "They explained the subjects to us well", "They explained well whatever they were talking about…..so much that I could understand clearly what they were talking about" and "If we did not understand the questions that were asked the teachers explained to us what they meant”. According to Cameron (2004), a few of the most important characteristics of an effective educator is being knowledgeable and having the
ability to explain and clarify concepts, as well as to point out relationships between concepts.

In addition, learners reported enjoying experiential learning activities in which they actively participated in the learning process. They enjoyed that they were learning other skills as well, such as team building and establishing trusting relationships. Verbatim responses include: "The group discussions really helped us a lot with us understanding the topic", "The teachers encouraged us to talk about the topics during breaks and so it was easy for the knowledge to stick", "I enjoyed the role plays ……this taught us to work as a team", "I liked the role plays….it taught us to trust each other and not putting each other down", "We were taught to listen to each other" and " It taught us to live in harmony". The positive perceptions of the learners with regards to an interactive approach was not surprising, since research states that participatory methods work best for young people (Mugabe, 2001) and are particularly enjoyed by this particular age group (Aggleton & Rivers, 1993). Furthermore, as discussed in Chapter Four, this type of learning focuses on developing existing strengths and life experience of the learners, acknowledging values, and uses the existing knowledge and competence of every learner in the group (Rooth, 1995). It allows learners the opportunity to explore their own attitudes and feelings towards issues such as HIV/AIDS, rape and child abuse.

The learners reported that they felt comfortable to actively participate in discussions. Personal qualities of the educators might have played a significant role in how they perceived the educators and the levels of comfort they experienced. The learners perceived the educators who presented the Life Skills Programme positively. It was reported that they were kind, approachable, patient, trustworthy and non-discriminatory.
Verbatim responses included: "They were kind people", "I liked the way the educators spoke to us – they were not rude and very honest", "What I liked was that the things that I wanted to know about, they spoke directly about them, and did not hide them from us", "What I liked was that if things were hidden from us at home we were able to approach and ask them about the things that we wanted to know about", "They are easy to talk to", "They let you speak what you wanted to speak about", "what I like was that they did not cut you off when you were speaking – you asked the question that you wanted to ask and they did not cut you off", "You weren’t afraid that they would cut you off", "I liked the fact that the educators were patient.", "What I also like was that when you approached them you knew that if you discuss something with them no one else would know about it", "What I liked was that they were people we could trust and you could discuss your problems with them", "What I liked was when they spoke to us they did not choose certain people and were not wary of anyone", and "….they did not discriminate against them…..and say I am going to pick this child and not this one".

The learners responded positively to caring, open and trustworthy educators. As discussed in Chapter Four, according to the social cognition theory's concept of reciprocal determination, behavioural changes are determined by the interactions between a person and his/her environment. Therefore a child that perceives an educator positively is more likely to find his/her environment conducive to disclose abuse to an educator.

Furthermore, having a positive view about the educator/presenter is likely to facilitate the learning process. According to Cameron (2004), teacher qualities, such as being reasonable, open, concerned and imaginative beings encourages effective education.
Although most learners perceived the Ubuntu Education Fund Educators positively, other individuals suitable to present the Life Skills Programme, were identified. Learners' perceptions of individuals suitable to present the Life Skills Programme will be discussed in the following section.

6.2.2 Learners' Perceptions of Who Must Present the Life Skills Programme.

This main theme presents the learners' perception of who must present the Life Skills Programme. Sub-themes and specific aspects relating to these sub-themes are presented in table 5 below.

Table 5

Main theme: The learners' Perceptions of Who Must Present the Life Skills Programme

<table>
<thead>
<tr>
<th>Sub – themes</th>
<th>Specific aspects of sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Teachers</td>
<td>1. Ubuntu educators</td>
</tr>
<tr>
<td></td>
<td>2. School teachers</td>
</tr>
<tr>
<td>2. Health care professionals</td>
<td>1. Counsellors</td>
</tr>
<tr>
<td></td>
<td>2. Social Workers</td>
</tr>
<tr>
<td></td>
<td>3. Medical staff</td>
</tr>
<tr>
<td>3. Family members</td>
<td>1. Parents</td>
</tr>
<tr>
<td></td>
<td>2. Uncles</td>
</tr>
<tr>
<td></td>
<td>3. Aunts</td>
</tr>
<tr>
<td>4. Peers/friends</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
</tbody>
</table>

All of the learners of one school suggested that the Ubuntu health educators should teach the Life Skills Programme and no other presenters were suggested. Learners in the
other schools agreed that the Programme should be presented by their teachers or health care educators. Verbatim responses included: "The teachers that present it to us should present it again", "……and …..should present it …we feel comfortable with them", "Teachers should teach the programme…..but maybe also the educators….they are easier to talk to”.

Some learners disagreed that teachers should present the programme as they mainly felt that the teachers at their school were not approachable. Verbatim responses included: "It would be hard to talk to a teacher, because they are unapproachable", and "I would not feel comfortable with the teachers knowing private stuff about me". As stated in Chapter Four, the role of teachers in presenting Like Skills Programmes is globally recognised. It is suggested that teachers can serve as confidants, instructors and positive role models and monitor learner's emotional and physical health and behaviour (Gilligan, 1998). However, some learners might feel uncomfortable with teachers discussing sensitive issues of a sexual nature. This may well be due to presence of abuse, too often incurred by the learners in South African schools (Bower, 2002). Furthermore, the teacher's own discomfort toward issues of sexual nature or their unfamiliarity with useful teaching techniques can inhibit the education process (Kinsmend & Harrison, 1999) and increase learners' discomfort.

Most learners of the other schools suggested that other health care professionals, such as counsellors, social workers and medical staff should also be involved in teaching the Life Skills Programme as they can provide professional services. Verbatim responses included: "I also think that counsellors should teach the Life Skills, because counsellors will discuss the problems with you and administer counselling at the same time", "I think
that social workers should come and teach us because it is what they do….. coming to talk to the people in the community – also because they know what they are talking about", "I also think that social workers are good because even if you go to them they have the training to administer counselling to you," and "I think nurses should teach us the programme, because they experience the things that we talk about on a day to day basis…they also have posters to show us". The above-mentioned verbatim responses highlight the need for a global approach in the combating of HIV/AIDS/STIs, rape and child abuse. Collectively, health care professionals, teachers and other stakeholders should take responsibility for educating the youth.

To a lesser degree it was suggested that family members should be involved in teaching Life Skills. Verbatim responses included: "I also think that uncles, aunts and a lot of other people close to us should teach the programme" and "I think that parents as well as teachers should teach us …..I think it is important that these people teach us, because they are trustworthy". However, it should be noted that research indicates that most parents do not feel comfortable or skilled enough to discuss sexuality and HIV/AIDS with their children (Planned Parenthood Association, 2002). Likewise, within the African tradition, discussions about sexual matters between adolescents and adults, such as parents (and teachers) are often regarded as an unwelcome intrusion (Schoef, 1999). Furthermore, with regards to learners discussing topics related to child abuse with family members, it should be noted that parents and family members account for 50 % of reported child abuse cases (South African National Council for Child Welfare, 2004).

Learners disagreed upon whether peers should be involved in educating each other. Verbatim responses included: "Friends should teach us", and "I do not agree with the
comments about friends, because friends might mislead you”. As discussed in Chapter Two, social development during adolescence is characterised by strong identification and involvement with peers (Newman & Newman, 2003; Van Dyk, 2001) and therefore the role that adolescents play in educating peers should not be underestimated. Furthermore, research has indicated that this age group will share their knowledge with others, both in their families and communities, thus networking preventative campaigns wider than just the classroom (Balding & Regis, 1993; Kalra et al., 2000; Perloff, 2001; Umeh, 1997).

As it is evident that presenters of Life Skills Programmes have a great responsibility to learners, it is recommended that presenters should receive sufficient training, ongoing support and monitoring. In addition, is suggested that presenters should deal with their discomfort and misperceptions about modern sexuality and their lack of confidence (Grier & Hodges, 1998) and should be more aware of their own behaviours and attitudes since they can convey prejudice which learners can easily acquire.

6.2.3 Learners' Perceptions of the Degree of Comfort in Discussing Various Topics

This main theme presents the learners' perceptions of the degree of comfort in discussing various topic of the Life Skills Programme. Sub-themes and specific aspects relating to these sub-themes are presented in table 6 below.
Table 6

Main theme: Learners' Perceptions of the Degree of Comfort in Discussing Various Topics

<table>
<thead>
<tr>
<th>Sub – themes</th>
<th>Specific aspects of sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV/AIDS</td>
<td>1. Easy</td>
</tr>
<tr>
<td>2. STI's</td>
<td>1. Difficult</td>
</tr>
<tr>
<td>3. Rape</td>
<td>1. Difficult</td>
</tr>
<tr>
<td>4. Child abuse</td>
<td>1. Difficult</td>
</tr>
</tbody>
</table>

Most learners stated that they felt comfortable discussing HIV/AIDS. Verbatim responses included: "It is easy to talk about HIV/AIDS – it is a topic that is discussed each day", "I am not shy to talk about AIDS, because it is talked about in the media and everywhere you go", "It is easy to talk about AIDS, because a lot of people are dying of AIDS, so we understand it – it is something we live with", and "…it is easy to talk about, because it is stuff we have to deal with each day". From the verbatim responses it can be deduced that the learners' comfort talking about HIV/AIDS primarily relate to the fact that it has become reality for them as they are exposed to it in their daily lives.

Few learners, however, reported that it was difficult to discuss issues relating to HIV/AIDS. Verbatim responses supporting this included: "I thought AIDS was a difficult thing to discuss, because if I were to announce that I have AIDS to my friends for instance, maybe the friend would go about announcing it to other people that I have AIDS" and "That is what we are afraid of – and once people know that we have AIDS and look at you in a bad way it kills you more and more" (sic). All the learners that expressed their difficulty talking about HIV/AIDS related it to prejudice surrounding a HIV positive status. As stated in Chapter Two, people diagnosed with HIV/AIDS and
their family members have to cope with the prejudice, discrimination and rejection associated with the disease which makes it difficult for them to openly talk about HIV/AIDS. The importance of educating people in order to lessen prejudice is once again highlighted.

Unlike the expressed ease of most learners to talk about HIV/AIDS, learners expressed that it was difficult to talk about other STIs as they do not have sufficient knowledge about the topic. Verbatim responses included: "I think STIs were difficult to talk about, because we did not have knowledge or information about them previously", and "It is difficult to talk about STIs since we did not have knowledge about what STIs were and how they could be treated and how do you tell if someone have a STI" (sic). Learners reported feeling more comfortable discussing STIs having gained some knowledge about the topic as illustrated by the following verbatim response: "STIs was easier to talk about in the sense that we learnt a lot about it".

Learners expressed different opinions with regard to the perceived comfort to discuss child abuse and rape. Verbatim responses included: "Rape was easier to talk about, because it is something that is happening around us in the community", "Child abuse was easy to talk about…..as learners we know a lot of about abuse and see a whole lot of abuse happening". The verbatim responses suggest that, like HIV/AIDS, rape and child abuse, are a reality for many learners which is supported by the statistics of rape and child abuse statistics in South Africa (Bower, 2002; Sookha, 2004). Nevertheless, these phenomena remain disturbing as illustrated by the following verbatim response: "Rape was difficult to talk about, because you hear about gang rapes and that makes you feel a
bit terrified, because of the mere fact that a person is gang raped means that they were really treated horribly and were abused horribly".

6.2.4 Learners' Perceptions of the Relevancy of the Life Skills Programme.

This main theme presents the learners' perception of the relevancy of the Life Skills Programme. Sub-themes and specific aspects relating to these sub-themes are presented in table 7 below.

Table 7
Main theme: The Learners' Perceptions of the Relevancy of the Life Skills Programme.

<table>
<thead>
<tr>
<th>Sub – themes</th>
<th>Specific aspects of sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Life Skills Programme</td>
<td>1. Relevant</td>
</tr>
<tr>
<td>2. Relevant HIV/AIDS/STI topics</td>
<td>1. Modes of transmission</td>
</tr>
<tr>
<td></td>
<td>2. Prevention</td>
</tr>
<tr>
<td></td>
<td>3. Treatment</td>
</tr>
<tr>
<td>3. Relevant child abuse topics</td>
<td>1. Types/Definitions</td>
</tr>
<tr>
<td></td>
<td>2. Post - crisis intervention</td>
</tr>
<tr>
<td></td>
<td>3. Rights of children</td>
</tr>
<tr>
<td>4. Relevant rape topics</td>
<td>1. Types/Definitions</td>
</tr>
<tr>
<td></td>
<td>2. Post - Crisis intervention</td>
</tr>
<tr>
<td></td>
<td>3. Rights of children</td>
</tr>
<tr>
<td></td>
<td>4. (Prevention)</td>
</tr>
</tbody>
</table>

In response to the question dealing with what the learners perceived as important for them to know with regards to the Life Skills Programme, the discussion centred around the relevancy of the programme. Learners of all the schools perceived the Life Skills
Programme to be very relevant. Verbatim responses to verify this statement included the following: "What I liked was that they talked about the things that I really wanted to know about", "The things they teach are things that happen to us and they talked about exactly what is happening in our lives", "All the topics were interesting, because we have reached this stage in life ...and we want to know how to help others in this stage", and "All of the things were important for us".

As adolescence is characterised by an interest in, and curiosity about, sexual relations, and an increase in sexual activities ((LaFreniere, 2000; Papalia & Olds, 1998; Van Dyk, 2001), it is not surprising that learners perceived topics related to HIV/AIDS/STIs as important. Furthermore, as previously stated, HIV/AIDS/STIs, are directly and indirectly affecting millions of adolescents world wide. Likewise, rape and child abuse is a reality for many adolescents as abuse usually continues into adolescence (Finkelhor et al., 1990; Flemming et al., 1997), making rape and child abuse relevant topics for this age group.

Learners specifically identified the following topics related to HIV/AIDS/STIs as being important for them to learn about: the modes of transmission, preventative measures and treatment. Verbatim responses related to modes of transmission included: "It was important for me to know that if you sleep with a person once you can get AIDS", "It is important to know that there are people who are positive and you can not prevent getting it if you are raped", and "I liked that they told us about that if you do drugs these are the bad things that can happen to you....."

The following verbatim responses suggest that learners regard information about HIV/AIDS/STI prevention measures as important: "It was important for me to learn from the AIDS subject that every time you have sex, it is important to use a condom", "......I
learned that you must not sleep with a boyfriend until you are married" and "What I liked is that they gave us preventative measures to use".

Verbatim responses related to HIV/AIDS/STI treatment included: "It is important for us to know about the treatment for AIDS", "It is important to know how to protect yourself when you are infected with AIDS", and "You must know what to do if you are infected with STIs".

As discussed in Chapter Four, the IMB model identifies information as one of the components as an integral for the process of behavioural change (Perloff, 2001). According to Harvey (2000), basic information of HIV/AIDS/STIs, namely symptomology, diagnosis, how viruses are transmitted and what preventative measures can be taken, are essential in changing risky behaviour. This process of knowledge acquisition is made easy by the stage of cognitive developmental stage of the learners during which formal operational levels of thinking and hypothetical thinking allow adolescents to think possibilities through and to identify future consequences of their actions (Seaver, 2000). Therefore, adolescence is identified as the best time to convey information about sex and installing values (Van Dyk, 2001).

With regards to rape and child abuse, learners identified various topics that were relevant and important for them to know about. This includes having knowledge of what rape and child abuse exactly entail. Verbatim responses included: "It is important for us to know about different types of abuse as many of us suffer from abuse", "I think rape was important, because we learned about the different types of rape" and "…it was important, because we were able to distinguish between different crimes and were able to decide if something is a crime or not…".
Furthermore, most learners agreed that it was very importance for them to learn what to do when they, or someone they know, is being abused or raped. This incorporates reporting of rape and child abuse, as well as receiving post rape treatment and counselling. Verbatim responses included: "It was a very important topic, because we wanted to know who to call when you are abused.....and now we know", "It was important to learn what to do after you have been raped", and "I learnt from the abuse one – where for instance your father is beating you up – what to do....it was important".

In one school learners reported the usefulness of learning ways of preventing rape. Verbatim responses included: "It was important for me to learn a preventive measure – that sometimes it is a good idea to look at the way you are dressing, not to wear things that are too short and also when you are going to taverns and shebeens that you must be careful of the company you keep" and "....even if you do not go to taverns – for instance, your father is a person who drinks a lot at home – try not to wear things that are suggestive to him...". This perception of learners that the prevention of rape is the responsibility of children, opposed to that of the adult, is alarming and emphasise the role of education in rectifying misconceptions.

Related to the above-mentioned topics, some learners stressed the importance of knowing their rights. Verbatim responses included: "I think it is important for us to know what our rights are", "It was important for us to learn about our rights as children.....saying no to rape" The verbatim responses above illustrate that in addition to the acquisition of knowledge, learners enjoyed the empowering nature of programme. Bower (2002) emphasised the importance of empowering the youth by making them
aware of their rights and providing them with skills. This includes the right of children to protect them from abusive situations and rape. Empowering the youth requires creating an awareness in them and providing them with choices. Additionally, it should focus on prevention through building self-esteem and increasing assertiveness, and by encouraging healthy relationships and communication.

6.2.5 Learners' Perceptions on Recommendations regarding Future Prevention

This main theme presents the learners' perceptions on recommendations regarding future prevention. The sub-themes are presented in table 8 below.

Table 8

Main Theme: Learners' Perceptions on Recommendations regarding Future Prevention

<table>
<thead>
<tr>
<th>Main themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recommendations</td>
<td>1. More individuals</td>
</tr>
<tr>
<td></td>
<td>2. Counselling services</td>
</tr>
</tbody>
</table>

As mentioned before, the learners' perceptions of the Life Skills Programme in general were very positive and only two themes emerged from the data with regards to recommendations for future intervention. Firstly, most learners felt that more children, especially children from deprived communities, should be involved in the programme. Verbatim responses included: "I felt something must be included for street kids about the education we have been taught…..and to others that does not know" (sic), "I think they should include a whole lot of other youth and not just here in school, but also in the locations" and "In the sense that this should be going to the community people and to the
other youth in general”]. The learner's cognitive stage of development, which is characterised by greater compassion and empathy (Van Dyk, 2001) explains the concern that learners expressed for the well-being of other youth”.

Secondly, most learners felt that counselling services should be available in conjunction with the Life Skills Programme. Verbatim responses included: "I think it is important to that we have counselling services after these programmes so that if a problem comes up then at least you are able to speak to someone or do something about problem", "There should be counselling services, because a lot of children is being abused at home" (sic), and "I think counselling services should be provided for students who have problems relating to the different topics". As illustrated by the above-mentioned verbatim quotes, the provision of counselling services is a need for learners, firstly due to the sensitive nature of the topics, and secondly due to the possible need of learners to disclose about abuse. Although the recommendation for counselling services is very valid, it is not always feasible. Therefore, the role of the educators in early detection of abuse is significant. Educators should be able to readily notice unusual behaviour in or change in behaviour that might signify that a child is suffering abuse. Educators are thus uniquely placed to contribute to the prevention of abuse, emphasising the need for mandatory training of educators in this regard.

Various other suggestions were provided by learners which included the following: It was suggested that additional resources, such as books, should be made available for them to gain additional information. It was also suggested that educators make use of visual aids in presenting the various topics. Educational literature suggests that the use of visual aids in teaching results in a greater degree of learning (Stokes, 2004) and indicates
that inclusion of visual aids in conveying information enhances the processing and retaining of information, if verbal information is supplemented with visual aids.

Learners also felt that Life Skills Programmes should receive increased government support. The importance of governmental support in the implementation of Life Skills Programmes is widely recognised. However, in addition to government support for Life Skills Programmes, Casey and Thorn (1999), stressed the importance of monitoring and support by non-governmental organisations (NGO's), to ensure the ongoing success of Life Skills Programmes in schools.

Finally, learners at one school suggested involving more staff members to monitor possible disturbances, for example noise disturbances, which could interfere with the presentation of the programme. This recommendation stresses the importance of a needs assessment prior to the intervention, which should acknowledge uniqueness of different populations.

6.2.6 Learners' Perceptions of Being Part of the Research Process

This main theme presents the learners' perception of being part of the research process. Sub-themes and specific aspects relating to these sub-themes are presented in table 9 below.

Table 9

Main theme: Learners' Perceptions of Being Part of the Research Process

<table>
<thead>
<tr>
<th>Sub – themes</th>
<th>Specific aspects of sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perceptions of the pre-testing process</td>
<td>1. Uncomfortable</td>
</tr>
<tr>
<td></td>
<td>2. Not knowledgeable</td>
</tr>
</tbody>
</table>
Differences were noted in completing the first and the second questionnaire. The learners in general felt more comfortable completing the second questionnaire, and found that it was easier to complete once they had been through the programme and had acquired knowledge about the various topics. Verbatim responses included: "In the first one I felt uncomfortable, because it was topics that we had not been taught at first", "In the first questionnaire I was not sure how to answer, because we had not been taught these things", "The second time I was happy, because I gained knowledge" and "The second time it was a challenge, because I knew the things".

To a lesser degree it was reported that discomfort during the pre-testing related to misinterpretation of the aim of the research process. Verbatim responses included: "The first time they did not teach us well – we thought we were going to fail" and "The first time I was not sure that whether they would show the answers to other people". The verbatim illustrates that the importance of explaining the aim of the research to the participants as well as to ensure the protection of participants by assuring them of confidentiality.
Furthermore, the above-mentioned findings were congruent with other research findings, in that learners experienced the post-testing more positively than the pre-testing as they felt that they were more knowledgeable by the time they completed the second questionnaire (Julies, 2003; Makalima, 2003).

Although it was not the researcher's aim to assess the learners' perceptions of the content of the questionnaire, valuable information was gained with regards to the content of the questionnaire which can be useful to guide further research. For example, learners responded positively to having the "I don't know" option included in the questionnaire. Verbatim responses included: "It was nice that I could tick "I don't know", and "I liked that there was an option of that saying that I did not know when I was not sure about something."

In addition, learners indicated that the content of the questionnaires was clear, especially having both English and Xhosa versions of the questions. Verbatim responses included: "If I did not understand a question, there were English and Xhosa sections where if I did not understand the language" (sic) and "It was nice, because there was a slot where they translated it into Xhosa if we did not understand the English". As mentioned in Chapter Four, the findings emphasise the importance of acknowledging that language barriers may serve as a barrier to the implementation of education programmes (Grier & Hodges, 1998).

Learners perceived the interviewing process positively. It was reported that they felt very comfortable and it was easy to talk about things they were knowledgeable about. Verbatim responses included: "I felt comfortable with the session, because they were recapping on stuff we have learned.", "I felt comfortable and at ease as I knew the
answers and it was easy to reply.", "I was free…", and "The interviewer was nice….I enjoyed it". The learners enjoyed the participatory nature of the interviewing process and responded well to being interviewed. As stated before, learners of this age group enjoy discussing topics relevant to them. The need for the inclusion of participatory methods in teaching is therefore once again highlighted.

Research findings suggested that learners feel more comfortable if they have knowledge about the topics under discussion. However, the interviewer’s role in making learners feel comfortable should not be underestimated. According to De Vos (1998) the interviewer needs to be aware of the following principles, amongst others, to ensure that the participants feel comfortable:

1. Treating the participants with respect and courtesy.

2. Reflecting empathy with participants and not condemnation or disdain.

3. Ensuring that their identity and any information that they provide will in all circumstances be treated as confidential.

4. Accepting and recognising the uniqueness of every participant with regard to nationality, religion, race, personality and background.

6.3 Summary of Research Findings

An analysis of the qualitative data regarding the Life Skills Programme, revealed six themes, which were consistent across all the focus groups. Therefore, the results can be generalised to all grade eight and nine learners of the schools in which the programme was implemented. The major findings of the present study, based on the six general themes, include the following:
7. Most of the learners perceived the educators as well as the teaching methods utilised by the educators, positively.

8. Although the learners perceived the presenters of the Life Skills Programme positively, it was suggested that teachers, health care professionals, family members and peers should be involved in presenting the Life Skills Programme.

9. Learners reported various levels of comfort discussing different topics presented in the Life Skills Programme.

10. Learners of all the schools perceived the Life Skills Programme to be very relevant.

11. Learners recommended that more children, especially children from deprived communities, should be included in the programme. In addition, learners' felt that counselling services should be available in conjunction with the Life Skills Programme.

12. Differences were noted in completing the first and the second questionnaire. Learners reported that they felt more comfortable completing the second questionnaire. They perceived the interviewing process positively.

6.4 Conclusion

After experiencing the Life Skills Programme, learners were in a position to comment on their perceptions of the Life Skills Programme on HIV/AIDS/STIs, rape and child abuse. The results of this study have succeeded in identifying the perceptions of grade eight and nine learners with regard to Life Skills education programme.
The last chapter focuses on the conclusions reached about this study, which are based upon the results presented in this chapter. The limitations of this study are discussed and recommendations are made based on the major findings of this study.
CHAPTER SEVEN

CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

South Africa has not only one of the highest incidences of rape and child abuse in the world, (Italo, 2003; Simmons, 2001), but also has one of the highest levels HIV/AIDS transmission. As outlined in Chapter Four, in order to combat these phenomena, the youth have been identified as the group in need of education. This investigation focused on the perceptions of grade eight and nine learners with regards to a Life Skills Programme on HIV/AIDS/STIs, rape and child abuse.

The final chapter of this present study outlines the conclusions based upon the research findings of Chapter Six. Limitations in conducting the present study are documented as well as recommendations for future studies.

7.2 Research Findings and Conclusions

Most of the learners perceived the educators, as well as the teaching methods utilised by the educators, positively. Learners welcomed the educators providing them with new information, knowledge and advice and they liked that the educators explained and clarified concepts. Experiential teaching methods such as group discussions were perceived very favourably. In addition, learners perceived the educators positively and stated that they were kind, approachable, patient, trustworthy and non-discriminatory.
Although the learners perceived the presenters of the Life Skills Programme positively, it was suggested that teachers, health care professionals, family members and peers should be involved in presenting the Life Skills Programme.

Learners reported various levels of comfort discussing different topics presented in the Life Skills Programme. In general learners reported it was easy to talk about HIV/AIDS, but more difficult to discuss issues related to STIs, rape and child abuse.

Learners of all the schools perceived the content of the Life Skills Programme to be very relevant. Learners specifically identified the following topics related to HIV/AIDS/STIs as being important for them to learn about: the modes of transmission, preventative measures and treatment. With regards to rape and child abuse, learners identified various topics that were relevant and important for them to know about. These included having knowledge of what rape and child abuse exactly entail. Furthermore, most learners agreed that it was very important for them to learn what to do when they, or someone they know, is being abused or raped.

Differences were noted in completing the first and the second questionnaire. Learners reported that they felt more comfortable completing the second questionnaire and found that it was easier to complete once they had been through the programme and had acquired knowledge about the various topics. To a lesser degree, it was reported that discomfort during the pre-testing related to misinterpretation of the aim of the research process.

They perceived the interviewing process positively. It was reported that they felt very comfortable and it was easy to talk about things they were knowledgeable about.
7.3 Limitations of the Study

As stated in Chapter Five, Guba's model of trustworthiness was employed in this study. However, certain limitations pertaining to the research process and methodology were noted during the present study. The limitations of the various methods employed in the present study were discussed in some detail in Chapter Five and are therefore not repeated here. Limitations resulting from the research approach, which were not noted earlier, include:

1. As the approach is exploratory in nature, there is limited external validity and the findings are thus not generalisable to other populations.
2. The qualitative approach only allowed for tentative conclusions, therefore future research may be needed before basing decisions on these conclusions.
3. There was no control over extraneous variables such as the learners' background that could influence the research.
4. The interviewer could have characteristics, such as age and gender, that could influence the way in which the learners responded.

7.4 Recommendations made by the Learners to Improve the Life Skills Programme.

As discussed before, learners recommended that more children, especially children from deprived communities, should be included in the programme. In addition, learners felt that counselling services should be available in conjunction with the Life Skills Programme. Other recommendations include the following:

1. Additional resources, such as books, should be made available for them to gain additional information.
2. Educators should make use of more visual aids in presenting the various topics.

3. Involving more staff members to monitor possible disturbances, for example noise disturbances, which could interfere with the presentation of the programme.

4. Life Skills Programmes should receive increased government support.

7.5 Recommendations

After having conducting the research the following recommendations can be made:

As disturbances such as noise and interruptions by teachers and pupils might occur in a school setting, it is recommended that the focus groups are conducted in a venue that is conducive to eliminate these disturbances. It is furthermore recommended that focus groups are conducted preferably during the morning opposed to in the afternoon when learners might be tired after a school day.

As focus group participants are randomly selected from different grades and classes, they might be unfamiliar with each other. In addition, they are unfamiliar with the researchers. Therefore, it is recommended that an ice-breaker activity is used to decrease possible discomfort which might interfere with the interviewing process.

As stated in Chapter Four, research indicates that the most effective educational programmes are based upon theoretical approaches derived from behavioural change models. It is suggested that status assessment of the target population, involving several of the model constructs, should occur before constructing the intervention. Therefore it is recommended that the Programme designers, such as Ubuntu Education Fund, re-consider the fundamental concepts of theoretical models as well as the research on their effectiveness and then alter their interventions accordingly.
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APPENDIX A

FOCUS GROUP INTERVIEW SCHEDULE

Briefly explain the purpose of the interview.

Ask permission to make recording.

Emphasise confidentiality.

Ask permission to continue.

1. Perceptions about the programme as presented by the educators:
   • What did you like about the way in which the educators presented the Life Skills Programme?
   • What did you dislike about the way in which the educators presented the Life Skills Programme?
   • Who should teach you the Life Skills Programme?

2. Perceptions about the content of the Life Skills Programme:
   • What was easy to talk about?
   • What was difficult to talk about?
   • What in the Life Skills Programme was important to you to know?

3. Suggestions to improve the programme:
   • What else must be included in the programme?
   • What other suggestions do you have for making the programme better?

4. Perceptions about being part of the research project:
   • How did you feel about filling out the questionnaire both the first and second time?
   • How do you feel about being interviewed?
Dear Parents

The Health and Development Research Institute and Psychology Department at the University of Port Elizabeth are currently evaluating the Lifeskills Programme presented by Ubuntu Education to Grade 6, 7, 8, and 9 learners in schools. Your child has been chosen to participate in this study along with other learners at the school. To assist us with our evaluation, we require of learners to complete a questionnaire in the beginning of 2004 and repeat this towards the middle of the year to test their knowledge, attitudes and perceptions on issues such as HIV and AIDS, rape and child abuse. We can give you the assurance that we treat all the information provided to us as highly confidential and your child will therefore not be identified or linked to his or her answers.

The school that your child attends has granted permission for the children to take part in the evaluation programme, provided that you are in agreement. The first questionnaire will be administered in May 2004 during school hours.

If you give permission for your child to participate, please sign the form provided below and return to your child’s school as soon as possible. Should you require additional information, please contact Francois Potgieter (504 2344) or Di Elkonin (504 2816) or alternatively your child’s school principal.

Thank you
Yours sincerely

FE Potgieter
Acting director

SCHOOL NAME: ____________________________

I hereby grant permission for my child, ____________________________ (name and surname) to be tested by the Psychology students for research purposes.

PARENT’S NAME: ____________________________ Signature: ________________

Date: ________/_______/2004

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APPENDIX C

COVERING LETTER EXPLAINING THE PROPOSED RESEARCH STUDY

Dear Sir/Madam

Thank you for your co-operation with the completion of the post-test questionnaire. We trust that we have gathered valuable information with regards to the knowledge the learners have gained from the programme.

As discussed previously we also need to establish how the learners perceived the Life Skills Programme. For example, what did the learners like and dislike about the program. To reach this aim we need to conduct focus group interviews with 10 to 12 learners from each school. The length of such a focus group will be about 1 hour and 30 minutes and the learners involved will be selected on a random basis. The names of the learners will be forwarded to the principal of each school.

We appreciate your help very much in this regard.

Regards

Tania Lambert