Community-based educational programmes as support structures for adolescents within the context of HIV and AIDS

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Community-based educational programmes as support structures for adolescents within the context of HIV and AIDS

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"From Him, and through Him and to Him are all things: to whom be glory forever"
(Romans 11:36).

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DECLARATION

I, William Louw, declare that this thesis titled: *Community-based educational programmes as support structures for adolescents within the context of HIV and AIDS.* which I hereby submit for the degree Philosophiae Doctor at the Department of Early Childhood Education, University of Pretoria, is my own work and has not previously been submitted by me for a degree at any other tertiary institution.

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William Louw

March 2013

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ABSTRACT

Community-based educational programmes as support structures for adolescents within the context of HIV and AIDS.

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South Africa is one of the countries with the highest prevalence of HIV infection in the world, particularly among the youth between the ages 15 and 24 years. The number of infections among the youth in South Africa is still increasing and this does not exclude the youth under study in the community of Eersterust.

The HIV and AIDS epidemic is affecting large numbers of adolescents, throughout South Africa leading to serious psychological, social, economic and educational problems. Because of the devastating effect and rapid increase of HIV-infections among adolescents, it has become evident that not only government departments (Department of Health and Department of Education), but also community-based educational support structures (organisations) should share the responsibility by playing a pro-active role in awareness and the curbing of the spread of HIV-infection among adolescents.

Various researchers have been focusing on the knowledge, attitudes and behaviour of adolescents but limited research has been done on the contribution of community-based educational support programmes with regard to creating awareness and the curbing of the further spread of HIV-infection among adolescents. This study which seeked to address the need for ongoing research in this field, attempted to investigate whether and how community-based educational programmes address the educational needs of adolescents within a particular community, namely Eersterust.

In order to determine these needs, quantitative and qualitative descriptive research approaches were utilized comprising of a questionnaire survey and focus group interviews. The questionnaire survey explored the knowledge, skills, attitudes and sexual behaviour of

the 916 participants. The results from the questionnaire were utilized to determine the educational needs of adolescents.

Focus group interviews were conducted with 11 adolescents who attended the educational support programmes at the Youth Development Outreach Centre and the Circle of Life Centre. The latter are two community-based organisations in the community under study (Eersterust). The focus group interviews were utilized to determine the views of the adolescents with regard to the mode of delivery and effectiveness of the community-based educational support programmes.

From the data in the questionnaire the educational needs of adolescents were identified and compared with the content of the community-based educational support programmes of the two community-based support structures. The findings revealed that the community-based educational support programmes are to a large extent addressing the HIV and AIDS educational needs of the adolescents under study.

The focus group interviews revealed that the participants are of the opinion that they find the programmes interesting and enriching. They benefit educationally by attending the educational programmes and they would recommend the programmes to other adolescents. The findings indicate that the educational programmes are appropriate to address the HIV and AIDS educational needs of the adolescents. The educational needs identified in the empirical research are however not fulfilled because many of the adolescents do not attend the educational programmes. There are only a few adolescents who attend these educational programmes. The latter might be a contributing factor to the high HIV-infection among adolescents.

LIST OF KEY WORDS

Adolescent
Community-based organisation
Experimentation
Heterosexual
Non-governmental organization
Prevalence
Programme
Support structures
Transmission
Vulnerability

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CHAPTER 1
INTRODUCTION AND ORIENTATION

1.1 INTRODUCTION

South Africa is one of the countries with the highest prevalence of Human Immunodeficiency Virus (HIV) infection in the world; with the most alarming prevalence among youth between the ages of 15 and 24 (Hallett, Stover, Mishra, Ghys, Gregson & Boerma 2010; UNAIDS 2010; UNAIDS 2012). Research (UNAIDS 2010; UNAIDS 2012; Van Dyk 2008) has revealed that the number of infections among the youth in South Africa remains to be increasing. Furthermore, the HIV-infection rate among adolescent girls in South Africa is five times higher than among boys of the same age group (Van den Berg 2008).

The goal of this study was to explore and describe how community-based educational support programmes[1] in Eersterust[2] address the HIV and AIDS educational needs of adolescents. The research investigated the knowledge, skills, attitudes and sexual behaviour of adolescents with regard to HIV and AIDS to determine their specific and unique educational needs. A comparison was then done in order to determine to what extent the HIV and AIDS educational needs of adolescents are addressed in the programmes of Youth Development Outreach (YDO) and Circle of Life (COL).

Research (Hartell 2005; UNAIDS 2010; Van Dyk 2008) indicates that a variety of factors cause the high numbers of HIV-infection among the youth in South Africa. These include a lack of skills, misconceptions, inaccurate information with regard to HIV and AIDS, high-risk sexual behaviour, early and unprotected sexual intercourse, coercion, pressure to have a child, lack of access to user-friendly health services, negative perceptions with regard to condom use and unfavourable perceptions with regard to personal risk.

Research by Van den Berg (2008) reveals that HIV and AIDS programmes in schools do generally not adequately address the needs and problems of adolescents. This can be ascribed to contextual factors such as the following:

- educators questioning their roles in sexuality education and HIV and AIDS education;
- the unwillingness of educators to speak to learners about sexual matters;

[1] Educational support programmes refer to additional HIV and AIDS programmes that are presented at community-based educational support structures.
[2] For the delimitation of the study, refer to par 1.14 of this chapter.

- educators experiencing anxiety with regard to the possible violation of sexual taboos and consequently offending parents;
- educators being accused of encouraging promiscuity and immorality;
- educators being accused of using sexuality and HIV and AIDS education as a form of sexual outlet;
- educators and stakeholders not discussing the topic of HIV and AIDS with learners;
- educators having the opinion that HIV and AIDS do not really affect their school and are therefore no real issue to them (Hartell 2005).

Research by Kelly (2000:1) indicates that *adolescents receive very little if any information from their parents or other adults with regard to HIV and AIDS or sexual and reproductive health issues.* Adolescents make decisions about engaging in sexual intercourse without having accurate information about the consequences and often do not acknowledge the disease to be a problem in their area or cultural group (Human Science Research Council 2009; Omi 2001). Schools and parents generally do not sufficiently educate young people to develop the necessary knowledge, skills and attitudes to manage their emerging sexuality responsibly.

The apathetic attitude of parents (HSRC 2009; UNAIDS 2000) and the seemingly insufficient educational efforts by government departments (e.g. the Department of Health and the Department of Basic Education) to curb the high infection rate among the youth implies an urgent call on community-based educational support structures (organisations) to assist with the curbing and mitigation of the epidemic[3]. Community-based organisations can serve as a supplementary resource for schools and parents in the awareness of HIV and AIDS and the curbing of the spreading of the disease among adolescents.

1.2 RATIONALE OF THE RESEARCH

The high HIV-infections (30.4%) and the rapid increase of AIDS-related deaths among the residents of the Eersterust community (Eersterust Clinic 2010[4]) motivated me to do research about the educational needs of adolescents concerning HIV and AIDS in this community as a case study. Eersterust is a small residential area with a culturally diverse population of about sixty thousand people. The main languages that are spoken are Afrikaans and English coupled with a few vernacular languages. Although various community projects have been

[3] The term *epidemic* is derived from the Greek ***epidemia***, which means *(illness) prevalent among people; common.* With regard to disease, *epidemic* means that the disease is spreading rapidly and extensively among many individuals in an area (Readers Digest Universal Dictionary 1989:518).

[4] The most recent statistics.

initiated to enhance awareness of HIV and AIDS in Eersterust, the HIV-infection rate among adolescents had raised serious concerns by the end of 2010.

Voluntary Counselling and Testing (VCT) statistics for 2010 at Eersterust reveal that HIV-infection among young people has reached an alarming 30.4% at that stage (Eersterust Clinic 2010). The results further show that a few adolescents younger than 15 years also tested HIV-positive. Due to the high infections among adolescents it became imperative to investigate the HIV and AIDS educational needs of adolescents in Eersterust.

Judging by the high infection rate among adolescents, it seems as if their educational needs are not being fulfilled or as if current educational support programmes are not sufficient or that learners do not utilise or benefit from the educational opportunities offered in schools and by community-based educational support structures. I therefore regarded it as necessary to investigate and determine how community-based educational support programmes may address the HIV and AIDS educational needs of adolescents.

Many parents in Eersterust are subjected to long working hours on a daily basis. Parents often leave their homes very early in the morning and return late from their workplaces in the evening, leaving the children without supervision. Being the head of a high school in this suburb and formerly head of the disciplinary committee of the school, I have attended to various behavioural problems that learners encounter in a normal school day. These include the following:

- learners hosting house parties (housa[5]);
- learners consuming alcoholic drinks;
- learners using different kinds of drugs;
- learners especially boys, who are fighting;
- learners engaging in sexual activities, with in some instances, girls having consensual sex with more than one partner without the use of contraceptives.

These particular incidents as well as the high HIV-infection rate in Eersterust have raised my concern about the lack of knowledge, skills, attitudes and sexual behaviour of adolescents. More than 50% of all new infections in South Africa occur among young people between the ages of 15 and 24 years (UNAIDS 2010).

The HIV and AIDS epidemic has affected large numbers of adolescents throughout South Africa which leads to serious psychological, social, economic, educational and health

[5] 'Housa' refers to house parties where learners gather during school hours to consume alcohol or use drugs and engage in sexual activities with casual partners.

problems (Hartell 2005). The complexity of the HIV and AIDS epidemic has exceeded the capability of the health and educational departments to cope with the curbing and the further spread of HIV among adolescents (Cabassi 2004). As the HIV and AIDS epidemic continues unabated, local communities are particularly affected by a decline in skilled and professional services, resulting in more strain on the health and education departments (Richter, Manegold & Pather 2004). Owing to the devastating effect and rapid increase of HIV-infection among adolescents, it has become evident that not only government departments but also as many as possible community-based support structures (organisations and institutions) should share in the responsibility by playing a proactive role in the awareness and the curbing of the spreading of HIV-infection among adolescents.

It is imperative for communities to take ownership and to create a sense of mutual responsibility in the fight against the further spread of HIV-infection. According to Cabassi (2004:17), *the experience of individuals and communities is an essential ingredient in effective community response to the challenges of HIV and AIDS.* Due to the complexity of HIV and AIDS, communities have to mobilize and collaborate with other organisations (e.g. YDO and COL) in finding appropriate solutions to the problem posed by HIV and AIDS. I am of the opinion that the educational programmes on offer at community-based support structures can be utilised to inform and empower adolescents to exercise more control over a healthy lifestyle.

Research (Coombe 2000; Hartell 2005; Kelly 2000; Larson & Narrain 2001; Odu & Akanle 2008; Swart & Mthembu 2003; UNAIDS 2008; UNAIDS 2010) on the status of HIV and AIDS education in South Africa has revealed that most studies have been focused on the knowledge, skills, attitudes and behaviour of adolescents but limited or no research has been done on the contribution of community-based educational support programmes with regard to awareness and the curbing of HIV and AIDS infection among adolescents. This study, which seeked to address the need for ongoing research in this field, attempted to investigate whether and how community-based educational programmes address the educational needs of adolescents within a particular community, namely Eersterust. Within the context of the above statement this study also focused on the high prevalence of the HIV and AIDS epidemic, as contextual background.

UNAIDS (1999) identifies three reasons for the involvement with adolescents as being essential for action with regard to awareness and the curbing of HIV and AIDS. The first is the high infections among and the vulnerability of adolescents to HIV-infection. Of all the young people across the globe who are infected after infancy, the majority are under 25 years. The second reason *relates to young people accounting for millions of people in the*

developing world where the epidemic is concentrated. If the prevention of HIV in this huge youthful population is unsuccessful, developing countries will face the escalating human and economic costs of huge numbers of adult AIDS cases (UNAIDS 1999:4). Finally, *working with young people is sensible because adolescents are a force of change. Young people are still at the stage of experimentation and can learn to make their behaviour safe or to adopt safer sexual practices from the start* (UNAIDS 1999:4). If adolescents can get support from effective community-based educational support programmes, they may be able to influence the course of the HIV and AIDS epidemic.

1.3 PROBLEM STATEMENT

Research (HSRC 2009; Stadler, Morrison & McGregor 2000; UNAIDS 2008; UNAIDS 2010) provides substantial evidence of increasingly early and widespread adolescent sexual activity in South Africa. Evidently the adolescents in Eersterust are no exception to the rule (Circle of Life 2010). Early sexual debut among the youth is related to entry into sexual relationships and consequent vulnerability to HIV- infection. *Among females 15-24 years, 8,9% had had sex before the age of 15 in 2002, with 8,5% reporting the same in 2008* (HSRC 2009:1). Adolescent boys and girls have the tendency to form sexual relationships with partners who are older than themselves (HSRC 2009). In my opinion, girls may be more vulnerable to HIV-infection due to a lack of knowledge and skills to negotiate condom use. Many girls have a traumatic experience by being forced into their first sexual encounter by their partners. The prevalence of forced first sexual intercourse among adolescent girls younger than 15 years is ranging between 11% and 45% globally (UNAIDS 2010).

Furthermore, the increasing HIV-infections among the youth in South Africa (e.g. Eersterust) has greatly enhanced the need for government institutions and non-government organisations to collectively address the educational challenges posed by HIV and AIDS (Cabassi 2004; Freeman 2004; Maher, Floyd, Sharma, Nkoma, Nyorka & Wilkinson 2000; Richter *et al.* 2004). This has prompted new educational challenges for community-based educational support structures to contribute to HIV and AIDS prevention strategies.

In the light of the abovementioned challenges this research was directed by the following primary research question: *To what extent do community-based educational support programmes address the HIV and AIDS educational needs of adolescents in Eersterust?*
In order to answer this primary research question the following secondary research questions were formulated:

- What are the knowledge, skills, attitudes and sexual behaviour of adolescents in Eersterust?

- What are the views of the learners in Eersterust with regard to the mode of delivery and effectiveness of community-based educational support programmes?

1.4 AIM OF THE STUDY

The primary aim of the study was to *investigate to what extent community-based educational support programmes address the HIV and AIDS educational needs of adolescents in Eersterust.*

The secondary aims of the study were the following:

- To record the knowledge, skills, attitudes and sexual behaviour of adolescents in Eersterust.
- To determine the views of the learners in Eersterust with regard to the mode of delivery and effectiveness of community-based educational support programmes.

1.5 ASSUMPTIONS

I approached this study with a number of assumptions in mind. I assumed that:

- the high HIV-infection prevalence among adolescents can *inter alia* be ascribed to specific gaps in the existing educational support programmes that are presented by community-based organisations and government institutions;
- adolescents lack sufficient knowledge, skills and attitudes with regard to HIV and AIDS;
- the adolescents of the community under study (Eersterust) have unique and specific educational needs and the high HIV-infections prove that a “one size fits all” approach is not sufficient to curb the further spread of the epidemic in this community;
- community-based educational support programmes can play a proactive role in awareness and the curbing of the further spread of HIV-infection among adolescents;
- the sexual behaviour of adolescents is the cause of the high HIV and AIDS prevalence;
- effective HIV and AIDS educational support programmes are the solution to curbing the further spread of HIV and AIDS among adolescents.

1.6 CLARIFICATION OF KEY CONCEPTS

Core concepts that have been utilised in this study are now defined.

1.6.1 ADOLESCENT

According to Soanes and Stevenson (2004:17) and Waite (2012:9) the term *adolescent* refer to *the process of developing from a child into an adult and being emotionally or intellectually immature; a boy or girl who is changing into a young man or woman; that the physical changes taking place at this time are known as puberty.*

For the purpose of this study, the term *adolescent* refers to a boy or a girl between childhood and maturity who is emotionally or intellectually immature and in the process of growing up and developing into adulthood.

1.6.2 COMMUNITY

The term *community* originated from the Old French word *communite* which in turn is derived from the Latin word *communitas* (*cum,* "with/together" + *Munus,* "gift") which refers to fellowship or organised society (Wikipedia 2009). Many researchers define and utilise the concept *community*, attaching meaning from their own perspective.

Wagner, Swenson and Henggeler (2000:212) define the term *community* geographically, as the *combination of social units and systems that perform the major social functions within a given location* (city, town or village) in which people live. Functionally the term *community* is defined *as a mediating structure between individuals and society, typically organised around an activity, function or interest.* Many c*ommunities* are constantly faced with serious challenges such as the increasing number of HIV and AIDS infections among community members. Communities cannot only rely on government institutions (Department of Health and Department of Basic Education) to address such challenges but should rather establish prevention strategies to overcome the challenges they face as a community. I assume that community support structures (YDO and COL) in Eersterust together with government institutions (Department of Health and Department of Basic Education) can collectively address the challenge (HIV-infection among adolescents) and find appropriate solutions.

According to Maher *et al.* (2000:18), Rundell and Fox (2000:277) as well as Waite (2012:139), the term *community* refers to *a group of people who have a sense of common purpose(s) for which they assume mutual responsibility, acknowledging their interconnectedness, respecting their individual differences and committing themselves to the well-being of each other and the integrity and well-being of the group. The group of people in a larger society share the same cultural heritage, language and beliefs.*

Bender (2004) describes the term *community* as a particular type of social system which includes the dimensions of a geographic location, psychological ties and people working towards a common goal. A community's operations depend considerably on voluntary cooperation and its multi-functionality which is expected to produce many things and to be attuned to the various dimensions of interactions. I agree with this description as it is in line with my study. I view the community of Eersterust as a social system which consists of other parts (subsystems) that assumes mutual responsibility and collectively address the challenge of HIV. Although each of the subsystems functions independently, they are interconnected in the finding of solutions to the challenges posed by HIV and AIDS. As such, community support structures (YDO and COL) which form the focus of my study, together with government institutions (Department of Health and the Department of Basic Education) are functioning as the subsystems within the community of Eersterust (social system).

Within the context of this study the term *community* thus refers to a group of people living together in one place (Eersterust), who share a common interest or purpose (vulnerability of adolescents to HIV-infection) and will act together in the best interest for which they assume mutual responsibility (awareness and the curbing of the further spread of HIV-infection among adolescents). The group of people would acknowledge their common interconnectedness, respect individual differences among members and commit themselves to the well-being of each other and the integrity and well-being of the group.

1.6.3 SUPPORT

According to Rundell and Fox (2000:1425) and Waite (2012:733) the term *support* refers to *the act or process of supporting; the condition of being supported; to promote the interest or cause of something; to give support to (a course of action); to contribute to the success of an undertaking; to help someone and to be kind to them when they are having a difficult time; to provide other things that someone needs in order to live; people who support an organisation; an idea; money that is provided to a person or organisation in order to help them work or achieve a particular aim; to be actively interested in a person or organisation.*

For the purpose of this study the term *support* refers to the help of a person or a community by one's assistance, countenance, adherence or presence; to provide other things that someone needs in order to live; or to people who support an organisation in order to help them work or achieve a particular aim.

1.6.4 STRUCTURE

According to Rundell and Fox (2000:1425) and Waite (2012:723) the term *structure* refers to *something arranged in a definite pattern or organisation; the organisation of parts as dominated by the general character of the whole; the aggregate of elements of an entity in their relationship to each other; the way in which the parts of something are organised or arranged into a whole; an organisation or system made up of many parts that work together; to plan or organise something.*

Within the context of this study the term *structure* refers to an organisation or an institution or a system made up of many parts as dominated by the general character of the whole that works together. It follows that the concept support structure refers to a governmental or non-governmental organisation or an institution that provides support and education to adolescents by promoting awareness and the mitigation of HIV and AIDS.

1.6.5 PROGRAMME

According to Hawkins (2000:498) and Waite (2012:575) the term *programme* refers to a *printed outline of the order to be followed of the features to be presented and the persons participating in a public exercise or performance; plan of activities for achieving a goal; descriptive notice or list of an organised series of events; group of related services or projects organised by a government or a non-government organisation; plan of activities organised by an educational institution.*

For the purpose of this study the term *programme* refers to a plan of intended procedure that are organised by government or non-governmental organisations for adolescents that aims to enhance awareness and the prevention of the spread of HIV-infection.

1.6.6 COMMUNITY-BASED EDUCATIONAL SUPPORT PROGRAMMES

Within the context of this study the term community-based educational support programmes refers to the educational support programmes that are implemented by community-based organisations i.e. non-governmental organisations to adolescents in Eersterust. This study specifically explored HIV and AIDS educational support programmes at the Youth Development Outreach Centre (YDO) and the Circle of Life Centre (COL).

1.7 EPISTEMOLOGICAL COMMITMENT AND PARADIGMATIC PERSPECTIVE

A brief discussion of the selected research paradigm, the methodological choices and processes that should serve as a general orientation and a background to this thesis is now provided. A detailed discussion of these aspects is included in Chapter 3, paragraph 3.2.

1.7.1 VIEW REGARDING KNOWLEDGE

According to Mouton (2001:138) it is rather *impossible to produce scientific results that are infallible and absolutely true for all times and contexts.* I agree with this statement and I support the idea that *all knowledge and truths are relative to the context in which they are applied* (Mouton 2001:138). I thus view knowledge and truths as subjective and based on one's personal experiences and insights (Cohen, Manion & Morrison 2007).

During the research process I adhered to causality which is the universal law of *cause and effect*. *Causality* serves as the substantiation of events and phenomena that occurs in society (Muijs 2004; Cohen *et al.* 2007). I therefore aimed to generate knowledge that is truthful (valid and reliable) to the contextual realities within the social realm of education that might have a negative influence on the successful implementation of community-based educational support programmes for adolescents.

I followed a mixed method research approach in order to address the purpose of the study. I firstly applied a quantitative approach (through questionnaires) in order to determine the knowledge, skills, attitudes and sexual behaviour of the adolescents under study. This was done to determine the educational needs of the adolescents that should be addressed in programmes. Secondly, I applied a qualitative approach by utilising interviews to determine the views of adolescents with regard to the mode of delivery and effectiveness of community-based educational support programmes. A more detailed discussion of these aspects is included in Chapter 3.

1.7.2 A POSITIVISTIC EPISTEMOLOGY (QUANTITATIVE COMPONENT)

Quantitative research is usually based *on some form of logical positivism which assumes that there are stable, social facts with a single reality, separated from the feelings and beliefs of individuals* (Macmillan & Schumacher 2001:15). The term *positivism* is based on the utilisation of research methods and practices derived from the natural science and application of these to the social sciences.

According to the positivistic view objects and events have intrinsic meaning, and knowledge is an explanation of an association with what is real (Cohen *et al.* 2007; Hittleman & Simon 2006). Data are viewed to be linear and objective in nature, value-free and theory independent as well as relatively free from researcher bias (Jansen 2004). Reality is perceived as external and knowledge about human behaviour is attained through a method of scientific enquiry.

For the quantitative part of my study, I employed a questionnaire survey in order to determine the educational needs (knowledge, skills, attitudes and sexual behaviour) of adolescents with regard to HIV and AIDS. A statement was considered as supportable only when the conditions under which the statement was verified, were known. In this way knowledge could be considered true only if research results accurately explain an independent world (Hittleman & Simon 2006). Positivism assumes that reality can be best understood by breaking it up into its smallest parts.

Taking a positivistic stance, I interpreted the quantitative results of this study in terms of quantifiable units and reported deviations as significant deviations (Cohen *et al.* 2007). A more detailed discussion of positivistic epistemology is included in Chapter 3, paragraph 3.2.1.

1.7.3 AN INTERPRETIVIST EPISTEMOLOGY (QUALITATIVE COMPONENT)

The term *interpretivism* implies *the interpretation of human behaviour on both a verbal and a non-verbal level, against the background of the participants' life worlds, as well as their past experiences and their existing understandings thereof* (Cohen *et al.* 2001:3). Giving meaning always takes place within a particular context which implies that human behaviour, feelings and experiences (the manner in which community-based educational support programmes are aligned with the HIV and AIDS educational needs of adolescents) take place within a particular context (Nieuwenhuis 2011; Terre Blanche & Durrheim 2002). The qualitative part of my study was guided by and anchored in the interpretivist paradigm.

Having studied the participants in this particular context I aimed to understand what the participants experienced in their daily struggles. Their experiences were interpreted in a personal and unique manner. Reality within the context of this study is constituted by different interpretations, namely mine and those of the participants in the study.

Interpretation implies a search for wider perspectives on particular events and offers possibilities but not certainties for the outcomes of future events (Bassey 1999; Nieuwenhuis

2011). The interpretivist paradigm enabled me to conduct the qualitative part of my study among participants in their natural settings in order to gain information and insight on the views of adolescents with regard to the mode of delivery and effectiveness of community-based educational support programmes (Cohen *et al.* 2007; Macmillan & Schumacher 2006).

The data collected consisted of transcriptions and reports on the focus group interviews with the participants (learners at community-based support structures). Interpretivist researchers are usually not interested in averages but rather in the synthesis of understandings that comes about by combining different individuals' detailed reports of particular events (Rubin & Rubin 2005; Nieuwenhuis 2011). A more detailed discussion of the interpretivist epistemology is included in Chapter 3, paragraph 3.2.2.

1.8 THEORETICAL FRAMEWORK

The study was conducted within the framework of the systems theory. A *system* can be described as a *complex of interacting components together with the relationships among them that permit the identification of a boundary-maintaining entity or process* (Lazlo & Krippner 1998:2). Human activity systems for example individuals in a nuclear family or musicians in an orchestra are inclined to have multiple purposes of which it is possible to distinguish three levels: the purpose of the system, the purpose of its parts (subsystems) and the purpose of the system of which it is a part (whole). Lazlo & Krippner (1998:2) describes systems theory as *complex entities created by the multiple interaction of components which concentrate on the dynamics that define the characteristic functions and relationships that are internal or external to the system*.

Systems theory *sees different levels and groupings of the social context*[6] *as 'systems' where the functioning of the whole is dependent on the interaction between all parts* (Donald *et al.* 1997:36). This study focuses on the community of Eersterust which functions as a social system (whole) as well as the interrelationships among its constituent parts (subsystems). In view of the systems theory different community-based educational support structures (subsystems) exists within the community of Eersterust which are interrelated and interdependent with regard to the curbing of the further spread of HIV and AIDS among adolescents (Lazlo & Krippner 1998).

System theory is suitable for the study because it recognises the interconnectedness and interrelatedness of Government institutions (Department of Education and Department of

[6] Social context refers to *all aspects of the position which a person, group or organization occupies in the social structure as a whole* (Donald, Lazarus & Lolwana 1997:3).

Health) as well as non-governmental organisations as subsystems within the wider community of Eersterust (whole). The HIV and AIDS educational support programmes presented by community-based educational support structures can be utilised to inform and empower adolescents to effect change in risky sexual behaviour and to adopt a healthy lifestyle which may lead to the curbing of the further spread of HIV-infection. Systems theory assisted me in establishing an understanding of the way in which community-based educational support structures in Eersterust respond to the educational needs of adolescents with regard to HIV and AIDS. A more detailed discussion of systems theory as a theoretical framework for this study, is included in Chapter 2, paragraph 2.6.

1.9 RESEARCH DESIGN AND METHODOLOGY

The term *methodology* refers to *the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of the methods to the desired outcomes* (Taylor & Bogdan 2001:4). I undertook in-depth field research in a typical South African township (Eersterust) in order to explore and describe how community-based educational support programmes address the educational needs of adolescents.

According to Taylor (2002:165) a research design can be defined as *constructed plans and strategies developed to seek, explore and discover answers to qualitative and quantitative research questions.* This research was conducted by following a mixed methods research approach. According to Ivankova, Creswell & Plano Clark (2011), Leech & Onwuegbuzie (2009) as well as Teddlie and Tashakorri (2003), the combination of quantitative and qualitative elements in a single study, results in a mixed methods approach. The mixed methods approach includes the collecting, analysing and mixing of data at some stage of the research process in order to best understand a research problem.

First a preliminary quantitative data collection strategy (questionnaire survey) was applied in order to record and address the challenges and needs that are unique to the sample under study (adolescents). The questionnaire assisted me in determining *whether educational support programmes of community-based organisations address the educational needs that are unique to the sample under study (adolescents*).

Secondly, to achieve the stated purpose of the study I also relied on qualitative techniques. A multiple case study was utilised to examine two research sites (YDO and COL) in Eersterust. This was done in operational detail with the aim of providing a rich and a diverse range of data regarding the views of adolescents on the mode of delivery and effectiveness of community-based educational support programmes. I closely observed the interactions of

participants in dialogue with other participants during focus group interviews. The participants in this study are regarded as the experts who hold the key to any understanding and insight into their own unfiltered social life and insight on how community-based educational support programmes are implemented among adolescents (Creswell 2007).

The above strategies allowed me to gain rich and detailed descriptions (Creswell 2007) on the extent to which community-based educational support programmes address the high HIV-infection rate among adolescents and how the adolescents view or perceive these educational programmes.

1.10 SELECTION OF RESEARCH SITES AND PARTICIPANTS

The mixed method research approach that I selected for this study required two different groups of participants. For the quantitative study I utilised learners from two secondary schools in Eersterust. For the qualitative part of my study I interviewed adolescents who attended educational support programmes at community-based educational support structures.

1.10.1 QUANTITATIVE SELECTION OF RESPONDENTS

A questionnaire survey was conducted with learners from the two high schools (Eersterust Secondary School and Prosperitus Secondary School) in the community under study (Eersterust). The sample for this study was drawn from a list of all the Grade 10 to 12 learners from both high schools. The lists of possible classes for selection were provided by the principals of both schools.

Classes were randomly selected from the provided list containing the total population (Grades 10 to 12). This sample comprised 410 learners from Eersterust Secondary School and 506 learners from Prosperitus Secondary School. The total number of learners amounted to 916. A more detailed discussion of the selection of respondents is included in Chapter 3, paragraph 3.6.3.5.

1.10.2 QUALITATIVE SELECTION OF PARTICIPANTS

When selecting the community-based educational support structures that form the focus of this research, I utilised a purposive sampling technique. The term *purposive sampling* refers to *handpicking the cases to be included in the sample on the basis of the judgement of their typicality. The sample should be satisfactory to specific needs of the researcher* (Cohen *et al.* 2001:102).

Care was taken in selecting community organisations that specifically focus on HIV and AIDS educational programmes for adolescents (Nieuwenhuis 2011). The participants of the study were adolescent learners who attended educational programmes at the specified organisations. I conducted focus group interviews with the adolescents in an attempt to interpret their experiences and views with regard to the educational programmes that had been presented to them.

The community-based educational support structures under study included Youth Development Outreach (YDO) and Circle of Life (COL). I chose Eersterust as the research site based on my employment as an educator over the past thirty years with much experience of the community. This also enabled me to fairly easily build rapport and facilitate communication in schools and in the educational support organisations. A more detailed discussion of the selection of participants is included in Chapter 3, paragraph 3.6.4.5.

1.11 DATA COLLECTION

Multiple methods were employed as data collection strategies that could permit triangulation of data across the inquiry techniques. The different strategies yielded different insights into community-based educational support programmes that could increase the credibility of the research findings (Macmillan & Schumacher 2006; Nieuwenhuis 2011).

1.11.1 QUANTITATIVE DATA COLLECTION STRATEGIES

Quantitative research is *research that applies procedures that involve the assignment of numerical values and variables* (Hittleman & Simon 2006:309). I obtained quantitative data by applying a questionnaire survey. Grades 10 to 12 learners (adolescents) from two selected schools in Eersterust took part in the completion of the questionnaires. The reason for using questionnaires in the study was not only to determine the knowledge, skills, attitudes and sexual behaviour of adolescents but also to determine the thoughts, beliefs, values and perceptions of the respondents with regard to HIV and AIDS.

The use of a questionnaire as data collection technique was based on the underlying assumption that the respondents would be willing and able to supply truthful answers to the questions in the questionnaire (Burns 2000; Maree and Pietersen 2011). The information that was acquired from the questionnaire survey provided me with insight that helped to determine the educational needs of adolescents in the Eersterust community.

I used close-ended questions in the questionnaire that allowed the respondents to choose from two or more fixed alternatives. Dichotomous items offered alternatives such as yes/no

or agree/unsure/disagree. I did not identify any restrictions on either the content or the manner in which the respondents replied, resulting in the potential of richness and intensity of responses (De Vos 2002; Maree and Pietersen 2011).

The questionnaires were designed for self-completion and were administered by trained conveners at the selected schools. These conveners were in turn assisted by trained invigilators when learners completed the questionnaires. After the learners had completed the questionnaires these were placed in envelopes that I provided and collected from the conveners on agreed times.

The main advantage of this method of data collection lies in its familiarity to users, in the fact that it allows users to complete questionnaires at their own convenience and in the fact that it allows respondents some time to think about their answers (Muijs 2004; Maree & Pietersen 2011). A more detailed discussion of the questionnaire as data collection instrument is included in Chapter 3, paragraph 3.6.3.

1.11.2 QUALITATIVE DATA COLLECTION STRATEGIES

Qualitative data were captured by means of focus group interviews and document analysis. I also relied on a field journal to document my field notes and reflective thoughts.

1.11.2.1 Focus group interviews

According to Berg (1998:100) *focus group interviews* can be described as *either guided or unguided discussions addressing a particular topic of interest or relevance to the group and the researcher.* In order to gain insight into and to understand how participating adolescents view the implementation of the educational support programmes and how it addresses the HIV and AIDS educational needs of the adolescents, two focus group interviews were conducted. Adolescents who attended educational support programmes at YDO and COL participated in the focus groups. The focus group interviews were guided by exploratory and descriptive questions.

The informal atmosphere of focus group interviews encouraged participants to speak freely and openly on the content of the HIV and AIDS educational programmes and how it was presented to them as adolescents. The first focus group involved five participants and the second focus group six. We (the participants and I) met only once on the agreed dates.

The participants gave their consent that I could audio-record the interviews. I assured them of safety, anonymity and confidentiality of the discussions. The conversations were

transcribed soon after the discussions, to avoid uncontrollable and unmanageable volumes of transcriptions (Bogdan & Biklen 2003; Nieuwenhuis 2011).

The advantages of focus group interviews as a qualitative technique are that they can enable a researcher to observe and note the processes of interaction among participants. I had access to the substantive content of verbally expressed views, opinions, ideas, attitudes and experiences of the participants (De Vos 2002: Nieuwenhuis 2011).

1.11.2.2 Field journal

According to Bogdan and Biklen (2003:259) field-notes *are written accounts of what researchers hear, see, experience and think in a data collection session.* I utilised a field journal in order to document my field notes and reflective thoughts.

Field notes enabled me to do the following:

- keep record of the time I had spent in the setting of the research;
- book appointments to conduct interviews.

Notes on important dates and interviews with participants were documented (Wilkinson & Birmingham 2003; Seidman 2006). In addition to that I utilised reflective field notes to document my reflections, my feelings and frustrations, my successes or failures, my experiences with the promoters as well as all the areas in which I could improve. More detailed discussions on the qualitative data collection strategies follow in Chapter 3, paragraphs 3.6.2 and 3.6.4.

1.12 DATA ANALYSIS

Quantitative data analysis (Cohen *et al.* 2007) commenced as soon as the questionnaires had been completed by the respondents in order to establish the unique educational needs of adolescents in the community under study. Research questions for focus group interviews were subsequently identified to determine the views of adolescents with regard to the mode of delivery and effectiveness of educational support programmes.

A detailed analysis followed after the focus group interviews had been conducted during which sections were identified and explored. Analysing interviews inevitably implies content analysis to evaluate key words, meanings, symbols, themes or messages communicated during the interviews. The term *content analysis* refers to *the gathering and analysis of textual content* (Struwig & Stead 2001:14).

Data were analysed to determine the views of adolescents with regard to the mode of delivery and effectiveness of community-based educational support programmes. A comprehensive account of the findings is supplied and annotated in Chapter 4.

1.13 ETHICAL CONSIDERATIONS

Before I commenced with the empirical study I applied for ethical clearance from the Ethical Committee of the University of Pretoria. Written permission to conduct research with the learners (Appendix B) was also acquired from the former Department of Education (Gauteng), the respective schools and the selected community-based educational support structures (Appendix A).

Since the participants were expected to provide true reflections and honest information on relevant issues when completing the questionnaires and during focus group interviews, they were assured of anonymity and confidentiality (De Vos 2002; Maree & Van der Westhuizen 2011). The respondents who completed questionnaires were provided with a letter of informed consent which had to be signed by the parents or guardians and returned to me by the learners (Appendix B). Each interviewee had to sign an informed consent form before the interviews commenced.

The participants were not deceived, did not experience any form of distress, knew what was going on during the research process and knew that they could withdraw from the study at any time (Babbie & Mouton 2001). As the style of interviewing and level of professionalism could impact on the value of the data, it was essential to establish a relationship of co-operation and trust in order to elicit accurate and truthful perspectives and information from the participants (Cohen *et al*, 2007).

The following guidelines concerning research with human beings were kept in mind throughout the research process (Hayes 1981):

- I considered the ethical implications and psychological consequences for the participants at all times;
- All the participants were duly informed of the objective of the research project;
- I refrained from withholding information or misleading participants and I avoided intentional deception;
- The principle of safety of participants implied that the participants were not placed at risk or harm of any kind.

A detailed discussion of the various ethical guidelines that I adhered to when conducting the research with human participants is included in Chapter 3, paragraph 3.11.

1.14 QUALITY CRITERIA

As stated, I relied on both quantitative and qualitative research methods.

1.14.1 CRITERIA FOR RELIABILITY AND VALIDITY

As a questionnaire survey was employed, the criteria of validity and reliability had to be met. A detailed discussion of these criteria is included in Chapter 3, paragraph 3.11.1 and 3.11.2.

1.14.2 QUALITATIVE CRITERIA FOR RIGOUR

I attempted to meet the criteria of credibility, transferability, dependability and confirmability in an attempt to enhance the trustworthiness of the qualitative part of the research. A detailed discussion of the said quality criteria is included in Chapter 3, paragraphs 3.11.3 to 3.11.6.

1.15 DELIMITATION OF THE STUDY

This research project was conducted in the Eersterust suburb[7] which has a culturally diverse community. The study focused on how two community-based educational support programmes (YDO and COL) address the HIV and AIDS educational needs of adolescents. For this purpose I conducted a questionnaire survey with the Grade 10 to 12 learners from both high schools in the community under study (Eersterust). The aim was to determine the adolescents' knowledge, skills, attitudes and sexual behaviour (thus their needs) with regard to HIV-infection.

Furthermore, I conducted focus group interviews at two community-based educational support structures (YDO and COL). I attempted to determine the views of the adolescents with regard to both the mode of delivery and effectiveness of educational support programmes. A detailed discussion of the YDO and COL programmes is included in Chapter 2, paragraphs 2.7.1 and 2.7.2.

[7] Rundell and Fox (2000:1433) define the word suburb as "*an area or town near a large city but away from its centre, where there are many houses, especially for middle-class people*".

1.16 OUTLINE OF THE CHAPTERS

The outline of the chapters in this thesis is provided below.

CHAPTER 1: ORIENTATION AND BACKGROUND

Chapter 1 serves as an orientation and background to the thesis. This chapter provides an introductory orientation, general overview and a brief discussion of the study. The rationale, problem statement, aim of the study, assumptions and clarification of key concepts are provided followed by a brief overview of the selected research paradigm, theoretical framework, research design, data collection strategies, selection of research participants and data analysis. In addition, the quality criteria of the research are briefly introduced and the delimitation of the study provided.

CHAPTER 2: LITERATURE STUDY

Chapter 2 provides a theoretical framework for the study in the form of an extensive literature study on the HIV and AIDS epidemic. The lack of knowledge, skills, attitudes and risky sexual behaviour (thus needs) among adolescents with regard to HIV and AIDS are reviewed and discussed in detail.

This chapter further includes a detailed literature study on the contextual background of HIV and AIDS, vulnerability due to cultural perspectives, violence against women and children, the effects of poverty on HIV and AIDS, the need for educational programmes in this field, the selected theoretical framework and the existing community-based educational support structures in Eersterust.

CHAPTER 3: DESIGNING AND CONDUCTING RESEARCH IN THE FIELD

In this chapter the research process is described in detail in terms of the selected research paradigm, research design and methodological choices that I made and followed during the empirical research of this study. The methods of data collection, data analysis and data interpretation are outlined and justified, followed by discussions of strengths and challenges implied my methodological choices. This chapter concludes with a discussion of ethical considerations and quality criteria of the study.

CHAPTER 4: RESULTS AND DISCUSSION

Chapter 4 consists of the presentation and discussion of the acquired data and information obtained from the questionnaire survey and the focus group interviews. An interpretation and discussion of the results are provided based on the data analysis I completed.

CHAPTER 5: REVIEW, FINDINGS AND RECOMMENDATIONS

In this chapter the conclusions, implications and recommendations of the study are presented. A synopsis of the research is provided that may inform resolutions and recommendations for future research.

1.17 SUMMARY

In the introductory chapter a general orientation to the study was provided against which the rest of the thesis can be read. The rationale explored the challenges of HIV and AIDS in the community under study. The problem statement of the research study was outlined, leading to the formulation of the following primary research question: *To what extent do community-based educational support programmes address the HIV and AIDS educational needs of adolescents?*

After introducing the aim of the study, stating the assumptions with which the study was approached and clarifying the key concepts, I provided an overview of the selected paradigm, theoretical framework and my methodological choices. In addition, I introduced the ethical considerations and quality criteria that were adhered to during the study. These aspects are explained in more detail in Chapter 3, paragraphs 3.11 and 3.12.

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CHAPTER 2
LITERATURE STUDY

2.1 INTRODUCTION

In this chapter various literature resources on the contextual background of HIV and AIDS, the response of the South African Government, the extent of the epidemic, the effects of poverty with regard to HIV and AIDS, its impact on families and the educational sector as well as the factors that contribute to the vulnerability of adolescents with regard to HIV-infection are reviewed. The prevalence of HIV and AIDS is investigated from a global perspective followed by a South African perspective and finally the way in which the prevalence of HIV and AIDS manifests in the community under study (Eersterust) is examined.

Other aspects such as violence against women and community-based educational support for vulnerability are also reviewed. These factors are some of the problems that could enhance HIV-infection among adolescents. Even though limited, the available literature on the positive influence of community-based educational support programmes is also reviewed.

The focus of this study is the exploration and description of the extent in which educational support programmes of community-based support structures could address the educational needs of adolescents with regard to HIV and AIDS. After the review of existing literature on HIV and AIDS the contribution of existing community-based support structures in Eersterust and the potential role of community-based educational support programmes are thus discussed.

The research questions and the purpose of the study are utilised as guidelines to review existing literature. Aspects such as the vulnerability of adolescents owing to a lack of knowledge, skills, laissez faire attitudes, risky sexual behaviour, cultural perspectives, violence against women and the effects of poverty are subsequently discussed. Contributory to the susceptibility to HIV-infection among adolescents is the lack of sufficient and effective educational support programmes. There is a great shortfall in the literature in terms of the contributions of community-based educational support programmes with regard to HIV and AIDS. This is where my research may best fit into the existing knowledge base.

2.2 CONTEXTUAL BACKGROUND: HIV AND AIDS

HIV and AIDS are a global epidemic. Its impact is widespread and influences countries, communities, families and young people worldwide. It is estimated that 34 million people were living with HIV worldwide at the end of 2011 (UNAIDS 2012). Young people account for almost 40% of all new adult infections worldwide (UNAIDS 2012). In 2011, it was estimated that 1.7 million people died from AIDS-related causes worldwide. These statistics represents a 24% decline in AIDS-related mortality compared with 2005 when 2.3 million AIDS-related deaths occurred. It is estimated that 16,6 million children became orphans before the age of 15 (UNAIDS 2012).

By the end of 2011, it was estimated that two thirds of the 34 million who were infected people globally, were residing in Sub-Saharan Africa (UNAIDS 2012). Sub-Saharan Africa had an estimated 22,5 million adults and children who were living with HIV in 2011. It is estimated that 316 000 adults and 63 600 children have been newly infected with HIV by the end of 2011 (UNAIDS 2012). The complexity of the HIV-epidemic implies that mobilisation and collaboration are needed at community level in order to respond effectively to its impacts.

Developing countries responding to awareness and the curbing of HIV-infection have the highest number of people that are either vulnerable to or affected by HIV and AIDS. HIV-prevention campaigns often does not necessarily address the challenges of the affected or infected people in these countries (HSRC 2009). In many of these resource-poor countries antiretroviral treatment may not be readily available (UNAIDS 2010). *In the absence of effective efforts to mitigate the effect of AIDS, societies can thus subsequently become dysfunctional, with negative consequences for human development* (UNAIDS 2001:9).

South Africa is one of the countries with the highest prevalence of HIV in the world with more than 50% of all new infections occurring among young people between the ages of 15 and 24 years (Statistics South Africa 2008). Life expectancy at birth is estimated to be 54 years for males and 59 years for females (UNAIDS 2012). Adult HIV-prevalence was reported to be 16.6% by the end of 2011 (UNAIDS 2012). The HIV-prevalence among South Africans is overwhelming and gives an indication of the challenges that South Africans face with regard to awareness and the mitigation of HIV-infection in their respective communities.

The HIV-infection rate among the residents of Eersterust, including adolescents, had reached an alarming 30.4% by the end of 2010 (Eersterust Clinic 2010). Factors such as the lack of skills, misconceptions, high-risk sexual behaviour, early and unprotected sexual

intercourse and a lack of user-friendly health services, among other reasons, may cause the high number of HIV-infection among adolescents. I am of the opinion that some of these adolescents might end up as street children and continue being involved in high risk sexual behaviour or even child prostitution. Before I focus on the challenges that are typically experienced by adolescents within the context of HIV and AIDS an overview of the South African Government's response to the epidemic is provided.

2.2.1 SOUTH AFRICAN GOVERNMENT'S RESPONSE TO HIV AND AIDS

According to Shell (2000), the first AIDS case in South Africa was diagnosed in 1982. Today, three decades later, the incidence of AIDS related deaths have risen significantly to an estimated 1,8 million people (UNAIDS 2012). When the first AIDS cases were recorded in the early eighties, the government of the day initially seemingly ignored the problem. The South African Government merely initiated *ad hoc* presentations with regard to HIV and AIDS prevention although such efforts were often discredited because of racial differentiation. When the first cases occurred among the black heterosexual population, the Government regarded HIV and AIDS as a problem that the homelands, rather than the national government, should be dealing with. The early stages of the epidemic were thus mismanaged at the time.

Following on this, Dorrington and Johnson (2002) mention that when the first democratically elected South African Government came to power in 1994, its primary concern was to ensure that transformation took place. HIV and AIDS was merely one item on a rather long list of challenges. The Sarafina 2 scandal of 1995 erupted when irregularities were identified in the awarding of a tender for a musical stage production that was intended to tour the country with a message about AIDS, and the value of the production was questioned in terms of AIDS awareness. I find it remarkable and strange that the Government, in the identification of campaigns and activities, seemed to display limited enthusiasm, rigour, consistency and systemic delivery at that stage - something it was also largely criticised for.

UNAIDS (2012) revealed that by 2011 the estimated number of HIV-positive people in South Africa had increased radically and was in the region of 5,6 million people. In 2011 approximately 2000 people were infected daily compared to the 700 people being infected on a daily basis in 1996. By then South Africa was already the country in the world with the largest number of people living with HIV and AIDS (UNAIDS 2010). The Government's response to HIV and AIDS incidence ultimately intensified due to the rapid rise in HIV infection, particularly among young people between the ages 15 and 24, and due to the increase in AIDS orphans. The Government introduced a number of communication

campaigns in order to raise awareness of HIV and AIDS. These campaigns include the publication of free counselling and testing, door-to-door campaigning and billboard messages that highlighted the personal experiences of AIDS victims (HSRC 2009).

By then, Khomanani was the premier AIDS awareness campaign that utilised radio announcements and situational sketches on television with its focus on thematic days such as World AIDS day, being commemorated annually on the first day of December. Two multimedia campaigns (Soul City and Soul Buddyz) followed, utilising broadcasting to promote good sexual health practices. Youth centres that provided sexual health information, clinical services and skills development, were introduced by Lovelife around the country. The target audience of awareness campaigns was young people, particularly 15 to 24 year olds (HSRC 2009). The Nelson Mandela foundation, an independent organisation, introduced the 46664 campaign that aimed at promoting the prevention of HIV and AIDS. This campaign has been conducted nationally and is now internationally recognised.

In 2002, HIV and sexuality education was implemented in all schools as part of the Life Orientation curriculum. The high dropout rate in South African schools necessitated the start of prevention programmes before learners become sexually active or before they drop out of school (HSRC 2009). Other government initiatives include voluntary medical male circumcision targeting all men between the ages 15 and 49 and free antiretroviral drugs to HIV-positive people in public hospitals.

2.2.2 THE EXTENT OF THE EPIDEMIC

According to UNAIDS (2010), the global number of people living with HIV increased from around 8 million in 1990 to 34 million by the end of 2011. The HIV and AIDS epidemic has to date resulted in nearly 30 million AIDS-related deaths (UNAIDS 2012). These statistics indicate that the HIV and AIDS epidemic has reached a crisis stage in communities worldwide. It is evident that communities should take up the responsibility to respond effectively to the extent of the epidemic by treating it as an emergency.

Sub-Saharan Africa still has the highest HIV-infection rate with an estimated 1.8 million adults and children being newly infected in 2009 (UNAIDS 2010). It is further estimated that the number of children living with HIV had increased to 2.5 million in 2009 (UNAIDS 2010). The estimated number of children younger than 15 years who are infected with HIV had increased from 140 000 in 2005 to 160 000 in 2009 (UNAIDS 2010). These statistics provide an indication of the devastating effect of the epidemic on the lives of people despite numerous preventative measures and ongoing research with regard to HIV and AIDS.

The HIV and AIDS epidemic is one of the greatest threats facing South Africa. To some extent the high HIV-infection rate reflects the young people's attitude regarding their sexual behaviour. The main route of HIV-transmission in South Africa is heterosexual, largely because of concurrent sexual relationships – particularly among adolescents. The impact of HIV and AIDS on young people in South Africa is one of the most intense in the world. The transmission of HIV from mother-to-child in South Africa is poorly attended to, resulting in 40 000 children being infected on a yearly basis (Statistics South Africa 2010). I find these statistics on HIV-infection and AIDS-related deaths across South Africa devastating.

In 2008, it was estimated that the HIV-infection rate among South Africans of all ages was 10.6% and life expectancy at birth was 41 years for males and 46.5 years for females (UNAIDS 2008). AIDS-related deaths among South Africans increased from 250 000 in 2001 to an estimated 379 600 in 2011 (UNAIDS 2012). Considering the devastating HIV and AIDS-related statistics, I am of the opinion that research in this field has particular relevance.

Owing to the extent of the epidemic, I keep on wondering whether affected communities in South Africa are in a position to address the challenges and vulnerabilities that are posed by the HIV and AIDS epidemic. This research has the potential to make a contribution to the existing knowledge base on HIV and AIDS with special reference to the role of community-based educational support programmes in curbing HIV-infection among adolescents.

2.2.3 EFFECTS OF POVERTY WITH REGARD TO HIV AND AIDS

One of the main drivers of the HIV epidemic in South Africa is poverty. According to UNAIDS (2004) poverty leads to a decline in the quality of lifestyle maintained by a family, not only adding to the vulnerability of people but also intensifying the harshness of the impact of the epidemic. Poverty often makes sexual exploitation worse and this further contributes to the spreading of HIV and other sexually transmitted diseases.

Young people are particularly affected by poverty and a lack of access to choices, growth and development opportunities. Furthermore, people living in informal urban settlements have been found to be at the highest risk (Freeman 2004). Increased vulnerability to HIV-infection in turn implies the possibility of transmittance or infection with HIV.

Poverty plays a pivotal role in the spreading of HIV-infection as it can weaken an individual's resistance, especially young people who engage in commercial sex work (UNAIDS 2004). In areas where unemployment is rife, there may be few opportunities for young people to find

work. In addition, in most of the poor areas recreational opportunities for young people are limited (UNAIDS 2004).

Poverty can increase vulnerability in terms of HIV-infection for entire communities. Poor people may be more vulnerable to HIV-infection because they are compelled to exchange sexual favours for gifts or money. They might not have the necessary funds to buy condoms or for treatment of other sexually transmitted infections. Poor people typically struggle to fulfil their basic tasks, resulting in their not being concerned about immediate threats like AIDS. They may have little or no access to HIV counselling and testing facilities and they may unintentionally pass the HIV-infection on to others.

I believe that individuals and families in such context face double discrimination, firstly for living with HIV and AIDS, and secondly for suffering from poverty. Young men and women may subsequently be forced to leave their homes in search of work. In extreme cases, poverty can lead to increased levels of crime when individuals become desperate for money (UNAIDS 1999). Poverty can also be the cause of young people's lack of education as the family cannot afford to pay for school accessories.

Lower levels of education can contribute to little or no knowledge with regard to awareness of effective measures to prevent HIV-infection (UNAIDS 2012). Poor families rely on each family member's contribution to bolster the family's financial income. Children with little or no education are typically more susceptible to becoming victims where they may be dragged into prostitution and other activities that may increase their vulnerability to HIV-infection (Kelly 2000).

Poverty may thus enhance vulnerability to HIV-infection. The increasing HIV-infection rate in the poorer communities of the industrialised world and in developing countries is evident of the role of poverty in enhancing the spreading of HIV and AIDS (UNAIDS 1998; Van Dyk 2008). In this regard, *there has long been worldwide recognition of the negative impact of poverty on health and the need to undertake aggressive action towards poverty alleviation and development* (UNAIDS 1998:7).

The allure of money compels countless young people of both sexes into promiscuity. Many poverty-stricken young people resort to street-life, often depending on addictive substances for consolation and prostitution to support their habits while they are there (UNAIDS 1999; Van Dyk 2008). These teenagers are ill-equipped when it comes to bargaining or negotiation. During their sexual encounters they may find it very difficult to protect

themselves against pregnancies and sexually transmitted diseases. Commercial sex workers may consent to sexual activity without condoms for enhanced remuneration.

Additionally, rural areas and indigenous neighbourhoods are often poorly serviced by information campaigns dealing with HIV and AIDS and health services that could assist in curbing the spreading of HIV-infection through the treatment of sexually transmitted diseases (UNAIDS 1999; HSRC 2009). Young women are susceptible to coercion into sexual relationships with older men on the grounds of material gains. The older male partners usually compensate their younger female partners with money, ornaments and clothes in return for sexual favours. In many instances, the families of these female adolescents gain financially from these relationships (HSRC 2009).

2.2.4 THE IMPACT OF HIV AND AIDS

HIV and AIDS is the cause of the most urgent health, welfare and socio-economic challenge in South Africa (Department of Social Development 2002:10). It seems as if the impact of HIV and AIDS is particularly severe in poverty-stricken areas and among marginalised populations in industrialised areas (Department of Health 2005). In the context of my study I focus my discussions in this section and subsequent sub-sections on the impact of HIV and AIDS on the family, education sector and individuals (adolescent learners) and educators.

South Africans, in particular, are affected by this scourge that has resulted in declining productivity, more expensive public services, collapsing family structures increases in child deaths and intensified poverty (UNAIDS 2004). Those who are most affected by HIV and AIDS live in anguished, deprived and often socially dysfunctional communities. They have to face, on a primary level, the challenges that are implied by the epidemic.

The fact that the HIV and AIDS epidemic has a devastating impact upon the lives of people has prompted me to do research on the challenges that individuals, families and communities have to face from day to day. The severe impact of HIV and AIDS on the Eersterust community served as a frame of reference to plan and conduct my research. In considering the high prevalence of HIV and AIDS in Eersterust I assumed that the strategies to prevent HIV and AIDS among adolescents may not be successful or successfully implemented as far as community-based educational support programmes are concerned.

For the purpose of this study I assumed that the adolescents of Eersterust are aware of and knowledgeable about the dangers that HIV-infection poses to them. The incidence of drug abuse has also increased although the age at which children are being exposed to

substance abuse is decreasing (Maag & Irvin 2005). In view of this it is evident that some adolescents may turn to prostitution for an income or to support their drug habits, thereby increasing the risk of contracting HIV.

2.2.4.1 The impact of HIV and AIDS on families

The HIV and AIDS epidemic has an emotional impact on families. South Africa has an estimated 1.9 million AIDS orphans where one or both parents have died due to AIDS-related illnesses (UNAIDS 2010). In most instances grandparents or extended family members are pressurised to take care of the orphans resulting in more financial hardships. The financial state of many families deteriorates due to HIV and AIDS and impacts negatively on the living standards and quality of life of all household members. According to Evian (2000) high levels of unemployment inevitably promotes migrant work and family disruption. People leave their homes and therefore their loved ones, friends, familiar surroundings and local community life. In far-away places, migrants often find themselves in lone, unfavourable, hostile or alienating environments. Based on a natural need for sex and intimacy multiple partner sexual relationships prevail.

Decreased income leads to fewer purchases, diminished savings and dissavings (UNAIDS 2001:10). The presence of AIDS in the family often means that children have to drop out of school, temporarily or permanently interrupt their schooling because of a shortage of money, or work full-time in the home to help sick parents (Van Dyk 2008). For example, in Thailand one third of the rural families plagued by the disease lose a half portion of their agricultural output which threatens the family's food supply. Some of the families are forced to withdraw their children from school while over half of the pensioners have been left to take care of themselves (UNAIDS 2001; Van Dyk 2008).

When an individual falls ill, family members typically experience physical and psychological pain and suffering, and are often not able to contribute to the household income anymore (UNAIDS 2008). Infected family members are unable to contribute positively to the household and subsequently their involvement in the community becomes reduced on various levels. In Cote d'Ivoire[8], when family members are ill, *they often return to their villages to be cared for by their families, thus adding to the pressure on scarce resources and increasing the probability that a spouse or others in the rural community will be affected* (UNAIDS 2001:10). In view of the above-mentioned facts it seems evident that affected families face great difficulties to care for HIV-infected and dying family members.

[8] Cote d'Ivoire is the official name of the Ivory Coast.

In addition, family expenses will increase when a family member becomes ill (in order to obtain treatment, health care and healthy dietary requirements), resulting in food insecurity and ultimately the weakening of the nutritional status of the people involved. The cost of treatment places a strain on savings as most affected families cannot opt for drug therapy or even the most basic painkillers. HIV and AIDS does not only have a negative impact on family life and family relationships but also on families' access to social and economic resources. Owing to HIV and AIDS-related illnesses, some family members may absent themselves from school or the workplace in an effort to support family members who are sick and dying. The sudden death of a parent could result in financial obligations, the loss of savings and/or psychological distress experienced by the people who are infected or ill.

When women are infected with HIV it has a direct impact on children in such households. Many households in South Africa are headed by women and the majority live in abject poverty (May, Budlender, Mokate, Rogerson, Stavrou & Wilkins 1998). Women have the responsibility to care for the sick and dying as well as for the children in the household which can constitute an extraordinary emotional burden (Barolsky 2003). It follows that the impact of HIV and AIDS on children and families who live in poverty-stricken communities with limited access to basic services and a poor infrastructure can be typified as severe (UNAIDS 2004).

Women, *inter alia*, are more vulnerable to HIV-infection for biological, social and economic reasons. They have diminished opportunities to become economically independent and some HIV-positive women struggle to meet their own and their families' basic care needs (Cabassi 2004). According to Evian (2000) they are vulnerable to HIV infection in situations where husbands or sexual partners have sexual intercourse with other partners. In this way HIV infection can be silently passed without a woman even knowing. Women are often forced to sell sexual favours to earn money for food and basic needs and to help raise their children.

2.2.4.2 The effect of HIV and AIDS on the educational sector

Education and learning can be regarded as the key to social, cultural and political participation, personal and community economic empowerment and national development. The increase in HIV and AIDS-related cases emphasises the need to educate children about the disease (Department of Education 2001; UNAIDS 2012). The HIV and AIDS epidemic is the largest single threat to the education process, because the scale of almost every existing problem of supply, quality and output has increased (Badcock-Walters 2001). My view is that

the threat has increased exponentially due to a general lack of recognition of the severity of the problem and its impact on the systemic functioning of education at all levels.

Upon the adoption of the Revised National Curriculum Statement, South Africa became the first country to deal formally with sexuality in its curriculum (Department of Education 2001). In 2002, HIV and AIDS and sexuality education was implemented in all schools as part of the Life Orientation curriculum. The quality of the education may not be effective at this stage, due to a lack or shortage of sufficient trained educators which may result in an unwillingness of educators to provide this education or perhaps one educator in a school being able to teach HIV and AIDS education. Some educators do not seem to be convinced of the importance of human rights education, which includes sexuality education (Department of Education 2001).

According to Badcock-Walters (2001), one third of all HIV-infected persons in South Africa are infected during their school years, while a further third are infected within the first two years after leaving school. This confirms the fact that schools are a high risk environment but also suggests that it is a key strategic ground on which the battle to mitigate the impact of HIV and AIDS can be addressed. Sexuality education can equip the children with vital skills such as assertiveness and being able to negotiate freedom out of difficult situations and in making the right choices to stay healthy and to protect themselves. Sexuality education can influence the course of the HIV and AIDS epidemic by empowering and protecting young people regarding the disease. I regard HIV as a health challenge that has crossed the path of education development and one that largely requires improved sexual and reproductive health education to resolve or mitigate its impact.

The threat of HIV and AIDS in South Africa has prompted the Government to respond through systematic and sustainable management programmes related to HIV and AIDS. The Department of Education has developed policies and programmes related to sexuality in general and HIV and AIDS in particular but they needs to be strengthened. HIV and AIDS affects the demand for education due to fewer children being educated, fewer children wanting to be educated, fewer children being able to afford education and fewer children being able to complete their schooling. The high prevalence of HIV and AIDS in South Africa is further eroding the supply of education because of a loss through death of trained educators, the reduced productivity of ill educators and the closure of classes or schools because of population decline. In addition, consequent decline in enrolments is likely to reduce the quality of education (Kelly 2000).

2.2.4.3 The impact of HIV and AIDS on learners

HIV and AIDS reduce population growth rates and can therefore alter the structure of a population. More specifically, the high HIV-infection rate among young people is likely to stop population growth in South Africa. Furthermore, as the proportion of potential parents declines, the number of orphaned children increases, poverty deepens, school enrolment rates decline and dropout rates increase (Badcock-Walters 2001). When one or both parents fall ill or die, children often drop out of school in order to generate funds to support themselves or their siblings. As such, they may become involved with petty criminal activities such as begging or stealing (Barolsky 2003).

In 2009 an estimated 1.9 million orphans lived in South Africa who had either lost one or both parents (UNAIDS 2010). Richter *et al.* (2004:5) predicted the following: *Because orphaning follows deaths by 8-10 years, orphaning is likely to remain high until 2030.* By 2001 there was already evidence in the province of KwaZulu-Natal of a rather dramatic impact on enrolments in Grade 1. An analysis of Grade 1 enrolment indicates a historical growth of between three and five percent per annum in the 20 years prior to 2000 yet in 1999 a three percent growth rate in 1998 reversed to a 12 percent decline (Badcock-Walters 2001). In 2000 there was a further drop of 24 percent, resulting in a decline constituted by regulations that stopped the entry of children under the age of seven from that year (Badcock-Walters 2001). While many apparent reasons can be raised for this decline, many of these reasons could be directly or indirectly related to HIV and AIDS, and confirm the extent of challenges facing the education system due to the epidemic in South Africa.

If learners are traumatised by HIV-infection they find it difficult to pay attention at school. Absenteeism has been found to increase, especially among children who are caregivers or heads of households or among those who help in supplementing family income (Guthrie 2003). Many learners are, for example, absent because of fear of stigma and the ridicule at school. I am of the opinion that such learners may often experience barriers to participation in educational support programmes.

All South African children have access to compulsory free education; unfortunately some of them are being forced out of school to become the heads of households as a result of HIV and AIDS (Department of Education 2001). The HIV and AIDS epidemic has thus resulted in reduced educational opportunities for learners who are forcibly entering adulthood prematurely and subsequently losing their rights to education. Learners who are ill, caregivers or wage earners might also opt for more flexible learning opportunities. This demand is often offset by the fact that families typically have insufficient income to afford

school fees, voluntary funds, transport costs and uniforms. In the light of the discussion above, I am of the opinion that community-based educational support structures may play an active role in educating young people, particularly out-of-school youth, about HIV and AIDS.

2.2.4.4 The impact of HIV and AIDS on educators

Education delivery and maintenance is significantly impacted by the illness and premature death of educators and officials at every level, and by the consequent erosion of systems and structures as a result of the loss of capacity, specialist skills and experience (Badcock-Walters 2001:30). Clear evidence exists that the South African Department of Basic Education is losing educators due to HIV and AIDS (Department of Education 2001; Van Rooyen 2010).

Besides losing educators, the impact of HIV on educators may manifest in long periods of absence. This will result in redused contact time with learners, a decrease in the quality of teaching which will lead to educators being substituted at high costs in the system (Marais 2005). Because of such problems, learners may not be sufficiently educated in schools. In this regard, community-based educational support structures may provide additional support.

When educators know they are infected with HIV, they often lose interest in continuing to development themselves professionally (Van Rooyen 2010). The quality of classroom performance of educators who believe that they are not infected and those who refuse to be tested is likely to deteriorate because they have to cope emotionally and financially with illness and death among their relatives, friends and colleagues (Marais 2005).

Educators who are uncertain about their own future and that of their families may take on additional teaching and other work-related duties to cover for sick colleagues. The prevalence of HIV-infection among educators is considered to be above that of the population as a whole. It is disturbing to note that in South Africa, educators form the largest occupational group that are infected with HIV and AIDS. According to a Business Report (2000) the number of South Africa's educators was 443 000 at the time. Available figures suggested that 12% or 44 400 of the 443,000 educators were reported to be infected with HIV by 2000 (Business Report 2000). In addition, many more educators are probably ill, absent and dying, or occupied with family crises.

2.3 VULNERABILITY OF ADOLESCENTS DUE TO HIV

Adolescents are at a period of sexual awakening, learning and experimentation and need extensive help and support in making constructive use of their new-found powers (Kelly 2000:47). The fact that adolescents become sexually active when they are young makes them vulnerable to HIV-infection. In 2007 it was reported that an estimated 45% of all new infections were among the 15 to 24 year olds (UNAIDS 2008). A study conducted among males from rural areas in South Africa revealed that 13% of the 15- to 24-year olds had sexual intercourse before reaching the age of 15 years, which commonly ranges between 9 and 14 years (HRSC 2009). *Young females in South Africa have three to four times the prevalence of HIV than their male counterparts* (HSRC 2009:1).

Early sexual debut can often be ascribed to alcohol and drug abuse which leads to experimentation with sexual intercourse; mixing with older groups that are sexually active or giving in to peer pressure (HSRC 2009). It is evident that girls who are sexually abused *are more likely to engage in riskier sexual behaviours compared to their peers* (HSRC 2009:65). Older males have a tendency to target particularly young girls, especially when they are virgins (HSRC 2009). The risk of HIV-infection increases when young people are having more than one sexual partner.

Condom use is particularly low, inconsistent or even absent among young people with many sexual partners due to the negative perceptions about condom use (HSRC 2009). Failure to practise safe sex makes adolescents vulnerable to HIV-infection and it can be ascribed to pressure to engage in early and unprotected sexual intercourse, forced sex, lack of access to user-friendly health services and low perceptions about personal risk to HIV-infection (UNAIDS 2012). Statistics like these have resulted in my belief that successful preventative efforts should start very early with HIV and AIDS education, before adolescents encounter their first sexual experience.

Adolescents are particularly vulnerable to HIV-infection owing to a number of factors, for example their limited knowledge, skills, attitudes and sexual behaviour which are discussed in the following paragraphs. As adolescents mature and experiment with sexual intercourse, they are confronted with serious health risks with too little factual information, too little guidance about sexual responsibility, a few skills on how to protect themselves from coercion and limited access to youth-friendly health services (Department of Education, Health and Social Development 2000). These contributing factors have prompted me to explore the potential challenges implied by the HIV and AIDS epidemic in terms of the

vulnerability of adolescents to HIV-infection. In the next few sub-sections vulnerability of adolescents is related to underlying contributing factors.

2.3.1 VULNERABILITY DUE TO A LACK OF KNOWLEDGE

Adolescents are often vulnerable to HIV-infection due to a lack of sufficient knowledge. Despite the availability of HIV and AIDS awareness campaigns, accurate knowledge with regard to HIV transmission was below 50% for both males (47.1%) and females (42.2%) in 2008 (HSRC 2009). The lack of accurate knowledge about HIV transmission can be ascribed to little or no information from their parents or other adults regarding sexual and reproductive health matters (UNAIDS 2010). A distinct need exists to identify and acquire information for at risk learners, such as female pupils, children who walk a long way to school as well as out-of-school youths.

Many young people do not have sufficient knowledge to protect themselves from HIV-infection. There are significant social and cultural barriers that impede the widespread availability of appropriate sexual health and HIV education for young people (Cabbasi 2004). Adequate communication about sexual matters in the home is seldom found. *Being left to grapple on their own adolescents may thus turn to one another for information and guidance* (Kelly 2000:2). The fact that parents fail to talk to their children about sexual related matters may also lead them to their peers where they may acquire wrong or misleading information. *This aspect of a peer culture serves as a substitute for information that adults fail to provide* (Kelly 2000:2).

Adolescents generally lack sufficient knowledge of the HIV-epidemic. As many as 95% of teenage women aged between 15 and 19 years are aware of HIV and AIDS but this does not always translate into safer sexual behaviour as shown by continued high rates of STD symptoms and low rates of condom use (UNAIDS 2010). Even with the threat of AIDS being highly publicised adolescents continue to be sexually active. Against this background I am of the opinion that education remains an important tool for the prevention of HIV and AIDS infection. Young people must acquire knowledge of HIV and realise their responsibility towards themselves and their partners not to become infected with HIV.

Adolescents are confronted with media[9] images that portray sexual activities, smoking and drinking as glamorous and risk-free. The media tell adolescents to abstain but they are also exposed to many advertisements containing sex symbols. Unfortunately youth-friendly information that keeps the realities of young people in mind is often lacking (Woodarsky &

[9] This covers a variety of media images, namely both broadsheet and tabloid newspapers, magazines, the Internet, television, billboard advertising and leaflets (HIV and AIDS).

Woodarsky 1995; UNAIDS 2010). Because of the lack of youth-friendly health services, young people are more reluctant to seek treatment for fear of being found out or because the services are unwelcoming and unattractive. Young people find it difficult to reach youth-friendly services where they can discuss issues related to sexual health or obtain condoms and other protective devices (UNAIDS 2010). Although health practitioners are prepared to attend to young people, the latter are typically reluctant to speak freely, perhaps because of embarrassment or because they are uncertain whether their privacy will be respected.

In view of the discussion above it seems that knowledge gaps with regard to HIV and AIDS do exist among adolescents and that these needs to be addressed. Many adolescents are aware of the dangers posed by HIV and AIDS, yet the number of infections continues to increase. Although young people are provided with the required information, they do not listen or are unwilling or unable to act accordingly. Furthermore, educational programmes related to HIV and AIDS at school level seem to be insufficient. It is clearly not enough simply to provide information to young people if they will not put this knowledge into action.

2.3.2 VULNERABILITY DUE TO A LACK OF SKILLS

Young people often lack the necessary confidence and skills to negotiate sexual issues, contraception and prevention of HIV-infection (Smart 1999; UNAIDS 2012). In general, adolescents possess poor decision-making and negotiation skills (Hartell 2005; Swart & Mthembu 2003). Yet, during this life phase, they face a series of important developmental decisions involving family and peer relationships, sexual expression, vocational and educational development as well as experimenting with drugs and alcohol or not (Maag & Irvin 2005).

Perhaps one of the consequences of these developmental transitions yet limited developmental skills is the number of HIV-infections that arguably seems to be at its maximum during adolescence (Maag & Irvin 2005). Decisions with regard to pre-marital sex are a major looming decision every adolescent faces. Hence a crucial need exists for adolescents to have an accurate, broad, well-rounded foundation of knowledge to draw upon when making sexually related decisions (Woodarsky & Woodarsky 1995).

Existing literature shows that effective, comprehensive educational support programmes and projects with regard to required skills are imperative if adolescents are to make well-informed decisions that will protect them against HIV-infection. Adolescents lack negotiating skills to prevent sexual encounters, to engage in safe sexual practices and to reduce the

number of sexual partners (Swart & Mthembu 2003). Females in particular have been found to lack the required knowledge and skills to reduce unplanned pregnancies.

Research by Kelly (2000), McClure and Grubb (1999) as well as Omi (2001) indicates that it is necessary to teach adolescents social skills and attitudes related to developing relevant educational competencies, handling current problems and stresses, anticipating and preventing future problems and advancing their mental health, social functioning and economic welfare. Some of the most important skills adolescents often lack are the ability to analyse situations and the behaviour of their peers. In the same manner they may have little insight into the consequences of their own actions and into the consequence of engaging in risky sexual behaviour. They thus need to understand what risky sexual behaviour entails and how to manage and avoid risky situations (UNAIDS 2012). In undertaking my study I regarded the development of the above-mentioned skills as vital for adolescents to be able to avoid sexual behaviour that would place them at risk of HIV-infection.

2.3.3 VULNERABILITY DUE TO A LAISSEZ-FAIRE ATTITUDE

Adolescents believe that they are invulnerable to disease, accidents and death. They often maintain a laissez-faire, irresponsible and irrational attitude with regard to HIV and AIDS. Yet many adolescents are exposed to situations and circumstances that make them vulnerable to HIV-infection. This is problematic as they may have an unfavourable perception of personal risk and do not immediately realise the threat of HIV and AIDS.

Only a few adolescents perceive themselves to be at risk or take the need for safe sex seriously. Adolescents may thus be inclined to consider themselves not vulnerable or even immortal, thinking that HIV and AIDS infection only happens to older people, or judge a person's HIV-status based on appearance and health. Research done by Chapin (2000) indicates that the more learners know about HIV and AIDS the less likely they are to believe that they will be affected by HIV and AIDS messages.

Some youngsters are more exposed to HIV-infection than others (UNAIDS 2012). People who live in especially difficult circumstances include young people who live on the streets, use drugs and take part in commercial sex, or who are sexually abused (UNAIDS 2012). It is also true that adolescents in general are often sexually active and do not always practise safe sex. The Youth Risk Behaviour Survey of 2002 by the Medical Research Council found that more than 40% of the learners who participated in the survey were sexually active and had more than one partner at the time; 13,8% were under the influence of alcohol or drugs

during sexual intercourse; 28,1% did not use contraceptives, 16,4% were pregnant and 7,4% of the learners who had sex, had a sexually transmitted disease (Greyling 2004).

Attitudes of adolescents relating to the epidemic itself, casual sexual partners and those who are living with HIV and AIDS are changing at a very slow pace and certainly not on a level within the scope of the epidemic itself. Available data suggest that AIDS education that improves positive attitudes towards HIV-infected people, has not changed the adolescents' attitudes towards adopting preventative behaviours (Huszti, Clopton & Mason 1989; UNAIDS 2010).

Time has a different meaning for adolescents compared to time experienced by older individuals. For adolescents even a month is far into the future, therefore they have difficulty in understanding the importance of periods as long as ten years or more. The latency period between HIV-infection and the onset of symptoms and illness can be longer than ten years. Therefore, when telling adolescents that when one is infected with HIV and AIDS it may lead to death in 10 to 15 years, the time factor may not be meaningful to them (Omi 2001).

2.3.4 VULNERABILITY DUE TO RISK BEHAVIOUR

Within the context of HIV and AIDS, *vulnerability is influenced by the interaction of a range of factors including personal factors, factors pertaining to the quality and coverage of services and programmes aimed at prevention, care, social support and alleviation of societal factors* (UNAIDS 1998:6). Personal factors include *sexual history (the number of partners, number of unprotected sexual acts and the nature of sexual acts), availability of knowledge and skills required to protect oneself and others in relation to care and social support, knowledge of treatment and social support programmes, as well as skills to access and take advantage of such programmes or support* (UNAIDS 1998:6).

Factors related to services and programmes that influence vulnerability may include *the cultural inappropriateness of HIV and AIDS programmes, the inaccessibility of such services because of distance, cost and other factors, and a lack of capacity of health systems to respond to a growing demand for care and support for people living with HIV and AIDS* (UNAIDS 1998:6). Societal factors that influence vulnerability include *cultural norms as well as laws or social practices and beliefs that act as barriers to essential prevention messages about awareness and prevention, condom use, and the importance of safer sex.* Societal factors can lead to negligence or deliberate social exclusion depending on the people's lifestyle, behaviours or choices and more often due to socio-cultural characteristics (UNAIDS 1998).

Within the context of HIV and AIDS the term *risk* is defined as *the probability that a person may become infected with HIV or transmits HIV to another person* (UNAIDS 1999:15). Risk arises when a person engages in risk-taking behaviour for a number of reasons (UNAIDS 1998). Adolescents *may lack information on HIV, be unable to negotiate safer sex, may think that HIV and AIDS affects a different social strata than their own, or may not have easy access to condoms* (UNAIDS 1998:4). Sexual activity often occurs in places where alcohol is consumed and the use of drugs is abused. Subsequently many young people have sexual intercourse, especially with casual partners when they are intoxicated or have used drugs (Maag & Irvin 2005; UNAIDS 2012).

The injection of illicit drugs implies another measure of risk and carries additional danger to HIV-infection. When drug users share needles and syringes to inject drugs, micro-transfusions of blood occur, which is efficient for transmitting HIV. Experimentation with non-injectable drugs may also impair judgement and lead to behaviour that increases the risk of HIV-infection (Maag & Irvin 2005). The abuse of alcohol and the smoking of drugs or glue-sniffing are prone to make young people forgetful or careless about safer sex practices and may thus reduce the use of a condom (UNAIDS 2012).

Excessive drinking can diminish the adolescent's inhibitions and may impair the likelihood to utilise important knowledge that has been acquired regarding AIDS prevention and how to make decisions about protection (UNAIDS 2012). As such, the use of drugs, body piercing and unsafe tattooing can accelerate the transmission of HIV.

Young people who are in detention or remand centres may be exposed to violence, abuse and unwanted sex. Adolescents who are kept in such facilities generally have limited options to prevent HIV and other sexually transmitted diseases. These young people's rights are in most instances violated and their risk of becoming infected with HIV is increased. Because of the lack of accurate information, adolescents may be susceptible to misleading assurances that there is no risk (McClure & Grubb 1999).

Young men who participate in sexual acts with other men, are exposed to high risk of HIV-infection. Accordingly, messages that are intended for gay men usually go unheard by young men who have occasional homosexual experiences. These young people, especially in developing countries are often ignored in educational programmes with the assumption that all sexual activities are heterosexual – despite credible evidence that same-sex relations occur in the world (UNAIDS 1999). For young men who partake in sexual activities with men the risk of being socially rejected is high. In an attempt to hide their sexual orientation, many have secretive affairs or rushed sexual encounters with little time for negotiating condom

use. Many also have unprotected sexual intercourse with women, either because they are bisexual or to mask their homosexuality. The risk of HIV transmission to both men and women through such unprotected sexual intercourse is high (UNAIDS 2012).

Heightened sexual awareness is characteristic of adolescent development. This is often characterised by experimentation which has the potential of placing adolescents at risk of unprotected sexual activity and sexually transmitted infections, including HIV (Swart & Mthembu 2003). Data suggest that 70% of teenagers are sexually active by age 20 and over half have had sexual intercourse by age 17 and fewer than half use condoms (UNAIDS/WHO 2005).

As such, certain behaviours of adolescents *create, enhance and perpetuate risk - for example, unprotected sexual intercourse with a partner whose HIV status is unknown, multiple unprotected sexual partnerships and injecting drugs with shared needles and syringes* (UNAIDS 1998:4). *Declining knowledge of the risks of multiple partnerships may be linked to the fact that multiple partnerships are common and are seen as normal* according to HSRC (2009:68). Although many young people are sexually active, not all have ready access to condoms, peer support or risk reduction information in a form that is understandable to them. Valuable information to reduce risk also exists for young people with intellectual, psychological and physical disabilities or mental illnesses (McClure & Grubb 1999).

Boarding schools show high HIV-prevalence rates and they are arenas of peer pressure, experimentation and consensual or non-consensual sexual contact (Department of Education, Health and Social Development 2000). *Providing term-time hostel accommodation for sexually active adolescents who receive inadequate guidance or support in a form that speaks to them, increases the risk that they will engage in sexual activity with one another or with individuals from the immediate surrounding community* (Kelly 2000:3).

Sufficient evidence exists to suggest that HIV and AIDS awareness is high in South Africa (Department of Health 2006). However, the dynamics of the epidemic are such that failure to act on risk reduction is bound to result in a substantially larger number of infected adolescents, further restricting the benefits from structural interventions against susceptibility. Existing studies, although limited, indicate that awareness and knowledge are not enough to instigate the desired changes in the sexual behaviour of adolescents.

2.3.5 VULNERABILITY DUE TO CULTURAL PERSPECTIVES

Globally, teenagers are becoming sexually active despite compelling cultural values against pre-marital sex in the majority of cultures (Omi 2001; UNAIDS 1999). In addition to the cultural evolutions resulting from resettlement and the adolescence crisis, HIV and AIDS prevention targeting sexual relations could add further strain to the life of the youth, because this area is sensitive and a taboo in many cultures (UNAIDS 1999).

Endeavours to promote behaviour change through the media may also have varied outcomes. In some societies adults impose a special burden on adolescents through expectations and conflicting messages. Much deeper and more influential is the customary view that construes the disease and its origins in terms of the cultural world of responsibility and witchcraft (Kelly 2000).

Adolescents appear to be unable to deem illness and death as likely ramifications of unprotected sexual intercourse and may thus be indifferent to conventional health messages (Huszti *et al*. 1989). Sickness and disease are almost always believed to have divergent roots other than the viruses, germs and microbes identified by medical science. Very often the external cause is considered to be a hostile, malicious human agent, who employs the powers and might that are available to those involved in witchcraft or sorcery.

External causes are often considered to be connected to ancestral spirits who are offended by the breach of certain taboos or failure to observe certain rituals or customs (Kelly 2000; Kalichman & Simbayi 2004). With regard to HIV and AIDS, this customary understanding of a disease and its causes derives from the incapacity of western science to bring into being a total cure.

The entrenched belief that sorcery and witchcraft are the root causes of HIV and AIDS manifests itself not only in rural people, but also in those from metropolitan and affluent surroundings. Knowledgeable people are no strangers to it; neither are those who support the major world religious conventions. Persons from all classes and groups wish to determine the source of the antagonism that brought them their sickness, believing that, once this root has been identified, appropriate corrective action can be taken (Kelly 2000).

During adolescence peer group norms gain relative power over personal and familial norms (UNAIDS 2000:40). In most instances peer groups range around the defiance of adult norms and authority and engage in risky sexual behaviour (UNAIDS 2000; Kalichman & Simbayi 2004). Many approaches fail to speak to young people because they do not enter the

underlying cultural imperatives which motivate young people from within more powerfully than anything that may be proposed from without (Mageza 2000).

Aspects of these underlying cultural demands and expressions include the following (UNAIDS 2000:6):

- *The power of peer pressure and the group, and the need to conform and belong.*
- *The message implicitly learned from parental failure to discuss sex with their children, that sex is something which should not be discussed across ages, between adults and the young, but only between the young themselves as equals.*
- *The socialisation process which teaches boys that they must be physically strong, emotionally robust, daring and virile and that they should not depend on others, worry about their health or seek help when they face problems.*
- *The widespread disbelief in the possibility of total sexual abstinence, particularly on the part of boys and even some suspicion and concern when there are signs of such abstinence.*
- *The social expectations that condone in men and boys what they condemn in women and girls.*
- *The enormous mix of cultural values and counter values coming from the weakening and progressive demise of traditional cultural systems, the importation of systems in which immediate pleasurable gratification assumes a dominant role and the presentation by the entertainment industry of situations and role models which give prominence to temporary relationships and casual sex.*

It seems necessary that programmes should be *culturally adapted and designed to cope with the unique issues of cultural transitions and cross-cultural interactions* (UNAIDS 2000:41). People's own cultural resources need to be mobilised for efficient and sustainable behaviour change towards HIV and AIDS. At present, very few educational support programmes exist (whether it be school-based or for out-of-school youth) in South Africa that take sorcery or witchcraft seriously and use this world-view in empowering adolescents to protect themselves against infection with HIV (Mageza 2000).

Educational support programmes have also failed to utilise the services of traditional healers and to have them share their expertise within educational programmes. Many of the HIV and AIDS prevention and care efforts have failed to bring about expected behaviour changes as they have not taken into account the cultural specifics of the target populations.

2.3.6 VULNERABILITY DUE TO VIOLENCE AGAINST WOMEN AND CHILDREN

Violence against women and children is a widespread problem in South Africa. Violence against women is related to high HIV and AIDS prevalence. Sexual abuse of children takes two main forms: *commercial sexual exploitation and sexual abuse in the home or community, whether by relatives, friends or associates of the child's family* (UNAIDS 1999:16). The perpetrators might also be other people with easy access to the child (UNAIDS 1999).

Sexual abuse in the home is a decisive factor in forcing children to leave their home, thereby creating a further cycle of vulnerability to HIV and AIDS. According to Evian (2000), women are often exploited and have a more inferior status than men, In some cultures women have little control over their sexual lives and the ways to prevent HIV and AIDS or STIs. Young women and girls in particular are victims of abuse in the form of domestic violence, rape and sexual assault, sexual exploitation and female genital mutilation. Many of the children who are in the sex industry tend to be girls between the ages of 13 and 18, and in some cases there are much younger children who are being sold (UNAIDS 2012).

Many of the abused children spend their entire lives on the street in an attempt to free themselves from violence or sexual abuse in the home. The belief that *children are less likely to be infected with the HI-virus has raised the demand for younger sex workers in recent years* (UNAIDS 1999:16). Adolescent women feel unable to refuse sex or to discuss safe sex, including contraception or condom use, for fear of violence (Smart 1999; UNAIDS 2012). As Kometsi (2004:31) states: *In South Africa, rape and sexual coercion form one part of the broader problem of gender-based violence which pervades society.*

Abusers are in very few cases complete strangers to abused children. More often than not, they are members of the young woman's family. According to Smart (1999) 38% of the men committing violence against women or girls are biological family members, 66% are known to the family and only 7% are complete strangers. The National Progressive Primary Health Care Network (NPPHCN) survey (2000) has found that boys determine when and how sex occurs and that girls commonly experience rape, violence and assault, even within relationships. Some young men justify rape because of the perception that young girls have sexual intercourse with older men for material gain.

While in some cases sex takes the form of actual rape, in other instances it ranges from enticement to coercion, especially for young girls from poor backgrounds. The growing phenomenon of *sugar daddies* illustrates the grey area surrounding the exchange of sexual

acts for goods and cash. Older men seek out young girls (often because they are HIV risk free) and entice them into sex with offers of meals, clothes, luxuries and cash, including money for school fees. *The age disparity between the girls and their sugar daddies, who are older and sexually experienced men, creates a particularly great HIV risk for the children* (UNAIDS 1999:17).

Many young girls are faced with the danger of being sexually harassed by their educators, peers or complete strangers. Adolescents who strive for academic excellence or those who want to progress to the next grade may consent to sexual relationships (heterosexual or homosexual) with educators or fellow learners who excel academically (Kelly 2000). Children are inevitably at risk of HIV-infection when they engage in consenting sexual intercourse with peers.

Girls who are employed as maids are particularly vulnerable to sexual abuse, where the main perpetrator is the male head of the household or other males in the employer's family. Sexual coercion in exchange for occupational or academic success is not restricted to household employees but also includes live-in domestic workers who are at great risk because they are accessible to the males in the family around the clock. Some reasons for not refusing sex, given by young women, include fear of abandonment or violence (UNAIDS 2012).

Young girls who are being abused may contract HIV and may in turn infect their sexual partners at school or abusive educators. A study on South African young girls reported that 30% of the girls' first experience of sexual intercourse was forced upon them (Department of Education, Health and Social Development 2000).

2.4 COMMUNITY-BASED EDUCATIONAL SUPPORT FOR VULNERABILITY

The HIV and AIDS epidemic affects families and communities worldwide and has to date, caused many family hardships, illnesses and death (Cabassi 2004; UNAIDS 2010). The quality and availability of the health, welfare and educational system is deteriorating which implies that communities themselves must take up the challenge to address the causes of vulnerability to HIV and AIDS and to find appropriate solutions to the curbing and mitigation of the epidemic (Richter *et al.* 2004).

Community-based initiatives are established out of concern by motivated individuals within a community. The group of individuals collaborate in order to decrease the prevalence of HIV-infection, especially among the youth (adolescents). Community-based educational support

programmes that are presented to vulnerable young people, have a firm focus on prevention efforts that reduce the risk of HIV infection. Community-based educational support for vulnerability is spontaneous, informal responses by fellow community members who strive to make a difference in the lives of vulnerable young people to HIV and AIDS (Richter *et al*. 2004). In my opinion collaboration and mobilisation is not only essential at national and international level but at community level as well, in order to respond effectively to the HIV and AIDS epidemic. In the next sections I discuss community-based educational support initiatives that serve as examples of successful interventions addressing the vulnerability of young people to HIV and AIDS.

2.4.1 THE BETHANY PROJECT

The Bethany Project is a Christian-based programme that assists children who are either affected or infected by AIDS in Zvishavane, a small Zimbabwean town. This programme was established in 1995 and launched in two wards (6-8 villages), each with 35 volunteers participating and identifying AIDS orphans and vulnerable children. These children were regularly visited by sub-committees on a monthly basis. From the outset this project was community-based having volunteers and leaders that were sourced from the churches and chiefs (Foster 2002).

The project expanded tremendously during the period of 1997 and 1999 to the remaining 16 rural wards that basically covered the majority of the district. Volunteer-numbers increased to 656 volunteers. Three categories of vulnerable children were catered for which comprised of the neediest orphans, other children in difficult circumstances and children who lost one or both parents, but are not among the neediest. The first two categories received regular visits and material support. Partners of the Bethany project included local government structures, NGOs and the Child Welfare Forum. Strong relationships with the Department of Social Welfare was particularly beneficial to the project (Foster 2002).

2.4.2 THE SALVATION ARMY PROJECT (ZAMBIA)

The HIV and AIDS epidemic has reached crisis proportions in Zambia with an estimated 1.2 million children having either lost one or both parents by the end of 2001 (USAID 2002). The Salvation Army initially responded with a home-care and prevention programme linked to the Salvation Army Mission Hospital. In addressing community concerns with regard to HIV and AIDS and to facilitate change, the response by the Salvation Army, was essentially community-based (Lucas 2004).

Community HIV and AIDS awareness and the willingness to be pro-active enabled the Salvation Army response to spread to 126 locations in 36 countries. The response was based on empowering communities to become "AIDS competent" – the acknowledgement of the existence of HIV and its effects on communities and individuals, care for the affected, to change in response to HIV and giving hope for the future (Lucas 2004).

The facilitation process which can be justified as successful in addressing HIV and AIDS, includes the following (Lucas 2004:4):

- *The establishment of community vegetable gardens that provide food and income from the sale of surplus food to orphans;*
- *voluntary counselling and testing for community members and requests for testing to be provided in nearby communities;*
- *increase in home-care programmes;*
- *more communities to actively respond to HIV;*
- *change in risky sexual behaviour.*

2.5 THE NEED FOR EDUCATIONAL PROGRAMMES

Kelly (2000:1) states: *In a sense, education is a crucial and currently essential element in society's armoury against HIV transmission. It is a necessary though not sufficient, component in all prevention activities.* Research (Department of Education, Health and Social Development 2000; Kelly 2000; UNAIDS 2000) indicates that HIV and AIDS educational programmes should start before learners have their first sexual experience. An obstacle to effective HIV and AIDS education in Eersterust is the young people who exit the education system prematurely. This suggests two things: the importance of starting sex and HIV and AIDS education at an early age; and the importance of programmes targeting out-of-school youth (LOVE LIFE 2003).

UNAIDS (2012) emphasise the need for HIV and AIDS awareness programmes to place a greater focus on adolescents and for a developmentally sensitive approach to sexuality education. Several countries have adapted their school curriculums to include HIV and AIDS education in the expectation that this will contribute to the reduction of HIV transmission. In the current South African curriculum HIV and AIDS are included in the Life Orientation programme.

In some cases sound family values or sexuality education programmes *have brought significant and positive adolescent reproductive health benefits and changed behaviours with the information and skills acquired, helping young people to delay the initiation of sexual*

activity (Gachuhi 1999:12). Programmes such as life skills, reproductive health, as well as sexual or HIV and AIDS education may however face a number of challenges and raise certain concerns. For example, fears that the integration of reproductive health and HIV and AIDS education into the school curriculum will enhance sexual activity among the youth, thereby potentially fuelling rather than to eradicating the problem. However, these fears seem to lack foundation on the basis of what has been investigated. Studies have revealed that sexuality education may lead to delayed sexual activity, reduction in the number of sexual partners and a willingness to adopt protective measures against HIV-infection (Kelly 2000). A UNAIDS (2000) study concluded that there is limited evidence to prove that sexual health and HIV education promote promiscuity.

Another raised concern that educational support programmes encounter is that their listeners hear messages at different levels. Firstly there is the level of the educational support programme itself, with its scientific messages about the cause of HIV and AIDS and how it is transmitted. Such educational programmes tend to be on an academic, notional level, where messages are received and stored for subsequent action within the context of the scientific, academic, modern, westernised world. In terms of what motivates personal behaviour, this may be at a rather superficial level (Kelly 2000).

Programmes are furthermore often not suitable to the changing needs of the people for which they are intended, owing to a lack of involvement of affected communities. Some educational support programmes may even lack sufficient resources. Intervention may be undertaken in isolation rather than in support of each other (UNAIDS 2010). In addition, some programmes appear to have been developed from the top, with minimal input from educators, parents and adolescents themselves. *Programme delivery is often almost exclusively in the hands of educators, again with minimal involvement of parents and young people* (Kelly 2000:4). Existing programmes occasionally seem to result in young people having knowledgeable facts rather than desirable changes in behaviour.

Both educators and learners generally prefer to have life skills and HIV and AIDS education as examinable subjects (Kelly 2000). This fact suggests that adolescents are aware of the potential dangers posed by HIV and AIDS but they do not put their knowledge into practice. *Many programmes seem to downplay the potential of abstinence as a means of preventing HIV transmission.* By doing so, *they fail to challenge the learners, but adopt a defeatist attitude towards what they regard as the inevitability of sexual activity among young people* (Kelly 2000:4).

It is also important to involve adolescents in the designing and delivery of educational support programmes that focus on the promotion of peer education. Community leaders, parents and the youth should be involved in the design and delivery of HIV and AIDS educational content. Young people should be provided with challenges (to make abstinence attractive) and to develop a learning climate that firmly re-affirms values such as respect, accountability and human rights.

As mentioned earlier, there is a widespread problem of limited educator knowledge and understanding with regard to HIV and AIDS. Educators sometimes question their role in HIV and AIDS education. They have anxiety and resistance concerns such as fear of violating sexual taboos, *offending parents, being accused of encouraging promiscuity and loose moral practices, or being regarded as using their teaching in this area as a form of sexual outlet* (Kelly 2000:4).

Existing programmes do not typically seek to contextualise messages with regard to HIV and AIDS from a cultural perspective that includes traditional ideas. However, these programmes do not acknowledge or build on the traditions and beliefs of those they aim to address. In many countries responsibility for programmes and their components appear to rest almost entirely with the education ministry (Kelly 2000). Little evidence exists of collaboration with other partners such as non-governmental organisations (NGOs), community-based organisations (CBOs) or the private sector.

While there is some evidence that educational programmes may lead to delays in the onset of sexual activities, the extent to which they lead to the curbing of HIV-transmission has not been evaluated (Kelly 2000:4).There are only a limited number of programmes that include awareness of the curbing of HIV and AIDS incidence among learners as their performance indicators (Kelly 2000). HIV and AIDS educational support programmes are also seemingly lacking in recognising traditional and cultural beliefs that may identify witchcraft, evil spirits or offence to ancestors as causes of AIDS.

In order to be successful, educational support programmes should incorporate sensitivity with respect to traditional belief systems in order to enlist the involvement of traditional leaders and healers. Educational support programmes *dealing with the wider perspectives of intimate and sexual behaviour, with a focus on sexual health care, are the preferred choice for adolescents* (UNAIDS 2000:41). The rate of HIV-transmission may be reduced and the onset of AIDS-related complications delayed significantly if well designed and sustainable programmes are undertaken (UNAIDS 2012). According to Piot (2004) education can be the most powerful force in combating the spread of HIV and AIDS.

The current situation of HIV and AIDS education in South Africa seems bleak. Unless significant, effective intervention programmes are put in place, further development in awareness and the curbing of HIV-infection among adolescents will not be accomplished within the near future. The challenge to political and civic leadership is huge. Leaders' task is to organise and sensitise all Government sectors, NGOs and CBOs as well as religious, cultural and educational institutions to determine what needs to be done, to assume responsibility and being accountable for the resultant responses.

Educational support programmes that seek to respond to these concerns stand a good chance in enabling adolescents to acquire behaviours that will protect them against infection. These are areas about which school programmes are too often silent, but about which they are supposed to communicate. It is to these areas that HIV and AIDS educational support programmes, broadly understood, must address themselves if they are to help with the curbing of the risk situation inherent in educational institutions and with equipping their learners to protect themselves against HIV-infection when they leave school.

According to UNAIDS (2001) a few systematic reviews on the effectiveness of HIV and AIDS programmes, were published. It was revealed that behavioural change interventions were effective when populations at high risk are targeted. Although the findings were mixed and results varied according to populations being studied it was concluded that (UNAIDS 2001:13):

- *HIV prevention interventions can be effective in changing risk behaviours and preventing transmission in low- and middle-income countries;*
- *when the appropriate mix of interventions is applied, they can lead to significant reductions in the prevalence of HIV at the national level;*
- *additional research is needed to identify effective HIV-interventions.*

What seems to be required is educational support programmes for prevention that is simple, standardised and comprehensive to the needs of adolescents which is applicable and adaptive to at risk populations.

2.6 THEORETICAL FRAMEWORK

Bronfenbrenner's ecological theory describes the individual's development within the context of the system of relationships which interacts with other systems in the external world (environment) of the individual. Bronfenbrenner (Allen 2010:3), assumes that *all individuals are part of interrelated systems that locate the individual at the centre and move out from the centre to include all systems that affect the individual*. This implies that individuals are

developed by means of processes, persons, within context and timeframes. The ecological approach to human development explores the interaction between a developing individual and the social and physical environment. As such, the physical environment serves as a background to the psychosocial, personal and physiological areas of input and functioning within the ecological system. Human development is not only about people and their immediate environment but it also includes the interaction with the larger environment.

Bronfenbrenner's ecological model was linked with my study to provide guidance and an explanation of the literature and the acquired results. According to Stokols (1995:287), a *major strength of the ecological theories is that they integrate strategies of behavioural change and environmental enhancement within a broad systems-theoretical framework.* Ecological models can incorporate two or more analytical levels, e.g. personal, organisational and social levels, which can assist researchers when they are examining both individual and group manifestations of health problems and the impact thereof on community interventions (Stokols 1995). Bronfenbrenner emphasised the way in which organised systems (human and non-human) respond in an adaptive way to cope with significant changes in their external environments in order to maintain their basic structures. The ecological theory is based on the systems theory which can be described as *a complex of interacting components together with the relationships among them that permit the identification of a boundary-maintaining entity or process* (Lazlo & Krippner 1982:2). Systems theory in organisations and human groups concentrate on identifying the particular challenges of the group or organisation that significantly affect the intended outcomes.

Systems theory focuses on the arrangement of and relations between the parts which connect them into a whole (Heylighen & Joslyn 1992). The importance of awareness and the curbing of the further spread of HIV and AIDS among adolescents in Eersterust, makes it suitable to conduct the study within the framework of systems theory. Systems theory *sees different levels and groupings of the social context*[10] *as 'systems' where the functioning of the whole is dependent on the interaction between all parts* (Donald *et al.* 1997:36). The following levels or systems with regard to this study were distinguished and discussed (Donald *et al.* 1997*)*:

- The wider community: people in the community (macrosystem);
- Local community: Department of Health, Department of Education. Youth Development Outreach Centre and Circle of Life Centre (exosystem);
- The family, peer group, neighbourhood (mesosystem)
- Individuals: adolescents who are also vulnerable to HIV and AIDS (microsystem).

[10] Social context refers to all aspects of the position which a person, group or organization occupies in the social structure as a whole (Donald *et al.*1997:3).

The view of systems theory is quite comprehensive since it includes all the systems within the community and their relationships at all levels. The systems each have an effect on an individual's development. A system characteristically have subsystems (that are different and sometimes overlapping) within them that interact with the whole system. The relationships between the parts of a system is necessary in order to differentiate between the system (developing individual) as well as other existing systems. The operations of a system depend considerably on voluntary cooperation, with a minimal use (or threat) of sanctions or coercion (Bender 2004). As such, systems have common patterns that can be utilised to develop greater insight into the behaviour of adolescents in an attempt to find solutions for the high HIV-infection rate. The systems approach is relevant to this study as it assumes that people voluntarily interact with each other, seek and take advantage of opportunities, identifying and using available assets and working together to create awareness to curb the further spread of HIV infection among adolescents (Provis 1992).

Applying the systems theory to understand the perception and experience of adolescents appears to be the most appropriate theoretical point of departure for this study since it explains the interaction and mutual relationship between adolescents and various systems within the wider community. Since the ecological model considers and incorporates factors inherent both within the adolescent, the school, other educational institutions and community, it provides a contextual map which aids in understanding the different factors contributing to the adolescents perception and experiences. This approach is based on the belief that human development is the process through which the growing person acquires a more extended, differentiated and valid conception of the environment. The developing individual becomes motivated and able to engage in activities that restructure the environment at levels of similar or greater complexity in form or content.

It may be assumed that the relationships of adolescents with one another within the context of the environment are reciprocal and interconnected. In this study the actions of all roleplayers in the context of the environment can affect the behaviours of everyone creating a dynamic context and culture. The dynamic interdependence[11], mutual benefit and shared responsibility between parts (subsystems) forms the whole (system) so that whatever happens in one part will affect all other parts (Bender 2004).

The systems model assumes that *an organisation functioning as a whole is formed to achieve objectives that cannot be achieved by individuals on their own. Likewise individuals join an organisation to achieve objectives that would be difficult on their own* (Bergh & Theron 2001:476). The main premise is that *individuals as self-systems can best be*

[11] Where two or more people or things need each other for their social functioning (Donald *et. al.* 1997:47).

understood by examining their functioning in the context of the wider and hierarchical systems that surround them (Bergh & Theron 2001:476). This understanding is important for the planning and implementation of interventions at the right place and right time. However, the focus for this study will be on the function and contribution of community-based educational support structures who are presenting HIV and AIDS educational support programmes to adolescents. Community-based organisations can serve as a supplementary resource for schools and parents in the awareness of HIV and AIDS and the curbing of the spreading of the disease among adolescents.

In view of systems theory and for the purpose of this study, the community of Eersterust is viewed as a social system (whole). This implies the existence of different community-based educational support structures within the community (systems) which include the Education and Health Departments and non-governmental organisations (YDO and COL) that are in relation and interdependent with regard to the curbing of the spreading of HIV-infection among adolescents. Reciprocal relationships exist that prevail among the parts of a particular system (Provis 1992). The parts have meaning only in reference to the whole which is greater than the sum of its parts. However, systems theory supports the idea that positive effects experienced in one part of the system can have a positive impact on the other parts of the system. Regarding the main purpose of this study, the contribution of the educational programmes of community-based educational support structures to promote awareness and to curb the spreading of HIV and AIDS among adolescents will be identified and described.

The systems approach provides a basis for integration and understanding how community-based educational support structures may interact with other systems within the wider community of Eersterust with regard to the curbing of the spreading of HIV-infection among adolescents. Systems theory postulates that each system contains its own parts that are regulated by boundaries. A fundamental principle of systemic thinking is that cause and effect relationships occur in cycles. Due to the interrelationship between the parts an action can be seen as triggering and affecting one another in cyclical, often repeated patterns. Such repeated patterns govern the system as a whole and may bind members to particular ways of relating to one another (Donald *et al.* 1997). The high infection rate among the youth implies a call on community-based educational support structures, schools and the community to collectively assist with the curbing and mitigation of the epidemic.

The systems approach seeks to improve the quality and quantity of HIV and AIDS prevention strategies within the community. Collectively addressing the issue of educational awareness and the curbing of the spreading of HIV infection among adolescents is systemic

as it promotes strategic plans to address the impact that HIV and AIDS might have on the community and the role that HIV and AIDS educational support programmes can play in turning the tide of the epidemic.

The systems approach of dynamic interdependence is an asset to communities whereby the challenges of communities are addressed by community support structures available to them, where they can employ strategies to overcome the challenges they face. There are definite linkages and similarities in the ways in which the community support structures in Eersterust address the impact of HIV-infection among adolescents. Community-based intervention emphasises collaboration, dynamic partnerships and the participation of community-based support structures with regard to the awareness and the curbing of the spreading of HIV-infection (Provis 1992). Communities should collectively address the challenges implied by HIV and AIDS by establishing and relying on the educational support programmes of community-based support structures.

I support the idea of community-based responses to the challenges implied by the epidemic. This implies that community members take the responsibility to address challenges by relying on their own knowledge, skills, competencies and other capabilities. These mechanisms empower communities to take up the management of the strategies with regard to the curbing and the further spread of HIV and AIDS among adolescents. The involvement of adolescents with a firm focus on empowerment is more likely to lead to effective and self-sustaining change in sexual behaviour. The implementation of community-based educational support programmes that address the issue of educational awareness and the curbing of the further spread of HIV-infection among adolescents can be a useful asset to communities.

The systems approach stems from a consideration of practical issues and emphasises the empowerment of people within a community (Boulding 2000). This study focuses on the interaction of two community-based educational support structures that address the issue of educational awareness and the curbing of the spreading of HIV-infection among adolescents. *The essential factors in public problems and programmes should always be considered and evaluated as interdependent components of a total system* (Von Bertalanffy 1968:4).

Bronfenbrenner's ecological systems theory was applied as a suitable theoretical framework. The various systems are distinguished as the microsystem, the mesosystem, the exosystem, the macrosystem and the chronosystem.

Bronfenbrenner's ecological model may graphically be depicted a follows:

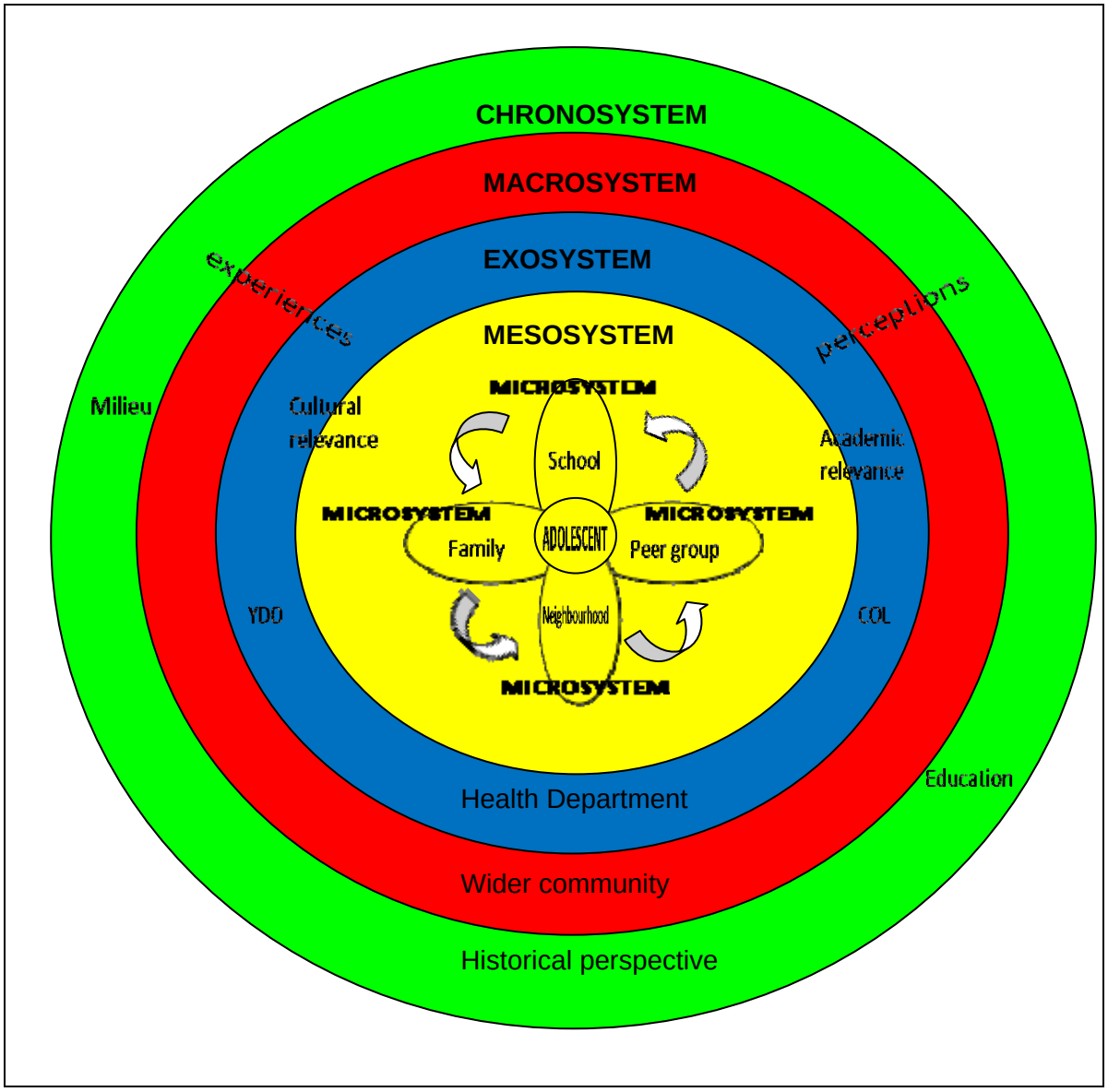

Figure 2.1: Graphic representation of Bronfenbrenner's Ecological Theory according to the literature of the study

2.6.1 MICROSYSTEM

The microsystem deals with the relationships between developing adolescents with significant people where a host of activities in a given face to face setting are experienced. According to Bronfenbrenner's ecological model, *adolescents live in an interactive flow with their microsystem which includes family, school, peers and the neighbourhood* (Abrams, Theberge & Karan 2005). In this study the microsystem focuses on adolescents who are vulnerable to HIV-infection in Eersterust and their immediate environment which includes the family, school, peers, local neighbourhood and the specific culture with which the family

identifies. The environment is the setting in which an individual lives and contains the structures with which an individual has direct contact. A developing adolescent spends a great deal of time engaging and experiencing an arrangement of social roles, activities and interpersonal relationships within this system.

2.6.2 MESOSYSTEM

Bronfenbrenner defined the mesosystem as *a set of interrelations between two of more settings* in which the adolescent lives (Bronfenbrenner 1979:209). The mesosystem is a set of microsystems which are associated with one another including factors such as the social, cultural and academic relevance and the impact thereof on the perceptions and experiences of a developing individual. According to Bronfenbrenner's ecological model, *interchanges between the adolescent and his microsystem are affected by the interrelationships among the home and school as well as the adolescents relationship with friends in the neighbourhood and adults in the community* (Abrams *et al.* 2005). For the purpose of this study the mesosystem refers to the relationship between adolescents, the family, school, peer groups and social institutions where the developing adolescent is involved in events or activities. The academic relevance of an organisation or institution and how it impacts on the academic adjustment (change) of the adolescent emerges from a particular academic background. There seems to be a relationship between the academic and cultural influence when the adolescent is at home, school or among their peers. According to Jasnotski & Swarts (1985), the developing person spends a good deal of time engaging in activities and interactions in this environment within this system.

2.6.3 EXOSYSTEM

Bronfenbrenner (1979:237) defined the exosystem as *one or more settings that do not involve the developing person as an active participant but in which events occur that affect or are affected by what happens in that setting.* The exosystem refers to external influences which affects the adolescents' development such as family health care or community-based educational support structues. The exosystem focuses on how the adolescent and his microsystem are affected by the settings that although perhaps not directly involving the adolescent, have an impact on the adolescent's life (Abrams *et al.*2005). Events occur that do not directly affect processes within the immediate environment in which the developing adolescent lives. For the purpose of this study the exosystem emphasizes the context in which adolescents do not participate directly but which has an impact on their perceptions and experiences such as the social context in which they interact with other settings that are associated with them.

2.6.4 MACROSYSTEM

According to Bronfenbrenner the macrosystem refers to the prevailing cultural and economic conditions of the community (Leonard 2011). Bronfenbrenner (1993:25) defined the macrosystem as *a context encompassing any group (culture, subculture or other extended social structure) whose members share value or belief systems, resources, hazards, lifestyles, opportunity structures, life course options and patterns of social interchange.* The macrosystem involves the broader cultural influences on the developing individual such as ethnic or religious values and peer group norms. The macrosystem encompasses culture, society and global events such as poverty or the HIV and AIDS epidemic. For the purpose of the study the macrosystem embraced the social interactions in relation to the adolescents' thoughts, attitudes and behaviour in response to the actions and feelings of others. The reference to behavioural patterns, beliefs, bodies of knowledge, material resources, customs and lifestyles, opportunity structures are passed on from generation to generation. This includes the mindset of the community regarding sexually related matters, contextual factors within the adolescents' lifeworld which influences their thoughts, attitude and behaviour in response to their particular approach to sexually related matters.

2.6.5 CHRONOSYSTEM

A chronosystem entails *developmental timeframes (which span the duration of an individual's life) pertaining to family structure, socio-economic status and living conditions or the stress and ability in everyday life* (Bronfenbrenner 1994:40). According to Leonard (2011) the chronosystem describe how settings and their developmental importance change over time. The chronosystem focuses on the time in the history that each individual (adolescent) lives his or her entire lifetime. Looking back over time, adolescents evolved in their engagement with the school. The schools and health care workers were tasked to educate adolescents about sexually related matters including HIV and AIDS. The developmental needs of adolescents became larger than what the school can address alone. Community partners (Youth Development Outreach and Circle of Life) gradually assumed greater responsibility in addressing the educational needs of adolescents with regard to HIV and AIDS. Rather than waiting for the school and health departments to solve the problem of HIV infection, community-based educational support structures came on board to join the fight against HIV-infection particularly among adolescents. The relationships that developed through collaboration between the schools and community-based educational support structures are empowering adolescents to protect themselves in risky situations.

2.7 EXISTING COMMUNITY-BASED EDUCATIONAL SUPPORT STRUCTURES IN EERSTERUST

Two community-based educational support structures currently operate in Eersterust that are actively involved with HIV and AIDS educational programmes for adolescents. These are (i) the Youth Development Outreach and (ii) Circle of Life (Permission has been granted for the names of the organisations to be mentioned). Although government initiatives are important in responding to the challenge of HIV and AIDS, I support the actions that are planned and initiated by community-based educational support structures that aim to address the educational needs of adolescents regarding HIV and AIDS. The educational programmes of community-based support structures include educational and awareness activities.

2.7.1 WHAT IS YOUTH DEVELOPMENT OUTREACH?

Youth Development Outreach (YDO) is a non-governmental organisation that was established in 1990. The organisation occupies the old library building that is situated in the centre of the Eersterust community. The organisation was established out of a desire to alleviate poverty, drug abuse and HIV and AIDS in the community. YDO offers Life Skills and Family centred programmes, with a firm focus on HIV and AIDS awareness. The main target group is the youth, especially the youth infected or affected by HIV and AIDS (YDO 2010).

2.7.1.1 Vision and mission of Youth Development Outreach

The vision of YDO is to encourage young people to play an active role in society. YDO believes that it is possible to curtail the scale of the HIV and AIDS epidemic and turn the tide over the next five years (YDO 2010).

2.7.1.2 Staff establishment at Youth Development Outreach

YDO staff comprises a managing director, a centre manager assisted by six fieldworkers and four cleaners. Apart from these staff members, ten presenters are stationed at YDO who are trained and remunerated by *Love Life.* They are periodically replaced by new presenters to gain experience with regard to presenting educational support programmes to adolescents. Staff members occasionally invites young HIV-positive people who appeal to adolescents, to share their experiences with the youth (YDO 2010).

2.7.1.3 Operation of YDO in Eersterust

YDO operates every day of the week from Monday to Friday, from 7:00 until 18:00. Youth are free to visit the facility to acquire information regarding HIV and AIDS. Programmes aimed at out-of-school youths are presented anytime between the latter timeframes. For school-going adolescents programmes are presented after school. The programmes makes provision for additional programmes during school holidays (YDO 2010).
Contact times with participants vary from 45 minutes to an hour, depending on the activity that is presented. In order to attract more adolescents, YDO also visits schools and advertises its services at shopping malls. The content of the educational programme is education driven and contains information about HIV and AIDS prevention (YDO 2010).

The programme is presented in the form of discussions, debates, poetry, sport, role-play, dramas and dances with an emphasis on the dangers of HIV and AIDS. Participants are encouraged to ask questions in order to acquire knowledge and skills that will protect them against HIV-infection (YDO 2010).

2.7.1.4 Educational programme of Youth Development Outreach

The educational support programme of YDO includes the following themes and topics (LOVE LIFE 2003:1-275):

"1.	**Sex and sexuality**
Aim:	**To acquaint participants with important concepts in sexuality.**
1.1	Sex refers to a person's biological make up. If your sex is male, you have male body parts, if your sex is female then you have female body parts.
1.2	To have sex refers to a range of sexual activities, including sexual intercourse.
1.3	Sexuality is a word referring to a person's identity as a sexual being. It has to do with you as an emotional, social, intellectual, physical and spiritual being. Sexuality includes how we feel about our body, sexual activities, feelings of sexual attraction and sexual relationships.
1.4	Sexism is the prejudice or discrimination against someone because of their sex. For example, the statement that women are less intelligent than men is a sexist statement. The South African constitution regard men and women completely equal in the eyes of the law and prevents discrimination.
1.5	Most people are attracted to members of the opposite sex. Others are attracted to members of the same sex. The main categories of sexual orientation are heterosexual, bisexual and homosexual.
1.6	Sexual behaviour includes a wide range of activities from kissing, holding hands, touching, hugging, masturbation, mutual masturbation to sexual intercourse.
1.7	Oral sex is sexual contact between one person's mouth and the vagina or penis of another person. It is safer than sexual intercourse but can still lead to transmission of HIV or some other STIs,-particularly if there are sores on the mouth or genitals.
1.8	Sexual abuse refers to any sexual behaviour which hurts, damages or is forced upon one person by another of any age. It also refers to any sexual activity performed by an adult on a minor.

1.9 Peer pressure is the pressure put on onto young people by friends, peers or reference group. Peer pressure can be both negative and positive. It is negative when young people do things against their will or better judgement for example, sexual activity, smoking or drinking. It can be positive when it helps to support a positive behaviour, e.g. a group of young people who think it is not cool to take drugs and influence others to do the same; or a group of girls who say 'no' and mean 'no' and support one another to do the same.

1.10 Sexual rights are rights that all people should enjoy, but many do not enjoy all over the world. Sexual rights relate to the right to enjoy one's sexuality free of coercion, discrimination and violence. It also relates to equal relationships between women and men in matters of sexual relationships and reproduction. Sexual rights promote sexual health which means we need to protect both ourselves and others.

2. Sexual orientation (a person's sexual identity)

Aim: To provide information about the different forms of sexual orientation.

2.1 *Heterosexual* refers to people who prefer emotional/sexual partners of the opposite sex. This is the group that most people belong to.

2.2 *Homosexual* refers to people who prefer to form same sex relationships.

2.3 *Bisexual* refer to people who are sexually attracted to both males and females.

2.4 *Homophobia* refers to fear of and prejudice expressed towards people who are homosexual.

2.5 Myths about homosexuals are, for example, that homosexuals are all paedophiles or that you can tell whether someone is homosexual by looking at him or her.

3. Getting to know your body

Aim: To acquaint participants with the sexual functioning of the body both males and females.

3.1 Sexual and reproductive body parts.

3.2 Genitals: male or female organs.

3.3 Penis is the (male) organ that hangs in front of the testes. Sometimes it may be small and soft, at other times it may be hard and enlarged. During an erection more blood flows into the penis. The penis then enlarges and stands stiffly away from the body. This helps the penis to fit into the vagina during sex to deposit sperm.

3.4 Testicles are male organs. Everyday millions of sperm cells are produced and stored in the testicles.

3.5 Sperm is produced and stored inside each testicle. Sperm is the male equivalent of the female eggs. It is only during and after puberty that the male can produce sperm.

3.6 The prostate gland produces special fluid. This helps the sperm to move as they begin their long 'swim' towards the female ovum. The two seminal vesicles provide nutrients to nourish the sperm when they are inside the woman's body. Semen is the creamy fluid that leaves the penis during ejaculation and contains the sperm.

3.7 Vagina is the passage which connects the inside sexual organs with the outside. This is a muscular tube that is usually about 10 cm long. The walls of the vagina are able to stretch. The vagina is the hole that allows menstrual blood to leave the body, babies to enter the world and where a male inserts his penis into a female.

3.8 The uterus is made of strong muscles and is connected to the fallopian tubes and the end of the vagina.

3.9 Urethra is the tube which carries both sperm and urine. When a man is having sex, the urine tubes closes.

3.10 The cervix is a small opening which connects the uterus to the vagina. It protects the uterus. It has a tiny opening to let menstrual blood out. A condom cannot travel up into the uterus because of the cervix. But the cervix can open up to give birth. In order to open it needs a certain hormone which is produced when a woman is ready to give birth.

4. Sexual health and wellness

Aim: To inform participants about basic sexual cleanliness.

Dealing with changes during puberty:

Boys	Girls
4.1 Physical changes	
Initial change in stature, shoulders broaden, spurt in growth and a more muscular look.	Change from having a straight up-and-down figure to one that is round and curved. Their hips widen and they grow breasts.
Genitals become larger with reddening of the skin and texture change.	Changes in vaginal secretions as hormones change
Shoulders become wider	Width and roundness of hips increase as fat is deposited.
Curly pubic hair appears at the base of the penis.	Curly pubic hair appears on the external genitals.
Temporary swelling of either one or both breasts. This generally stops.	Usually the nipples grow first. Sometimes one breast develops faster than the other
There is an early voice change, often referred to as a changing of the voice, followed by a more marked change.	Voice changes, becoming slightly deeper.
The first ejaculation of semen from the penis occurs.	Vaginal secretions increase, may have brown, reddish appearance with early menstruation.
Sweat glands develop with characteristic odour and pimples may appear on the face.	Sweat glands develop with characteristic odour and pimples may appear on the face.
Hair develops under the armpits. Facial hair spreads, especially under the nose and chin, also around the nipples and chest. Hair on legs grows and darkens.	Hair develops under the armpits. Additional facial and nipple hair may also appear. Hair on legs may increase and darken.
4.2 Emotional changes	
Mood swings – person sometimes feels positive and up, sometimes negative and down. The need for sleep often increases.	Mood-swings – sometimes person feels positive and up, sometimes negative and down. The need for sleep often increases.
May become very self-critical, especially if compared to others.	May become very self-critical, especially if compared to others.
4.3 Social changes	
Important to assert one's independence and to seek companionship from friends rather than parents and family members.	Important to assert one's independence and to seek companionship from friends rather than parents and family members.
Need for acceptance from and belonging to peer group.	Need for acceptance from and belonging to peer group.
Questions values of older generation.	Questions values of older generation
May have more arguments with parents and other authority figures.	May have more arguments with parents and other authority figures.
Romantic or sexual feelings towards opposite or same sex.	Romantic or sexual feelings towards opposite or same sex.

4.4 The menstruation cycle: when girls reach puberty they begin their monthly menstrual periods. This is when blood seeps out of the vagina. It appears as if much blood is lost, but actually there is not very much blood in the flow for each period.

4.5 Ejaculation occurs when a male gets very aroused. It can occur once a boy enters puberty and the body begins to produce sperm. Semen comes out in quick, short streams/bursts.

4.6 Masturbation means giving oneself sexual pleasure by rubbing, stroking or massaging one's sexual parts. Masturbation is a normal thing to do as long it is done with the appropriate privacy and respect for others. Masturbation is a good alternative to sex. Young couples can enjoy sexual pleasure together without the risk of pregnancy, disease or loss of virginity.

5. Relationships

Aim: To explore what demands relationships make on teenagers.

To develop a range of ideas about facing these challenges.

Exploring challenges that adolescents have in:

5.1 dealing with relationships with boyfriends and girlfriends;

5.2 dealing with demands of being in relationships;

5.3 relationships with family, friends, peer groups and other community members.

6. Types of behaviour

Aim: To inform the learner about the types of behaviour.

6.1 Passive behaviour makes one feel helpless, resentful, disappointed and anxious. The outcome is that one does not get what one wants, anger builds up, one feels resentful and that one's rights are violated. Passive people often avoids making decisions or taking responsibility and then complain about it afterwards. Some examples are giving in to peer pressure, lending a friends money even if one knows they will not pay one back.

6.2 Aggressive behaviour makes one feel angry, frustrated, bitter, guilty or lonely. The outcome is that one dominates, humiliates and wins at the expense of others. one puts people down and wants to get one's own way without listening to others. Some examples are threatening behaviour, shouting and banging the door.

6.3 Assertive behaviour makes one feel better about oneself, self-confident, in control and respected by others. The outcomes means one does not hurt others, one gains respect for oneself, one's and others rights are respected and everyone feels good. Assertive people can say no without feeling guilty, disagree without becoming angry, ask for help when they need it and have more honest friendships and relationships.

7. Safer sex and contraception

Aim: To understand the term *safer sex* and how it applies to the lives of young people.

To explore the relationship between safer sex and contraception and to understand it's importance.

7.1 The pill has to be taken every 24 hours by women; they keep the body's hormone level steady which turns off ovulation. Pills do not offer protection against STIs and HIV.

7.2 The injection is given by a doctor or nurse every two or three months. Primarily the injection works in the same way the pill does.

7.3 Male and female condoms involves a sheath made of a rubber or animal membrane that fits over the penis like a second skin. It catches and holds semen released in ejaculation, so no sperm can get into the vagina (and from there to the uterus and fallopian tubes). Female condoms are inserted into the vagina before the penis enters the vagina. The female condom allows females to exercise the choice to be protected and use the condoms themrselves.

7.4 Masturbation.

7.5 Kissing, hugging and holding hands.

7.6 Encouraging young people to delay having sexual intercourse until they are ready to deal with the challenges of negotiating safer sex and can consider the consequences of sex in a mature, informed manner.

7.7 Oral sex.

8. Sexually transmitted infections.

Aim: To develop improved knowledge of sexually transmitted infections (STIs) with an emphasis on protection and prevention.

8.1 Infections are transmitted from person to person during sexual intercourse. Gonorrhoea and syphilis are most common. The signs of an STI are the following:

- Unusual or bad smelling liquid from the penis or vagina
- Pain and burning on passing urine

- Sores on or around the sex organs
- Itching on or around the sex organs
- Warts or growths on the sex organ
- Lower belly pains in women
- Pain/bleeding during sex.

8.2 Pictures of different infections.

9. HIV and AIDS and risky behaviour.

Aim: To identify what are methods of HIV transmission.

9.1 Methods of transmission (STDs and HIV and AIDS)

10. HIV and AIDS Education/ Risky behaviour.

Aims: Identify gaps in the knowledge about HIV and AIDS.
Explore risks of HIV infection.
Identify ways of minimising those risks.
Understand what voluntary testing and counselling means.
How condoms are used.
Practise assertiveness skills in relation to sex.
Human rights regarding HIV and AIDS.

10.1 Common beliefs about HIV and AIDS in terms of truth and myth.

- Donating blood gives one HIV.
- All people with TB have AIDS.
- You can get HIV from mosquitoes.
- Putting sex workers in prison will stop HIV.

10.2 Basic information with regard to HIV and AIDS

- What the difference between HIV and AIDS is.
- Where HIV comes from

10.3 Voluntary testing and counselling: The test for HIV is a blood test. Becoming infected with the virus, will show in the blood, normally within three months of the date of infection. It therefore can take three months after infection before a test shows someone to be HIV-positive. If the test is negative, it only shows the status of somebody three months earlier.

10.4 Reasons for having or not having an HIV test:

- Reassurance.
- Pregnancy – if one is planning to start a family, one may want to know whether or not one have HIV.
- To make changes to one's way of living.

10.5 Condom usage: Regular condom usage during penetrative sex.

10.6 Living with HIV and AIDS: There is no cure for AIDS but there are many ways in which it is possible to live positively with the virus. Talk about problems. If one cannot talk to one's family members or friends, talk to a counsellor or health worker. Do not smoke or drink. Both of these are bad for one's health, especially if one is HIV positive. Stopping drinking and smoking will help one's immune system work well. Join a support group of other people living with HIV and AIDS. They will be able to offer support when one goes through bad times. Talking in the group will also help one to unburden oneself.

10.7 Caring for people with HIV and AIDS.

- Do not tell everyone else about their HIV status unless they want you to do this.
- Encourage the person to be positive about life.
- Do not stop them from doing things they want to do.

- Be honest about one's feelings.
- Help keep the house and room of the sick person very clean.
- Help to get them to the clinic or doctor.
- Spend time with the sick person and share positive stories**".**

2.7.2 WHAT IS CIRCLE OF LIFE?

Circle of Life (COL) is a non-profit community-based organisation which is dedicated to reduce the spread of HIV and AIDS in Eersterust. The organisation is registered as an NGO with the Department of Health and occupies the old building of the Department of Social Development which is situated next to the local clinic (COL 2010).

2.7.2.1 Vision and mission of COL

The vision of COL is to strive to reduce the infection rate of HIV and AIDS and to provide support to those infected with and affected by HIV and AIDS. The mission is to curb the spread of HIV and AIDS. The organisation strives to fulfil the following objectives (COL 2010):

- To provide care, support, counselling and education to infected and affected persons regarding the illness;
- To preserve the dignity, self respect and self esteem of people living with HIV and AIDS;
- To advocate for change of behavioural patterns and a value system that will ultimately result in the reduction of the infection.

2.7.2.2 Staff establishment at COL

The organisation is managed by an Executive Board committee comprising of a chairperson, secretary and six committee members helping on a voluntary basis. The Executive Board is responsible for fundraising and the day to day running of the organisation. Four permanent qualified staff members are employed at COL.

COL relies on the funds that are generated in the community of Eersterust. The community rallies around COL whenever they stage HIV and AIDS awareness or fundraising campaigns (COL 2010).

2.7.2.3 Operation of COL in Eersterust

The organisation operates weekly from Monday to Saturday between 7:00 to 16:30 where the staff attends to people who are in need of help or information with regard to HIV and

AIDS. The organisation has a mini-library that contains information on HIV and AIDS and a helpline service that is available during operating hours (COL 2010).

Programmes are presented to adolescents on Saturdays by qualified presenters. Programmes are divided in periods of one hour for the activities. Circle of Life presents additional programmes during school holidays. The facilitators (presenters) are young and well trained by professionals in HIV and AIDS. HIV-positive presenters are periodically invited to share their experiences with those who attend the educational programme. Programmes are presented in the form of discussions, art, poetry, drama, debates and sport focussing on the effects of HIV and AIDS (COL 2010).

2.7.2.4 The educational programme of COL

The HIV and AIDS educational programme at COL includes the following themes and topics (LOVELIFE 2003:1-275):

"1.	**Sex and sexuality (young people).**
Aim:	**To get acquainted with important issues around sex and sexuality.**
1.1	Gender: girls are often given dolls to play with and boys are given cars. Men are also thought to be stronger than women, both physically and emotionally. Saying things like 'big boys don't cry' or 'housework is women's work' forces men and women to behave in certain ways.
1.2	There are males who think of themselves as females and females who consider themselves males. In some cases people with these feelings feel born into the wrong body. This is called transexualism. In these rare cases the person may decide to have an operation to make themselves into a person of the opposite sex. This is different to sexual orientation (homosexuality and heterosexuality).
1.3	Self-image refers to how we see ourselves and how we think others see us. A positive self-image has a strong influence over a young person's confidence and helps them to withstand peer pressure.
1.4	Infatuation is the attraction and desire to be with someone who is seen to be unattainable. It is generally short and intense. It has a strong element of hero-worship. It is normal as a teenager to feel infatuation for someone.
1.5	Self-esteem is how we feel about ourselves; our confidence about our worth. A positive self-esteem means we feel good and strong about ourselves.
1.6	Sexual experimentation is a way we explore our sexuality, get to know what we like or do not like. For young people it is a way to understand this mysterious, strange, wonderful, scary world of sex. It is always important to be careful to protect yourself and others and to think about the consequences of your experimentation.
1.7	Creativity is the ability to express ourselves using different art forms dance, music, art, poetry. It is a form of self-expression where we find ways to express our thoughts, feelings and imagination.
1.8	Values are principles; beliefs and/or standards which help to guide our behaviour.
1.9	Incest is sexual activity between family members who related by blood. It is not right to experiment sexually with people in your own family. Most cases of incest are between a father or stepfather and a daughter.
1.10	Paedophile is an adult who enjoys having sex with children. It is not right for adults to experiment sexually with children.

2. Behaviour change.

Aim: To encourage learners to change their behaviour positively.

2.1 Behaviour and attitude change e.g. towards HIV and AIDS. In order to effect behaviour change, young people need to understand the need to change and feel personally convinced and motivated to change this behaviour. Young people also need to be encouraged to sustain current positive, healthy behaviour.

2.2 Support

- Skills to mobilise support.
- Identify sources, list them and describe ways to access (clubs, individual, printed media).
- Peer support groups.

2.3 Critically evaluate reasons for delaying sexual intercourse or practicing abstinence and presenting counter arguments for the reasons some youth find sexual intercourse tempting or attractive.

2.4 Informed communication around sex by being able to speak for yourself.

3. Importance of values.

Aim: To educate learners about the different values.

3.1 Accountability: the adolescents should be encouraged not to be negligent or indolent regarding their sexuality. Adolescents must be encouraged to be accountable for their actions and to take responsible decisions regarding sexuality.

3.2 Tolerance: adolescents have to be guided towards a deeper and more meaningful understanding of the value of human difference. Discrimination against others on the basis of race or sex mitigates against the development of tolerance.

3.3 Respect for oneself and others.

3.4 Developing a moral and value system.

4. Getting help for your health.

Aim: To feel encouraged to seek help when it's needed.

4.1 Good nutrition for good health.

4.2 Balanced diets e.g. less fats and oils and more protective foods.

4.3 Importance of exercise.

4.4 The importance of good hygiene especially during teenage years.

5. Personal challenges facing young people.

Aim: To encourage learners to deal with challenges they encounter in their daily lives.

5.1 Personal risk assessment. How vulnerable or at risk you are on a daily basis. The things that adolescents do that might put them at risk.

5.2 Understanding personal risk and the circumstances which may give rise to it. How adolescents can put themselves at risk. What the circumstances are which result in risky behaviour.

5.3 Risk reduction and behaviour change. What adolescents can do to make themselves less at risk. To encourage adolescents to change the circumstances which result in risky behaviour, for example, exploring different ways of dealing with transactional sex and sexual coercion.

5.4 Self-concept/ self-esteem/ body image. How adolescents feel about themselves. How does the way they feel about themselves influence their behaviour. These factors are important in determining how a person deals with peer pressure, is able to set limits or negotiate and enjoys sexuality.

5.5 Positive sexuality/ positive lifestyle. What adolescents can do to keep themselves healthy. How they can best protect themselves against HIV and AIDS, STIs, teen pregnancy, rape and sexual abuse. How adolescents can enjoy their sexuality as they grow up and ensure that what they do is not physically or emotionally harmful to others.

6. Common questions asked by adolescents.

Aim: To enable participants to ask questions.

6.1 What is ejaculation? It occurs when a male gets very aroused. It can occur once a boy enters puberty and the body begins to produce sperm. The sperms pass through a long tube to the seminal vesicles where they are mixed with a liquid-like milk to become semen.

6.2 What can I do to remove my pimples? Pimples, zits and blackheads can be familiar names for a skin condition called acne. Acne is related to the changing hormone levels in one's body. An increase in the hormone balance causes certain glands to produce an oily substance that is intended to lubricate and soften the skin. The hormone responsible is the testosterone hormone and that is why boys tend to suffer more than girls because they have more testosterone.

6.3 Can masturbation affect my health? No, if it could there would be many sick people in the world. Masturbation means giving oneself sexual pleasure by rubbing, stroking or massaging one's sexual parts.

6.4 I get erections anywhere, anytime. Is it normal? Boys can get erections for no apparent reason at any time of day. This can be very embarrassing. The best way to get rid of an erection is to try and concentrate hard on something else and not to keep worrying about it.

6.5 At which point can a girl fall pregnant? A girl is able to fall pregnant when she begins ovulating. This will generally be followed by her first period. Whilst menstruation is a visible sign that a girl can now get pregnant, she can still conceive just before her first period as she has begun ovulating and her period is not yet visible.

6.6 Does using tampons or sanitary towels mean that a girl is no longer a virgin? No, a girl's virginity is lost when she has sexual intercourse for the first time. A girl has a flexible stretch of skin (the hymen) which changes as they grow older but there is space where the menstrual flow comes out of the vagina.

6.7 Can you fall pregnant when you are menstruating? When a young woman begins her periods it takes a few years for her menstrual cycle to become regular. She therefore may get pregnant when she is menstruating. Menstruation is no protection against pregnancy and unprotected sexual intercourse is risky in terms of HIV and STIs as well.

7. Communication/relationships.

Aim: To introduce learners to ways to communicate when in relationships with people.

7.1 How to communicate and relate to parents.

7.2 How to communicate and relate to your partner.

7.3 How to communicate and relate to friends

7.4 How to communicate and relate to other community members

8. Peer pressure.

Aim: To explore how peer pressure operates.

8.1 How to resist peer pressure.

8.2 Unhealthy relationships with people.

9. Contraceptive methods.

Aim: To introduce contraceptive methods:

9.1 By not having sex at all.

9.2 Dual protection.

9.3 Male and female condom usage.

9.4 Injection to prevent oneself of becoming pregnant.

10. Young people need protection against:

10.1 Sexual abuse.

10.2 Pregnancy.

10.3 Sexually transmitted diseases.

10.4 HIV and AIDS.

11. Topics on HIV and AIDS include:

Aim: To introduce learners to HIV and AIDS

11.1 Basic information about HIV and AIDS. HIV stands for Human Immunodeficiency Virus. HIV only infects humans.

11.2 Attitudes with regard to HIV and AIDS.

11.3 HIV and AIDS: What does it mean.

11.4 HIV and AIDS: Risky sexual behaviour.

11.5 Voluntary counselling and testing.

* **Getting tested for HIV-infection?**

- The test for HIV is a blood test.
- It takes up to 3 months.
- If a person thinks that he/she is infected, it is recommended that they have a test to find out.

* **What you need to know about having an HIV test.**

Anyone who has a test should only do so voluntarily.

One has to be counselled before and after the test. This helps one to think through responses to the test result.

11.6 Living with HIV and AIDS.

- Live with hope. Just because you are HIV positive does not have to mean
- Giving up on life.
- Talk about the problems you experience.
- Go for regular medical check-ups at least every 3 to 4 months.
- Get help soon if you get any illness, no matter how small.
- Get plenty of good sleep. Do not stay up late too much.
- Do not forget your spiritual side. Many HIV-positive people find a lot of help in developing their spirituality.

11.7 Medication for HIV and AIDS.

- Medication for treating HIV and AIDS is freely available through some medical aids.
- It is important to keep strictly to the drug treatment plan and to take medication at the time it is prescribed.
- If you do not keep to the drug treatment plan, your body could develop resistance to the drugs.
- Always work closely with your health care provider.

11.8 Caring for people with HIV and AIDS.

- Give them medication to relieve pain.
- Consult religious leaders and other volunteers to help those needing counselling.
- If there are financial problems as a result of AIDS, ask the Department of Social Development for help".

In undertaking my study, I assumed that the educational support programmes at the organisations in service of the community is well positioned to address the educational needs of adolescents with regard to HIV and AIDS.

2.8 SUMMARY

In Chapter 2, I reviewed existing literature that deals with aspects relating to the vulnerability of adolescents within the context of HIV and AIDS. I commenced with an introduction followed by a detailed description of the contextual background to HIV and AIDS in terms of the government's response to HIV and AIDS, the extent of the epidemic, the effects of poverty with regard to HIV and AIDS, as well as its impact in relation to families, the educational sector, learners and educators.
In addition, I described the vulnerability of adolescents with regard to HIV-infection, referring to adolescents' vulnerability owing to a lack of knowledge, skills, a laissez-faire attitude, risky sexual behaviour and cultural perspectives. This was followed by descriptions of violence against women and children, community-based educational support for vulnerability, and the need for educational support programmes. The chapter is concluded with descriptions of two existing community-based support structures in the Eersterust community.

In Chapter 3, I explain the empirical investigation I undertook. I justify the methodological choices I made against the background and focus of my study.

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CHAPTER 3
DESIGNING AND CONDUCTING RESEARCH IN THE FIELD

3.1 INTRODUCTION

In this chapter the research methodology for the study is discussed and described in detail. This chapter therefore describes the methodological processes that were followed in this research. The literature study in Chapter 2 serves as a background to Chapter 3, which also enabled me to plan and conduct the empirical research.

Firstly, adolescents' level of knowledge, skills, attitudes and sexual behaviour was determined. This was done by means of a questionnaire survey with learners from two local high schools in the community under study (Eersterust).

Secondly, the views of adolescents with regard to the mode of delivery and effectiveness of community-based educational support programmes were investigated and described. This was done by means of focus group interviews with adolescents at two community-based educational support structures.

The research methodology was based on a mixed method research approach. According to Teddlie and Tashakkori (2003:20) a mixed research approach involves: *The mixing of quantitative and qualitative research methods and their characteristics with the aim to investigate a particular research problem*. As such, the study firstly involved a quantitative component, which was guided by a positivist paradigm and involved a questionnaire survey. Secondly, a qualitative component was included which was guided and anchored in the interpretivist paradigm, with relevant data collection techniques and strategies (focus group interviews and document analysis).

Besides presenting the methodological choices, I also justify the decisions that were made in terms of the research questions and the aims of the study in this chapter. After explaining the paradigmatic perspectives of the study, I describe the selected research design, pilot study, data collection and documentation strategies as well as the process of data analysis and interpretation in detail. The chapter concludes with discussions of the strengths of my methodological choices, my role as researcher during the study, the ethical guidelines that I followed and the way I aimed to enhance the credibility and trustworthiness of the findings and conclusions of the study.

3.2 PARADIGMATIC PERSPECTIVE

In following a mixed methods approach, I relied upon both positivist and interpretivist paradigms (Teddlie & Tashakkori 2003). Firstly, I utilised a quantitative approach to determine the knowledge, skills, attitudes and sexual behaviour of adolescents, as related to HIV and AIDS education. For this purpose I implemented a questionnaire, in order to determine the HIV and AIDS educational needs of adolescents.

Secondly, I employed a qualitative approach, investigating and describing the views of adolescents with regard to the mode of delivery and effectiveness of community-based educational support programmes. For data collection, I relied on document analysis and focus group interviews at community-based educational support structures in Eersterust. I now present my understanding of the said meta-theories, which provided me with lenses to interpret the quantitative and qualitative data I obtained.

3.2.1 POSITIVIST EPISTEMOLOGY (QUANTITATIVE PART OF THE STUDY)

Creswell (1998:53) states that *Positivist researchers postulate that there is one objective reality that is observable by an enquirer who has little impact on the object being observed - the object (or phenomenon) has ontological status in itself and therefore can be studied objectively from the outside.* As such, positivism regards the social sciences as *a combination of deductive logic with precise empirical observations of individual behaviour in order to discover and confirm a set of probalistic causal laws that can be utilised to predict general patterns of human activity* (Neuman 1997:66). Researchers who utilise a positivist approach prefer accurate quantitative data and often choose to conduct surveys, as I did for the first part of my data collection activities.

Positivists view knowledge as an awareness of objects that are independent of any subject (Fieser & Dowden 2004; Sauvage 2003; Trochim 2001). According to the positivist view, objects and events have intrinsic meaning and knowledge is an explanation of an association with what is real. Knowledge can be “revealed” or “discovered” through the use of scientific methods.

The use of scientific methods provides answers that are regarded as neutral and technical, and can thus be universalised and generalised to historical and cultural contexts. The “discovered” knowledge provides possible explanations of the causes of things that happen in the world - often independently of the intentions of people (Creswell 1998). Positivists generally require empirical evidence to determine the answer to their questions (Hittleman & Simon 2006).

According to positivism the world operates according to fixed laws of cause and effect. Scientific thinking is used to test theories about these laws and either reject or provisionally accept them (Cohen *et al.* 2007). By developing reliable measurement instruments, the physical world can be objectively studied. The quantitative view is described as being realistic. Realists adopt the view that what research does is to uncover an existing reality (Cohen *et al.* 2007). Reality is perceived as external and knowledge about human behaviour is attained through methods of scientific inquiry (Cohen *et al.* 2007). The underlying philosophy relates to the belief that the truth is out there and can be uncovered by the use of objective research methods (Cohen *et al.* 2007).

This study followed a positivist approach in inquiring about the educational needs of adolescents with regard to HIV and AIDS education. A questionnaire was implemented (with 961 learners of two high schools) in order to obtain answers to the quantitative research questions. Data was specifically collected in order to determine whether or not a need exists for community-based educational support programmes to enhance awareness and curb the spread of HIV and AIDS among adolescents.

De Vos (2002:357) states that *The questionnaire survey promotes objectivity and a highly standardised and controlled approach.* The respondents in this study provided objective answers to the questions in the questionnaire. However, some of the challenges I faced in applying a positivist epistemology relate to the sensitive sexually-related questions to which the learners had to respond. In an attempt to ensure that learners responded effectively to the sensitive sexually-related questions, I utilised closed-ended questions with four response options from which the learners could select a suitable option. I deliberately placed the questions that are easy to answer, for example the demographic questions at the beginning of the questionnaire and the sensitive sexually-related questions as the last stage of the questionnaire (Creswell 2005). In order to ensure a high response rate from the respondents, I utilised the services of two conveners who are in senior positions at the respective schools. The conveners were particularly helpful in the sense that they clearly explained the importance of the research and how the learners' views and opinions could ensure the success of the research, thus contributing to a high response rate.

3.2.2 INTERPRETIVIST EPISTEMOLOGY (QUALITATIVE PART OF THE STUDY)

Interpretivism has its roots in hermeneutics, which relates to the study of theory and practice of interpretation (Nieuwenhuis, 2011). According to Cohen *et al.* (2007), interpretivism implies the interpretation of human behaviour on both a verbal and non-verbal level against the background of the participants' life worlds, as well as their past experiences and their

existing understandings thereof. This is in line with the view of Max Weber (in Dowell, Huby & Smith 1995) that human behaviour can be interpreted with reference to the meaning that people attach to their own and others' actions. As such, human inquiry is seen as the study of people in terms of the interpretation of their own life world experiences. Interpretivism has a firm focus on the lived experiences of people, thereby providing a holistic picture of what their 'real life' is like (Miles & Huberman 1994).

The interpretive paradigm aims to provide insight and understanding into the subjective world of human experience. Interpretivism generally attempts to understand the meaning that individuals or communities assign to their experiences. The social context, conventions and norms and standards of the particular community are crucial elements in assessing and understanding human behaviour (Creswell 1998).

My decision to conduct the qualitative part of this study from an interpretivist paradigm relates to the primary aim of the study that explores to what extent community-based educational support programmes address the HIV and AIDS educational needs of adolescents. In my opinion one can only explore the effect of the implementation of educational support programmes in a community by interpreting the experiences of the participants to whom the programmes are presented.

Community-based educational support programmes play a vital role with regard to awareness and the curbing of HIV and AIDS in Eersterust. Participants (adolescents) who attend community-based educational support programmes participated in focus group discussions in order to determine their views with regard to the mode of delivery and effectiveness of community-based educational support programmes. Throughout, I aimed at understanding what the participants were experiencing. As such, I interpreted their experiences in a personal, unique manner, implying that reality within the context of this study is constituted by different interpretations namely mine, but also those of the participants.

It follows that this study reports on the experiences and perspectives of the participants as understood by them within their context, thus working with data in context (Cohen *et al.* 2007). As has been stated, the study was conducted to gain information and insight with regard to the mode of delivery and effectiveness of community-based educational support programmes. The nature and content of the reality that was researched can be defined as multiple, subjective and internal by nature (Cohen *et al.* 2007).

The main challenges that I faced in applying the interpretivist epistemology relate to some initial reluctance (due to the sensitive nature of the topic) among participants to speak freely about their sexual experiences. I found it challenging to discuss sensitive sexually-related issues with adolescents as I am an educator by profession. Before I conducted the focus group discussions, I engaged in informal discussions over a light lunch in an attempt to build rapport and a relationship of trust with the participants. This afforded me an opportunity to explain to the participants the importance of my research project and assured them that their responses to questions would be treated with confidentiality and anonymity.

The analysis of the data was at times complex and time-consuming (Cohen *et al*. 2007). After having audio-taped the two focus group interviews I had difficulty to transcribe the contributions of the participants. Some of the participants did not speak clearly and I had to listen repeatedly to the recording. They would occasionally also make statements and then immediately change them while being recorded.

3.3 RESEARCH METHODOLOLY

In making methodological choices I aimed at producing credible and trustworthy findings that might lead to a better understanding of the manner in which HIV and AIDS educational support programmes may address the educational needs of adolescents. In order to answer the research questions and achieve the aim of the study, it was necessary to combine quantitative research with qualitative research. As such, a mixed method approach was followed (Hittleman & Simon 2006). A mixed methods research approach involves *collecting, analyzing and interpreting quantitative and qualitative data in a single study that investigate the same underlying phenomenon* (Leech & Onwuegbuzie 2009:267). Researchers generally apply explanatory, exploratory, triangulation or the embedded design to their research with each one having its own unique characteristics (Ivankova, Creswell & Plano Clark 2011).

I found the embedded mixed methods design to be applicable in this study. The embedded design allowed me to answer the secondary questions that are different from but related to the primary research question (Ivankova, Creswell & Plano Clark 2011).

For the quantitative phase of the study I conducted a questionnaire survey with 916 learners from two secondary schools in Eersterust. This was done to explore and describe to what extent community-based educational support programmes addressed the HIV and AIDS educational needs of adolescents in Eersterust at the time of inquiry.

With regard to the qualitative phase of the study I conducted focus group interviews with 11 learners who attended community-based educational support programmes at two community-based support structures in Eersterust. This was done in order to determine the views of the learners with regard to the mode of delivery and effectiveness of community-based educational support programmes. The quantitative and qualitative data was collected simultaneously, analysed separately and then the mixing of results took place during the data interpretation stage (Leech & Onwuegbuzie 2009).

3.3.1 RESEARCH DESIGN

For the quantitative part of my study I utilised a descriptive survey design (questionnaire), while I relied upon a case study design for the qualitative component, using focus group interviews with selected participants (Hittleman & Simon 2006). I selected this combined approach in my attempt to obtain an understanding of the complex and evolving phenomenon of HIV-infection among adolescents, not only in terms of its measurable items, but also in terms of the meanings and interpretations that could have an impact on HIV and AIDS-related experiences and behaviour among adolescents. This combination of research methods implied the potential of maximising the quality of data collection and reducing the chances of bias (Leech & Onwuegbuzie 2009).

In order to determine the educational needs of adolescents with regard to HIV and AIDS, I designed a questionnaire for the Grade 10, 11 and 12 learners of Eersterust Secondary School and Prosperitus Secondary School. Survey designs relate to the collection of information from a pre-selected population with regard to their current status, values, ideas, beliefs, feelings, demographics, opinions and attitudes. An outstanding characteristic of survey designs is that the sample is normally large and ranges from hundred to a thousand respondents (Maree & Pietersen 2011). A descriptive survey design allowed me to obtain information from the learners and to focus on some of the characteristics that were under consideration. The questionnaire was carefully constructed to suit the level of the learners. Suitability was confirmed during a pilot study.

In support of the questionnaire, qualitative data collection was undertaken which was guided by and anchored in the interpretivist paradigm. This school of thought promotes an inductive mode of inquiry and a variety of data collection techniques. I therefore relied on a case study design (Johnson & Christensen 2004). A case study is defined as an empirical inquiry that investigates a phenomenon within a real-life situation in order to find a comprehensive understanding of how people relate and interact with each other in a specific situation and how they make meaning of a phenomenon (Nieuwenhuis 2011). Case study researchers

normally take into account the views and opinions of more than one participant and the interaction between the group. A case study was deemed suitable to determine the views and opinions of the participants with regard to the effectiveness of educational support programmes at two community-based support structures.

Macmillan and Schumacher (2001:395) describe interactive qualitative research as *an inquiry in which researchers collect data in face-to-face situations by interacting with selected persons in their natural settings (field research). Qualitative research describes and analyses people's individual and collective social actions, beliefs, thoughts and perceptions. The researcher interprets phenomena in terms of the meanings that people attach to them.* I view this description as suitable in terms of the strategy, method and purpose that I intended for this research project, as the study interprets the perspectives, views and priorities of the participants with regard to HIV and AIDS. The interpretivist approach assisted me in bridging the gap between what people say they do and what they are actually doing in practice (Nieuwenhuis 2011).

I identified with the participants who were interviewed by setting my prejudgements aside in an attempt to understand their views with regard to the mode of delivery and effectiveness of educational support programmes. Data were collected at two community-based educational support structures in Eersterust, working inductively and by developing insight and understandings from the behaviour patterns of participants in the data (Cohen *et al.* 2007; Taylor & Bogdan 2001).

When the focus group interviews were concluded, an analysis and interpretation of the raw data were done. Transcriptions of focus group interviews were made (see Appendix E). By employing an inductive approach I was able to make sense of a situation, not imposing my pre-existing anticipations but allowing the relevant topics to emerge from the raw data as the study and data analysis progressed (Babbie & Mouton 2001; Creswell 1998; Nieuwenhuis 2011).

Research by means of a case study design was somewhat challenging considering the typically small sample sizes of focus groups that are not representative of the target population and the fact that case studies are sometimes levelled against their dependence on a single case. As such acquired knowledge cannot necessarily be generalised to other people or other settings because the findings may be unique to the people that are included in the research study. I, however, did not aim at generalising the findings in this research. I guarded against being biased or becoming emotionally involved by cautiously listening to the

discussions regarding the views of the more outspoken participants and the views of the less assertive participants during the interview sessions that could influence my judgements.

3.4 PILOT STUDY

According to Hittleman and Simon (2006:308) a pilot study is *a limited research project, usually with a few subjects that follows the original research plan in every respect. By analyzing the results, research producers can identify potential problems.* A pilot study was conducted before the questions in the questionnaire were finalised and distributed to the conveners at the respective schools. The process that was followed during the pilot study is outlined in the following sub-sections:

3.4.1 AIM OF THE PILOT STUDY

The purpose of the pilot study was to increase the reliability, validity and practicability of the acquired data from the participants. I aimed to test the data collection instruments (questionnaires and focus group interviews) and the procedures that needed refinement before initially commencing with the final research (Cohen *et al.* 2007).

The aim of pre-testing the questionnaire survey and focus group questions was (Cohen *et al.* 2007) to:

- determine the time taken to complete the questionnaire;
- gain feedback on the attractiveness and appearance of the questionnaire;
- determine the clarity of the questionnaire items, instructions and layout;
- gain feedback on the validity of the questionnaire items, the operationalisation of the constructs and the purposes of the research;
- eliminate ambiguities or difficulties in the wording;
- determine whether questions were too invasive or of a sensitive nature;
- determine the appropriateness and relevance of the choice of words;
- determine the appropriateness and relevance of the content of questions;
- test the coding/classification system for data analysis;
- evaluate the strategies proposed for data collection and analysis.

3.4.2 SELECTION PROCEDURE OF LEARNERS WHO PILOTED THE QUESTIONNAIRE

Forty learners (20 boys and 20 girls) from the Eersterust Secondary School in Grade 10 to 12 were randomly selected to pre-test and comment on the questions in the questionnaire (Cohen *et al.* 2007). As an educator at the school it was logistically manageable for me to pre-test the questionnaire and to be personally involved during the pilot study.

The learners who were selected were regarded as representative of the adolescents under study. They probably possess similar knowledge, skills, attitudes and sexual behavioural patterns as those of other adolescents. The respondents for the pilot study were excluded from the main study in order to avoid data contamination (Cohen *et al.* 2007).

3.4.3 SELECTION PROCEDURE OF PARTICIPANTS FOR PILOT FOCUS GROUP INTERVIEWS

Before the focus group interviews were conducted, six learners from Grade 12 participated in a pilot focus group on sexual health issues in general. The chosen learners were randomly selected and interviewed by applying some of the intended questions for the focus group interviews (Cohen *et al.* 2007).

3.4.4 PRE-TESTING THE QUESTIONNAIRE

The following steps were employed in order to pre-test the questionnaire (Cohen *et al.* 2007; Neuman 1997):

- Firstly, a meeting was arranged with the principal of the school to explain the aim and purpose of the pilot project. Thereafter a letter was sent to her, requesting permission to conduct the pilot study at the school. The principal was also requested to grant the learners permission to participate in the pilot study.
- Respondents were addressed as a group, explaining their important role with regard to their input in the discussion and final draft of the questionnaire.
- The respondents subsequently completed the questionnaire in my presence.
- While the respondents were completing the questionnaire, they were encouraged to mark down the questions that they felt were unclear and these were discussed after completion of the questionnaire.
- The respondents were requested to comment on the instructions, the phrasing of questions, terminology used and content of the questionnaire.
- Comments and suggestions from the respondents were followed up.
- Finally, all the questionnaires were scanned and the respondents were specifically asked to comment on the questions that they had omitted.

3.4.5 PRE-TESTING THE FOCUS GROUP INTERVIEW

The following procedures were employed in order to pre-test the planned focus group interviews (Cohen e*t al.* 2007; Morgan 1997; Steward & Shamdasani 1990):

- I introduced myself to the participants and briefly explained the purpose of the research project.

- The interviewees were offered light refreshments in an attempt to make them feel at ease while building rapport.
- The participants sat at a table in a semi-circle, and I explained to them that recordings would be made of their responses.
- The focus group interview was conducted in accordance with pre-determined questions (see appendix E).
- Participants were encouraged to indicate any questions and probes that were not clearly understood.
- After completion of the focus group interview the participants were asked to comment on my instructions, phrasing of questions, the terminology that was used, the interview content and the method of interviewing.
- Comments and suggestions made by the participants were followed up where applicable.
- I tried not to let my own biases, opinions or curiosity affect my behaviour during the focus group discussion.

3.4.6 RESULTS OF THE PILOT STUDY

The objectives, method and results of the pilot questionnaire and focus group are summarised in Table 3.1

TABLE 3.1: OBJECTIVES, METHODS AND RESULTS OF THE PILOT QUESTIONNAIRE AND FOCUS GROUP

Objective	Method	Results
To determine the time that was taken to complete the questionnaire.	A stopwatch was utilised in order to determine the duration or time for completion of the questionnaire.	It took the respondents approximately 30 minutes to complete the questionnaire. I considered this as within suitable time limits.
To gain feedback on the attractiveness and appearance of the questionnaire.	The respondents were asked to comment on the attractiveness and the general appearance of the questionnaire.	Respondents agreed that the questionnaire was attractive and the appearance was presentable.
To determine whether questions were too invasive or of too sensitive a nature.	The questionnaires were scanned after they had been completed by the respondents. I tried to determine why certain questions had been omitted. I observed whether participants revealed any body language during focus group interviews that indicated that questions were too evasive or sensitive. Participants in the focus group interviews were also asked to identify any such questions.	No questions in the questionnaireor focus group discussion were seen as too invasive or of too sensitive a nature.

Objective	Method	Results
To determine the appropriateness and relevance of the choice of words.	Respondents were asked to comment on the clarity of instructions after completion of the questionnaire.	Some of the respondents preferred different terminology to that used in some questions of the questionnaire survey.
To determine the appropriateness and relevance of the content of questions.	Respondents were asked to comment on the appropriateness and relevance of the content of questions.	The respondents unanimously agreed that the content of questions were particularly relevant to the study and that the findings would be beneficial to adolescents in future.
To determine the clarity of the questionnaire items, instructions and layout.	Respondents were asked to comment on the clarity of the questionnaire items, instructions and layout.	The instructions to questions were clear to all the respondents.
To gain feedback on the validity of the questionnaire items, the operationalisation of the constructs and the purpose of the research.	Respondents were asked to comment on the validity of the questionnaire items, the operationalisation of the constructs and the purpose of the research.	After the respondents had been informed about the purpose of the research they unanimously agreed that a study of this nature was valid.
To eliminate ambiguities or difficulties in wording.	I coded the respondents' responses during the questionnaire survey.	The coding of responses was completed without any difficulty.
To evaluate the strategies proposed for data analysis.	I analysed data according to strategies proposed.	The strategies employed for data analysis seemed appropriate.

3.5 DATA COLLECTION AND DOCUMENTATION

Firstly, I utilised a field journal to document my field notes as well as my reflective thoughts during the research project. Secondly, I employed a questionnaire survey (see Appendix D), and focus group interviews (see Appendix E) as data collection strategies. These are described in detail in paragraphs 3.5.2 to 3.5.4. Before the data collection strategies are discussed, a brief overview of the field visits is provided.

3.5.1 FIELD JOURNAL

I utilised a field journal to document my reflective thoughts during the research process (Hittleman & Simon 2006). Field notes enabled me to:

- plan the dates for interview sessions;
- book appointments to conduct interviews;
- record the time spent at an organisation;
- review who has and who has not been interviewed.

Field notes are *written narratives of what a researcher hears, sees, experiences and thinks in a data collection session* (Hittleman & Simon 2006:305). The contextual information captured in my field notes varied between the two organisations. An organisation's assets and activities such as physical site, its present condition, educational support programme and its most recent history can only be understood fully within its context. I bore in mind that in order to focus solely on participants' behaviour or spoken word without attending to the context could increase the risk of misinterpreting the acquired data.

Contextual information was frequently included in my field notes. The context, in which interviews took place, was acquired from available written material (documents) at the community-based educational support structures. *Documents* refer to *records of past events that are written or printed which may be anecdotal notes, letters, diaries and documents* (Macmillan & Schumacher 2001:42).

3.5.2 THE QUESTIONNAIRE SURVEY

A questionnaire is a *self-report data collection instrument that is completed by each research participant as part of a research study. Questionnaires encompass a variety of questions in which the participant responds to written questions, to elicit certain reactions* (Macmillan & Schumacher 2001:40). My motivation for including a questionnaire survey in this study was based on the assumption and probability of the participants to provide truthful answers to the questions and information required from them in the questionnaire (Burns 2000).

3.5.2.1 Aim of the questionnaire

I employed a questionnaire survey in order to:

- obtain information from the participants (adolescents) about their knowledge, skills, attitudes and sexual behaviour with regard to awareness and the curbing of HIV and AIDS;
- determine whether local educational support programmes were addressing the educational needs of adolescents with regard to HIV and AIDS.

3.5.2.2 Justification for the use of a questionnaire

The use of a questionnaire survey as a data collection instrument was considered to be a suitable data collection strategy, for the following reasons (Muijs 2004):

- questionnaires are flexible (they make it possible to study a wide range of research questions);
- a situation or a relationship between variables can be described;

- questionnaires are efficient in gathering large amounts of data at reasonably low cost and with little effort;
- questionnaires allow respondents sufficient time to think about their answers;
- data analysis can be undertaken rapidly;
- questionnaires can be answered in privacy; therefore participants are more likely to express their true opinions and views.

I followed the guidelines stated below in an attempt to ensure a good response rate from the respondents (Cohen *et al.* 2007):

- all the selected respondents were issued with letters of informed consent which had to be signed by the parent or guardian and returned to me;
- the letters contained information with regard to the content of the questionnaire and other issues such as anonymity and confidentiality;
- a letter was forwarded to the principals of both secondary schools to remind them of the forthcoming questionnaire survey to be conducted on the agreed date;
- a convener, assisted by trained invigilators per school, was available and responsible for assistance while the participants completed the questionnaires;
- the questions on the questionnaire were arranged according to the direct relevance to experiences in their daily lives (Wilkinson & Birmingham 2003).

3.5.2.3 Language of the questionnaire

The community under study (Eersterust) was initially a Coloured residential area during the apartheid era. The main language that is spoken is Afrikaans and in some instances English. After 1994 the community of Eersterust became culturally diverse, resulting in more vernacular languages being spoken by some of the residents.

However, Afrikaans is still regarded as the primary language in the community. The medium of instruction at both schools is Afrikaans and English. The questionnaires were thus compiled in both Afrikaans and English in order to afford the participants an opportunity to answer the questionnaire in the language of their choice.

3.5.2.4 Format of the questionnaire

The questionnaire was designed by utilising relevant literature resources as well as guidelines for the construction of questionnaires as provided by Cohen *et al.* (2007). Being an educator by profession, I became aware of and identified five specifically important areas that may impact on adolescents' vulnerability to HIV-infection. In my opinion and based on

the literature review presented in Chapter 2, adolescents are particularly vulnerable to HIV-infection due to the following (Smart 1999; UNAIDS 1999):

- lack of knowledge;
- lack of skills;
- risky sexual behaviour;
- laissez faire attitudes with regard to HIV and AIDS;
- poor attendance of educational support programmes.

Two principles that were borne in mind when the questions were formulated were specifically to avoid confusion and to contribute to accurate understanding of the questions. Special attention was paid to the following aspects when the questionnaire was developed (Cohen *et al.* 2007):

- To be unambiguous and clear in the wording of the instructions and the questions;
- to ensure that the data that was acquired from the questionnaire survey would provide answers to the research questions;
- to place sensitive questions later in the questionnaire in order to avoid the creation of a wrong mindset of the participants;
- to ensure that the participants knew how to enter their responses to each of the questions, e.g. by either underlining or ticking.

The order of the questions within the questionnaire was considered as important, as some early questions could potentially embarrass respondents when answering questions later if not structured with care. For instance, if the first questions irritated respondents or made them angry, they would be unlikely to manage the irritation or anger to subside by the end of the questionnaire (Cohen *et al.* 2007). Therefore, questions were arranged in a logical sequence in order to minimise any discomfort and/or confusion among adolescents.

Subsequently the questionnaire commenced with non-threatening, factual questions (demographic information) which the participants could readily answer. According to (Oppenheim 1992; Maree & Pietersen 2011) one covert purpose of each question is to ensure that participants will continue to co-operate. I ensured that the questions covered all the important information that was needed.

Information was obtained in order to determine the knowledge, skills, attitudes and sexual behaviour of adolescents in relation to HIV-infection among adolescents. All information was utilised to clarify the identified needs of the adolescents. The questionnaire comprised 27 questions and consisted of the following seven sections:

- Section A: Demographic information

- Section B: Information with regard to relationships
- Section C: Knowledge with regard to HIV and AIDS
- Section D: Information with regard to skills of adolescents
- Section E: Information with regard to sexual behaviour of adolescents
- Section F: Information with regard to attitudes of adolescents
- Section G: Service delivery and the adolescent

The duration for the completion of the questionnaire was approximately thirty minutes. The allocated time was considered as being within reasonable time limits.

3.5.2.5 Respondents in the questionnaire survey

A total of 916 learners were selected to complete the questionnaire, excluding those learners that were utilised during the pilot study of the questionnaire. Learners who participated in the pilot study were excluded from the main study in order to avoid data contamination (Leedy & Ormrod 2001; Cohen *et al.* 2007).

The selected learners completed the questionnaire under the supervision of trained invigilators, supported by a convener at each school. The pencil-and-paper questionnaire method was employed in order to afford the participants ample time to complete the questionnaire at their own convenience and to allow them time to think about their answers (Muijs 2004).

3.5.2.6 Data collection by questionnaire survey

The procedure that was followed in order to collect data by questionnaire survey entailed the following:

- Firstly, I applied in writing for permission to conduct research at the two secondary schools that are situated in the community under study (Eersterust). The letter was hand-delivered to the District Director of the former Department of Education (Tshwane-South [D-4]). This process was very lengthy and time-consuming, as my application was referred to the former Gauteng Education Department's head office (Johannesburg) for approval. Permission was finally granted to conduct the research in the selected schools, after a rather lengthy period of six months (see Appendix A).
- Upon receipt of the letter of approval, personal contact was made with the principals of both schools to explain the purpose of the research project. My explanation of the proposed research project was well received by both principals. I then formally applied (in writing) for permission to conduct the research at the

respective schools. Both principals granted permission for the research to be conducted on the conditions stated in the application letter (see Appendix A).

- Each school appointed and provided me with a senior teacher that acted as the convener and a "go-between" the learners who were selected to complete the questionnaires, and me.
- The conveners at the respective schools appointed a team of trained invigilators who assisted with administering the questionnaires. The conveners at both schools were very helpful by explaining and promoting the importance of the research project to the learners, thus contributing to a good response rate.
- Before the questionnaires were completed, the parents or guardians were issued with a letter of *informed consent*, where the purpose of my research as well as issues such as confidentiality and anonymity were explained (see Appendix B). *Informed consent is the procedures in which individuals choose whether to participate in an investigation after being informed of facts that would be likely to influence their decisions* (Diener & Crandall 1978:44).
- The letter contained a return slip that had to be signed by the parent or guardian in which they granted permission for their children to become respondents in the questionnaire survey. The conveners and invigilators were instructed to double check that each learner who had received a questionnaire returned his or her return slip in order to ensure that permission had been granted by parents or guardians.
- Before the commencement of the completion of the questionnaire, learners were reminded by the invigilators not to write their names on the questionnaire in order to ensure confidentiality and anonymity.
- In order to ensure that the learners responded well to the questions, I requested the conveners and invigilators to issue the questionnaires ten minutes earlier in order for learners to be able to complete the questionnaire in full.
- The conveners collected the completed questionnaires, placed them in provided sealed envelopes and these were collected as agreed.
- Upon receipt of the questionnaires, each of the questionnaires was coded (allocating numerical numbers to answered questions) and forwarded to the Department of Statistics at the University of Pretoria where the data analysis took place.

3.5.3 FOCUS GROUP INTERVIEWS

Focus groups refer to *group interviews that are structured to foster conversations among the participants about particular issues. People are brought together and encouraged to talk*

about the subject of interest (Bogdan & Biklen 2003:101). I employed focus group interviews as an additional data collection strategy for this research. This was done in order to determine the views of adolescents with regard to the preferred mode of delivery and effectiveness of educational support programmes. Focus group interviews were conducted with participants (adolescents) at community-based educational support structures. An important advantage of focus group interviews is that they enabled me to observe and record the interaction between the participants (Dowell; Huby & Smith 1995; Cohen *et al.* 2007).

3.5.3.1 Aim of focus group interviews

By utilising focus group interviews, I aimed at determining the views of adolescents with regard to the mode of delivery and effectiveness of community-based educational support programmes.

3.5.3.2 Justification for the use of focus group interviews

Focus groups *involve the explicit use of group interaction to produce data and insight that would be less accessible without the interaction found in a group. The aim with focus groups is to draw information from local experience and traditions and to provide an understanding about the impact of the project on those involved* (Hittleman & Simon 2006:306). I employed focus group interviews in order to gather descriptive data in the participants' own words. By employing focus group interviews I aimed at developing insight into how the participants viewed existing community-based educational support programmes in terms of the mode of delivery and its effectiveness (Bogdan & Biklen 2003).

I regard the use of focus group interviews as suitable data collection strategy in this study for the following reasons (Dowell *et al.* 1995: Cohen *et al.* 2007):

- A wider range of responses from the participants could be generated from the discussions.
- it was useful to triangulate the findings with other data collection instruments, e.g. questionnaires.
- because it is confidential, personal and/or sensitive issues could freely be raised (by being safe and providing some anonymity).
- focus groups allowed for an opportunity to study the interaction among participants.

3.5.3.3 Language of focus group interviews

As has been mentioned in paragraph 3.5.3.3 the main languages that are spoken in the community under study (Eersterust) are Afrikaans and English, with a few other vernacular languages. I conducted focus group interviews in English as English is a universal language that is spoken by the members of the community either as a first or second language.

However, some interviewees preferred to respond to the questions in Afrikaans. Subsequently, the focus group interviews were conducted in the preferred language of the interviewees so that the data could be correctly interpreted.

3.5.3.4 Format of focus group interviews

I designed a focus group interview schedule (included in Appendix E) and utilised this for the focus groups with participants at both organisations (YDO and COL) after the questionnaire survey had been completed. Themes that arose from the questionnaire as well as other topics of interest that aimed at answering the primary research question were included in the discussions.

The focus group interview schedule covered five topics, and each of these topics had corresponding probes to guide the participants during the discussions (Wilkenson & Birmingham 2003). Guidelines for conducting focus group interviews were followed as proposed by Cohen *et al.* (2007). I allowed 45 minutes for each focus group interview.

An unstructured and semi-structured response mode was applied during the focus group interview. The unstructured response mode is flexible in the sense that the area of interest is determined although the discussion of issues is guided by the interviewees. Participants had the freedom to give their own answers rather than feeling constrained by the nature of the question. This allowed for some control over the interview for me as the interviewer (Cohen *et al.* 2007).

Semi-structured interviews are less flexible because it allows the interviewer to direct the interview more closely. Questions were thus predetermined to allow the participants an opportunity to shape the flow of information (Wilkinson & Birmingham 2003). When the questions were formulated, careful consideration was given to utilising suitable prompts and probes (Morrison 1993). Prompts enabled me to clarify the topics or questions, while probes enabled me to ask the participants to extend, elaborate, add to, provide detail for, clarify or qualify their responses, thereby addressing richness, depth of responses,

comprehensiveness and honesty that are some of the hallmarks of successful interviewing (Patton 2002: Nieuwenhuis 2011).

3.5.3.5 Participants in focus group interviews

Focus group interviews were conducted with learners who had attended educational programmes at the two community-based organisations (YDO and COL). Utilising focus group interviews allowed for accommodation of the participants' personal views, experiences and their perceptions.

(a) Youth Development Outreach

The participants at YDO consisted of five adolescents who attended educational programmes. The adolescents shared their knowledge and expertise with regard to the mode of delivery and effectiveness of educational support programmes on offer. The participants were from diverse cultures and were both male and female.

(b) Circle of Life Centre

The participants at COL comprised six learners (three boys and three girls) who attended the educational programmes. These learners were selected to relate their experiences with regard to their views on the mode of delivery and effectiveness of HIV and AIDS educational support programmes.

3.5.3.6 Data collection by means of focus group interviews

The procedure that was followed in order to collect data by means of focus group interviews is as follows:

- I applied for permission (in writing) from YDO and COL to conduct focus group interviews at the selected organisations. Permission was obtained from the gatekeepers at the selected organisations. Gatekeepers *are the people from the organisation who have the authority to give the researcher permission to conduct a research project* (Bogdan & Biklen 2003:259).
- The letter for permission was hand-delivered to the gatekeeper and briefly explained the purpose of the research project and other relevant information.
- Suitable dates to conduct focus group interviews were arranged with the participants at these organisations (YDO and COL).
- Before the commencement of the focus group interviews, each participant was issued with a letter of informed consent. The letter contained information about the purpose of the research, the right to refuse participation, or to withdraw once the research had begun (Cohen *et al.* 2007).

- Participants in each focus group interview first received some refreshments and sat around a table ensuring that each participant felt comfortable to participate in the discussions.
- Apart from the pilot study, two separate focus group interviews were conducted at the selected organisations and one interview schedule was utilised. At the first selected organisation the focus group interview was held with five participants that included adolescents who attended educational support programmes.
- The final focus group interview involved six participants comprising three girls and three boys who were willing to share their experiences with regard to educational support programmes regarding HIV and AIDS.
- The duration of each focus group was approximately forty minutes and it was conducted on the premises of the relevant organisations during normal working hours. This was arranged with the gatekeepers so that the participants did not feel resentful due to the extension of their normal working hours.
- The participants were approached beforehand for permission to audio-record the discussion in order for me to be able to compile written transcriptions of their responses.
- Notes were made about any non-verbal behaviour and facial expressions, such as gestures or frowning, that could help with the interpretation of the content of the audio-cassette recordings.
- After each focus group interview the participants were thanked for their contributions to the research project and they were informed that they would get feedback after the study had been completed.

3.6 DATA ANALYSIS AND INTERPRETATION

Data analysis commenced as soon as the questionnaires had been completed in order to establish the knowledge, skills, attitudes and unique sexual behavioural practices of adolescents in the Eersterust community. The aim was also to establish whether or not there was a need for educational support programmes with regard to HIV and AIDS. The procedure that was followed with regard to the analysis of the questionnaire broadly entailed the following Cohen *et. al.* (2007):

- The questionnaires were edited (checked) in order to identify and eliminate common errors that were made by the participants.
- During the editing of the questionnaires the focus was placed on three central tasks, namely *completeness, accuracy* and *uniformity.*

- The checking of the questionnaire was necessary to ensure that there was an answer to every question, that all the questions had been answered accurately and that the participants had interpreted the instructions and questions uniformly.
- Subsequently *data reduction* was applied that consisted of *coding for data analysis.* The mass of data obtained from the participants was reduced to a form that was suitable for analysis.

3.6.1 CODING OF QUESTIONNAIRES

After completion of the questionnaires each questionnaire was checked to ensure that it had been completed satisfactorily, after which each questionnaire was coded and taken to the Department of Statistics for data analysis. The responses could be entered rapidly and data could be examined automatically by producing graphs and tables, as well as a wide range of statistical data. The results that were obtained from the questionnaire survey are discussed in detail in Chapter 4.

3.6.2 CODING AND TRANSCRIPTIONS OF FOCUS GROUP INTERVIEWS

After the focus group interviews had been conducted and audio-taped the discussions were transcribed. The term *transcription* refers to *the records of every word an interviewer and interviewee say, and as such they are infinitely more reliable than any notes, quotes, remarks and summaries an interviewer might jot down during an interview* (Wilkinson & Birmingham 2003:47).

Analysing interviews inevitably implies content analysis, to evaluate key words, meanings, themes or messages communicated during focus group interviews. Content analysis was utilised to determine sound inferences concerning the attitudes and perceptions of participants (Cohen *et al.* 2007). The data were analysed, interpreted and discussed, and the recurring patterns, issues, concerns and common themes that are evident across the data were identified (Merriam 1998; Wilkinson & Birmingham 2003).

A full descriptive account of the findings was annotated. The results that were obtained from the focus group interviews are discussed in operational detail in Chapter 4.

3.7 STRENGTHS OF MY METHODOLOGICAL CHOICES

Conducting a questionnaire survey with learners at both secondary schools had some advantages. It was easy to gain access to the respective schools as I am an educator by profession. The selected conveners and invigilators at both schools were known to me on a

personal level. In order to ensure that learners answered the questions I included the following:

- Open-ended questions rather than close-ended questions.
- Familiar words and phrases.

Mitchell (1993:191) describes a case study as *a way of organizing social data so as to preserve the unitary character of the social object being studied. The social object can be a person, family or other social group, a set of relationships or processes (such as a family crisis, adjustment to a disease (HIV and AIDS)*, *friendship formation, ethnic invasion of a neighbourhood).* By including two cases (Youth Development Outreach Centre and Circle of Life Centre), I was able to highlight the differences and commonalities in their various approaches to the awareness and curbing of HIV and AIDS among adolescents. The fact that I introduced myself and emphasised the importance of the participants' contribution to the study before each interview, improved the relationship with the interviewees. This served as a good preparation for the discussion which might have been of a sensitive nature. Focus group interviews also allowed me to observe interaction among participants and aided me to explore sensitive issues.

3.8 CHALLENGES IMPLIED BY MY METHODOLOGICAL CHOICES

The use of a mixed methods research approach implied the use of both quantitative and qualitative research methods. By choosing the mixed methods approach, I was faced with the challenge of acquainting myself with a multiple methods approach in the way it is applied and in understanding how to appropriately mix the results and findings of such a study. The mixing of quantitative and qualitative research in this study was also costly and time-consuming. In this section I discuss some of the challenges that I encountered by combining the research approaches in my study and the possible ways in which I responded to them.

For the quantitative part of my study, I utilised a survey design (questionnaire) which was completed by 916 learners in Grades 10 to 12 at two secondary schools in the Eersterust community. The first challenge I experienced was the sensitive sexually-related questions contained in the questionnaire. I was aware that the respondents could be reluctant to disclose their intimate affairs, especially with me being an educator at one school where this research was conducted. My biggest concern was whether or not the respondents would provide truthful answers to sensitive sexually-related questions. In addressing this challenge, I enlisted the services of two senior educators who acted as conveners at the respective schools. The conveners addressed the learners before questionnaire completion and

explained the aim and importance of the study, why it was crucial to respond to all the questions and why they had to give their honest opinions to the questions. The learners were ensured that their answers would be treated with anonymity and confidentiality.

In an attempt to ensure a good response rate of the questionnaire survey, I aimed to be unambiguous and clear with regard to the wording of the instructions and the questions. I specifically designed the questions to avoid any confusion and to contribute to the accurate understanding thereof. Subsequently I arranged the questions in a logical sequence by starting with non-threatening questions (e.g. biographical questions) first to which all respondents could readily answer and by placing the sensitive sexually-related questions later in the questionnaire.

Maree and Pietersen (2011:9) state: *When different administrators administer the tests, this could lead to different responses*. Administering questionnaires with a large sample size (916 respondents) was challenging due to my dependence on the services of six educators (invigilators) who assisted me with administering the questionnaires in groups. I addressed this challenge by providing the invigilators with appropriate training and sufficient information with regard to the questionnaire content. I ensured that they were well equipped and in a position to assist the respondents with whatever problems they could experience during questionnaire completion.

Furthermore, I tend to agree with Cohen *et al.* (2007) on the opinion that the same question may have different meanings for different people if only closed items are used. On the contrary, if only open-ended items are used, respondents might be unwilling to write their answers for one reason or the other. I deliberately included simple, closed questions with four possible answers to overcome the challenge of the respondents attaching different meanings to the same questions.

For the qualitative part of my studies, I encountered the challenge of obtaining permission to conduct research from one organisation due to the busy schedule of the managing director. At times it became frustrating to repeatedly inquire about the managing director's whereabouts. She was absent from work for an undisclosed period of time. Unfortunately the managing director was the only person that could grant permission to conduct the research at YDO which turned out to be rather time consuming (Cohen *et al.* 2007).

After a lengthy period of time, I gained permission to conduct research on the premises of both organisations. The participants were duly informed (by the facilitators) about the forthcoming date of the focus groups and that I would be officially requesting their informed

consent to take part in the discussions. I was then confronted with the challenge of conducting interviews of a sensitive nature with learners (adolescents) who I presume, knew that I was an educator by profession. My immediate concern was the possible reluctance of learners to speak open and freely or to give their honest opinion to the sensitive sexually-related questions that I posed to them. In a sense, I realised that some of the participants might not necessarily have been comfortable in disclosing sensitive information about themselves during the interviews (Creswell 2005). Before I commenced with the interviews at both sites, I provided light refreshments for the group in order to create a feeling of comfort and establish a relationship of trust.

The seating was conveniently arranged in a semi-circle allowing the participants to sit wherever they preferred, thus ensuring that they felt comfortable enough to participate actively in the discussions. I explained to the participants that I was engaging with them in the capacity of a researcher and not as an educator. The participants were subsequently informed about the aim and importance of the research and I assured them that the information they shared would be treated with absolute anonymity and confidentiality and that their identity would under no circumstances be revealed. Creswell (2005:362) states: *A disadvantage of focus group interviews is that they require the researcher to find consensus on questions so one score can be marked for all individuals in the group.* I agree with this statement as I found that some participants were more outspoken than the other participants. I became aware of the fact that the dominance of individual participants could lead to responses that may not reflect the consensus that I aimed to achieve with the entire group. During the interview sessions, I faced the challenge of participants that dominated the discussions. In addressing this challenge, I constantly encouraged less outspoken participants to air their views during the discussions. By so doing, I could successfully strike a balance in the discussions between outspoken participants and those less outspoken.

With regard to the quantitative data analysis I completed, I was faced with the challenge of carefully checking each questionnaire in order to eradicate common errors that were made by the participants. This was done to ensure that all the questions had been answered accurately and that the participants had interpreted the instructions uniformly. The coding of the large number of questionnaires (916 learners) was time-consuming. After coding had been completed I submitted the coded questionnaires to the Department of Statistics at the University of Pretoria, where data capturing and analysis took place. I was subsequently provided with the completed results that allowed me to start with the interpretation of the results.

Regarding qualitative data analysis, I was faced with the challenge of transcribing large volumes of audio-taped interviews. This was a time-consuming process because some participants did not speak clearly and I listened to the recordings repeatedly. They also seemed uncertain at times and would change their statements during the interview sessions.

3.9 MY ROLE AS RESEARCHER

As a quantitative-qualitative researcher I had multiple roles to fulfil when data were collected. This included being the facilitator of focus group interviews, documenting field notes and arranging for competent conveners and invigilators to assist the learners in completing the questionnaires at the respective schools.

An advantage was the fact that I had prior knowledge of the community (Eersterust), because it allowed for easy access and some understanding of the complexities that are encountered by adolescents in the community due to the epidemic. At the same time, I became aware of my own perceptions and perspectives and how they could possibly influence my understanding and interpretation of the data. This was especially important since data mostly took the form of knowledge, insight, perspectives and opinions of learners at community-based educational support structures.

Conveners and invigilators administered the questionnaires at both schools. I was aware of how difficult it could become for learners to reveal their true reflections to me as a senior educator who holds an authoritative position at one of the schools, therefore my choice to utilise other parties as field workers.

3.10 ETHICAL CONSIDERATIONS

A critical aspect for consideration of this study was the ethics involved in the fieldwork. For participants to give an honest account of their opinions, thoughts and judgements on matters with regard to educational support for adolescents, they had to be assured of anonymity and confidentiality. The other basic ethical codes that were respected during this research are respect for autonomy, human rights and the dignity of participants. Therefore, participants were not exposed to motives not directly attached to the research study.

Prior to the empirical study, ethical clearance was obtained from the Research Ethics Committee of the University of Pretoria (see Appendix C). Copies of informed consent forms, questionnaire surveys, and the focus group guide were included in the application for ethical clearance. In the light of the sensitive nature of information and discussions that occurred, it was necessary to obtain permission from the relevant authorities, namely the former

Department of Education (see Appendix A), school principals (see Appendix A), parents or guardians (see Appendix B) as well as the participants (see Appendix B).

In order to protect the participants' privacy and ensure optimal responses during the completion of questionnaires and interviews, the participants' identities remained anonymous and information was regarded as private. Participants were offered confidentiality to guarantee that no participant would be identifiable from the research data, report or any subsequent publication, as well as anonymity, by not recording names in the research report (De Vos 2002).

I ensured that the participants in the study were not deceived, did not experience any form of distress, knew what was going on during the research process and knew that they were entitled to withdraw from the study at any time (Babbie & Mouton 2001). Based on the sensitive nature of the study, I remained alert and on the look-out for any child who could experience discomfort. Although this did not happen, I was prepared to refer any such cases for support if it would occur.

As my style of interviewing and level of professionalism had an impact on the value of the data it was essential to establish a relationship of co-operation and trust in order to elicit accurate and truthful perspectives and opinions from the participants (Cohen *et al.* 2007). I thus did not proceed with discussions before firm relationships of trust had been established.

I kept the following guidelines (Hayes 1981) in mind, concerning research with human beings, throughout the research process in mind:

- A covering consent letter was provided to all the participants explaining, outlining the aims of the research and stating that participation was voluntary; therefore participants were not coerced or manipulated into volunteering and had to give their informed consent to participate in the research project (Strydom 2002).
- The ethical implications and psychological consequences for the participants were considered.
- The participants were informed of the objectives of the research project.
- Informed assent was obtained from the participants prior to their participation in the study.
- I refrained from withholding information or misleading participants and intentional deception was avoided at all times.
- The principle of safety in participation implied that participants were not placed at risk or harm of any kind.

After completion of this research, a summary of the findings will be made available to the Department of Basic Education, the community-based educational support structures as well as the schools that participated in the research. Scientific articles based on the research will also be published.

3.11 QUALITY CRITERIA

The ultimate aim of producing a rigorous study lies in the value of trustworthiness and reliability; in other words, whether or not the research recipients can be convinced that a study is worth taking note of and whether or not the findings do indeed represent reality (Babbie & Mouton 2001). Qualitative data *are inherently subjective, dynamic and changeable over time* (Sussman & Gilgun 1996:313). Since the relevance and value of this study depended on trustworthiness and credible methods, several procedures were utilised to ensure trustworthiness and credibility throughout the research process.

3.11.1 VALIDITY

According to Cohen *et al.* (2007) *validity* is an important key to effective research. To validate is to check, to question, to theorise, to discuss and to share research action (Henning, Van Rensburg & Smith 2004). The term *validity* also refers to *the extent to which an instrument measures what it is intended to measure* (Hittleman & Simon 2006:311). Valid and reliable knowledge in a study is standard practice. One way of validating findings is to ask people, more specifically the research participants.

In this study focus group interviews contributed to the information provided by the participants being viewed as valid in that I (the researcher) acted as a moderator while conducting the interviews. This means that information was questioned and discussed with the participants during the course of the interview. I tried to grasp the meaning, interpretations and intentions of the participants (interpretative validity). Participants were also asked continuously whether the information made sense or not, and to identify the main issues. The research can therefore be considered to represent a rationalised version of reality.

I believe that my findings accurately describe the phenomenon (HIV-infection among adolescents) being researched (Cohen *et al.* 2007). Such accuracy refers to *internal validity.* According to McMillan and Schumacher (2001:391) *internal validity* refers to *the degree to which the explanations of the phenomena match the realities of the world.* This research provided sufficiently rich data for readers to determine whether or not transferability is possible (Hittleman & Simon 2006).

3.11.2 RELIABILITY

The term *reliability* is essentially synonymous with consistency and replicability over time, instruments and groups of respondents. Reliability implies that the information provided by indicators does not vary as a result of characteristics of the indicator, instrument or measurement device itself. If indicators have a low degree of reliability, the final results will be questionable.

In this study the reliability of the questionnaire was promoted by providing respondents with simple and concise instructions, keeping the length of the questionnaire within reasonable limits and ensuring that questions were reader-friendly and as effortless as possible to answer (Leedy & Ormrod 2001). The questionnaire was piloted beforehand in order to refine the content, wording and length for it to be appropriate for the sample (adolescents) that was targeted.

Validity of the responses was enhanced by stressing the importance and benefits of the questionnaire. Encouragement to participate was done by a friendly third party (conveners and invigilators) who understood the nature of the sample population in depth, so that effective targeting strategies could be utilised (Cohen *et al.* 2007).

3.11.3 CREDIBILITY

Credibility implies a feeling of confidence that my data collection, interpretation and conclusions are supported by raw data, thereby corresponding with the perceptions of participants. Credibility answers to the question as to what extent the findings are truthful. I addressed credibility concerns by separating reflective, interpretative comments from primary data in my field notes during data collection and at the conclusion of the study.

I conducted a thorough literature review to enhance the credibility of the theoretical underpinning of the study. The research aims were carefully constructed in order to form clear unambiguous goals for the research study (Reid & Gough 2000). The use of a combination of research methods such as a questionnaire survey and focus group interviews ensured credibility of the research design and outcomes.

As Miles and Huberman (1994:33) suggest *credibility of data depends to a large extent on the capacity of researchers and interviewees to complete valid and reliable information gathering.* I attempted to enhance the credibility of focus group interview outcomes by eliciting the specific information sought from the participants during the interviews (Leedy & Ormrod 2001). Conducting more than one interview also promoted credibility of the findings.

Throughout the research process I reflected on the possible influence of my background, perceptions, experiences and interests on the interpretation and findings I obtained. I was cautious against such biased influences. I audio-taped focus group interviews to provide a record of data that could be revisited when needed.

3.11.4 TRANSFERABILITY

The term *transferability* refers to *the dependability of the findings of a study, in order to determine whether or not the findings are applicable and can be transferred to other contexts. This relies on the possibility of the data being representative of the wider population* (Lincoln & Guba 2003:255).

The limitation of not being able to transfer focus group interview findings to the entire population of adolescents in South Africa was stated in paragraph 1.14, as this study merely involved a small purposefully selected sample of learners at two community-based educational support structures (Leedy & Ormrod 2001). Detailed descriptions of the participants, data collection instruments and procedures of this specific research were however, provided in order to allow transferable judgements to be made within other contexts. The anonymity of participants was however, not compromised by these detailed descriptions (Berg 1998).

3.11.5 DEPENDABILITY

The exact methods of data collection, recording, analysis, interpretation and discussion of results have been described in detail in order to provide information on the repeatability of the research. The use of a combination of research methods contributed to the dependability of the research. The dependability of participants' responses was further enhanced by not including questions that revealed their identity and by not portraying a judgemental attitude during participant contact.

These measures allowed participants to feel free to state their true opinions and views about the topics of discussion. A language editor served as an independent orator and verified that the translations were an accurate depiction of the participants' discussions. The dependability of focus groups interview responses was enhanced by discussing questions that were of particular interest and relevance to the participants. During data analysis, distinct steps were used in order to analyse and interpret data obtained from the focus group interviews. These steps were critical in order to establish the dependability of data analysis.

3.11.6 CONFIRMABILITY

I attempted to take an unbiased stand during data recording and when drawing conclusions from the data in order to satisfy confirmability (Reid & Gough 2000). The provision of transcripts of focus group interviews and the documentation of non-verbal gestures and facial expressions of participants within these transcripts, enhanced the confirmability of the findings.

Although complete reliability, validity and trustworthiness can never be achieved, the above-mentioned strategies contributed to ensure quality measures taken in this research (Leedy & Ormrod 2001; Cohen *et al.* 2007).

3.12 SUMMARY

In this chapter I provided a description and justification of the research methodology in terms of the research questions and the aim of the study. In the introduction the justification for embarking on this research project was provided. This was followed by the paradigmatic perspective (positivist and interpretivist epistemologies), the research design, pilot study, data collection and documentation, as well as data analysis and interpretation. The pilot study was found to be valuable for identifying aspects of the data collection instruments (questionnaire and focus group interviews) that needed refinement.

Special attention was paid to the strengths of the methodological choices I made, as well as the challenges that I encountered. Furthermore, my role as a researcher and the manner in which I adhered to ethical considerations were described. Throughout the study persistent attempts were made to obtain credibility and trustworthiness. In Chapter 4, I include a detailed report on the results of my study. This is followed by a discussion and interpretation of the findings against the background of existing literature.

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CHAPTER 4
RESULTS AND DISCUSSION

4.1 INTRODUCTION

The continuing high HIV infection rate among adolescents in South Africa (Maag & Irvin 2005) and the seemingly ineffective educational efforts by government departments are a reason for community-based educational support structures to contribute towards the awareness and education of the HIV and AIDS epidemic. The need for educating adolescents on HIV and AIDS in an attempt to curb the spreading of HIV infection among adolescents in South Africa has created new challenges for community-based educational support structures. Because of the high HIV prevalence a need exists for the acquisition of information about the educational needs of adolescents to determine whether existing community-based educational support programmes are aligned with the educational needs of adolescents. This study is limited to the context of adolescents in Eersterust.

This research combined a quantitative and a qualitative approach in the form of a mixed methods application (Teddlie & Tashakkori 2003). To answer the primary research question, *To what extent do community-based educational support programmes address the HIV and AIDS educational needs of adolescents,* the empirical study attempted to answer a few secondary questions, which are briefly described below.

SECONDARY RESEARCH QUESTION 1

What are the knowledge, skills, attitudes and sexual behaviour of adolescents? (see par 1.3, Chapter 1).

To answer this secondary research question, a comprehensive questionnaire survey was conducted with Grade 10 to 12 learners from two secondary schools in Eersterust. Findings from the questionnaire survey were interpreted to identify the educational needs of adolescents.

SECONDARY RESEARCH QUESTION 2

What are the views of the learners with regard to the mode of delivery and effectiveness of community-based educational support programmes? (see paragraph 1.3, Chapter 1).

To answer this secondary research question, focus group interviews were conducted with learners who had attended educational support programmes at the two community-based educational support structures. This was done to determine the views of adolescents with

regard to the mode of delivery and effectiveness of community-based educational support programmes.

The following aspects should be considered in interpreting this chapter:

- Although the primary aim of the study is to investigate how community-based educational support programmes provide for the HIV and AIDS educational needs of adolescents (or not), additional information (e.g. age groups and their current grade) was obtained and utilised to clarify needs;
- During the presentation of results all decimals were rounded off to the nearest integer;
- Specific sections were identified in the questionnaire in order to clarify the HIV and AIDS educational needs of adolescents;
- Unstructured interview techniques were utilised during focus group interviews;
- Appendix D contains copies of the questionnaire survey (Afrikaans and English) and Appendix E contains the unedited focus group interview transcriptions;
- An interpretation and discussion of the responses from the questionnaire survey and focus group interviews is provided at the end of each question;
- The presentation of the results includes graphic representations (figures and tables) as well as interpretations and discussions of the responses that were produced by this study.

The layout of this chapter is presented diagrammatically in Figure 4.1

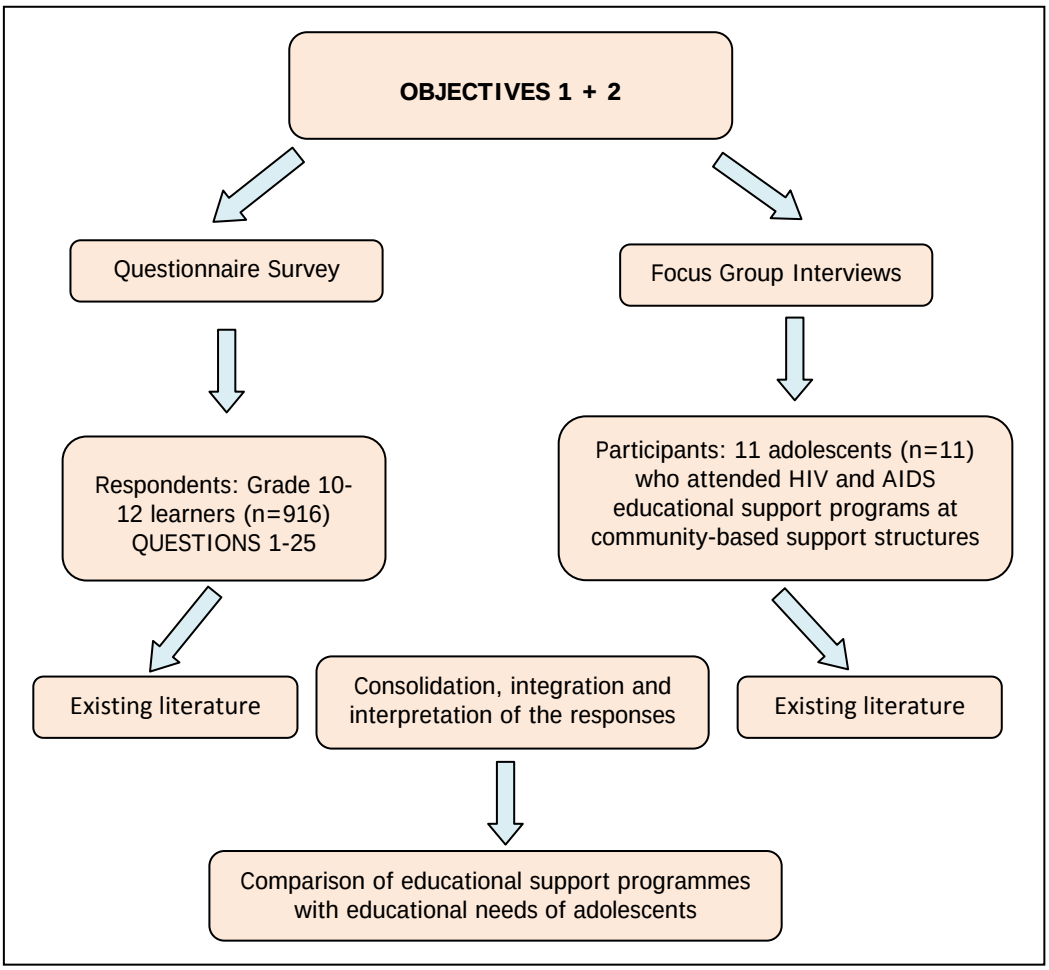

FIGURE 4.1: FLOW DIAGRAM OF THE PRESENTATION OF RESULTS

4.2 RESULTS AND DISCUSSION OF OBJECTIVE 1: KNOWLEDGE, SKILLS, ATTITUDES AND SEXUAL BEHAVIOUR OF ADOLESCENTS WITH REGARD TO HIV AND AIDS

The responses obtained from the questionnaire survey are hereby presented.

4.2.1 SECTION A: BIOGRAPHICAL INFORMATION

Questions 1, 2, 3, 4 and 5 were asked to gather biographical information such as gender, age, home language, grade and race group.

4.2.1.1 **Question 1: What is your gender?** (see Table 4.1)

The aim of this question was to determine the gender of the respondents who formed part of the research. For the purpose of my study I anticipated that knowledge of the gender of the respondents may be valuable to draw correlations during data analysis.

TABLE 4.1: GENDER OF RESPONDENTS

Sample size (n) 916 Gender	Number of respondents	Percentage
Male	410	45%
Female	506	55%
Total	**916**	**100%**

Table 4.1 reflects that 916 learners completed the questionnaire. The 916 learners consisted of 410 boys and 506 girls. I assumed that the responses of the participants would to a certain extent reflect the experiences of adolescents with regard to their HIV and AIDS educational needs.

4.2.1.2 Question 2: How old are you? (see Table 4.2)

The question was asked to determine the ages of the respondents in the research project.

TABLE 4.2: AGES OF RESPONDENTS

Sample size (n) 916 Age	12	14	15	16	17	18	19	20	21	22	Total
Number of respondents	4	11	121	259	288	155	63	11	3	1	916
Percentage	**.4%**	**1%**	**13%**	**28%**	**31%**	**17%**	**7%**	**1%**	**.33%**	**.11%**	**100%**

Table 4.2 provides a summary of the age groups of the respondents. The majority of the respondents were between 15 years and 18 years old at the time of data collection.

4.2.1.3 Question 3: What is your home language? (see Table 4.3)

The question was asked to determine the home languages of the respondents. For the purpose of the study I wanted to ensure that the language usage in the questionnaire was not ambiguous but reader-friendly to enable the respondents to provide truthful answers. The collected data are provided in Table 4.3.

TABLE 4.3: HOME LANGUAGE OF RESPONDENTS

Sample size (n) 916 Language	Number of respondents	Percentage
Afrikaans	584	64%
English	85	9%
Sotho	122	13%
Zulu	47	5%
Other	78	9%
Total	**916**	**100**

Table 4.3 indicates the home languages of the respondents. The majority of the learners (64%) speak Afrikaans. Sotho is spoken by the second largest group (13%). I did not foresee any problem in acquiring truthful answers from the respondents as the questionnaire was drawn up in Afrikaans and English. The learners had the choice to complete the questionnaire in any of these languages based on their preference.

4.2.1.4 Question 4: In which grade are you currently? (see Table 4.4)

This question was asked to determine the number of respondents (learners) per grade.

TABLE 4.4: NUMBER OF RESPONDENTS PER GRADE

Sample size (n) 916 Grades	Number of respondents	Percentage
Grade 10	326	36%
Grade 11	307	34%
Grade 12	283	30%
Total	**916**	**100%**

Table 4.4 indicates that the highest number of learners per grade who completed the questionnaire is the Grade 10 learners (36%). The respondents' age groups were between 15 and 18 years at the time of data collection. This seems to be the age when heterosexual relationships are typically formed.

4.2.1.5 Question 5: To which ethnic group do you belong? (see Table 4.5)

This question was asked to determine the ethnic groups to which the respondents belong. As has been mentioned in Chapter 1, paragraph 1.14, Eersterust has a diverse ethnic

composition. I wanted to acquire the views and opinions with regard to HIV and AIDS of adolescents from diverse cultural perspectives. Data are represented in Table 4.5.

TABLE 4.5: ETHNIC GROUPS TO WHICH RESPONDENTS BELONG

Sample size (n) 916 Race Group	Number of respondents	Percentage
White	4	.36%
Coloured	642	70%
Black	263	29%
Indian	6	.54%
Other	1	.1%
Total	**916**	**100%**

Table 4.5 indicates the number of respondents per race group. The majority (70%) of the respondents are Coloured based on Eersterust historically being declared a Coloured area. Since 1994 different racial groups have moved into Eersterust and all the learners attend school at the two local secondary schools, resulting in (30%) of the respondents belonging to ethnic groups other than coloured.

4.2.2 SECTION B: HETEROSEXUAL RELATIONSHIPS OF ADOLESCENTS

The questionnaire contained five items in order to elicit information with regard to heterosexual relationships[12] amongst the respondents in the study. The results consist of responses to the questions discussed below.

4.2.2.1 Question 6: Are you presently in a relationship? (see Table 4.6)

Question 6 was asked to determine whether or not the respondents were involved in heterosexual relationships at the time. For the purpose of the study I anticipated that the respondents may substantiate the fact that adolescents are often involved in relationships and that it is possible that such relationships may become sexually related. Data collected are represented in Table 4.6.

[12] For the purpose of this question "heterosexual relationships" refers to a relationship between a boy and girl who are in a steady relationship.

TABLE 4.6: NUMBER OF RESPONDENTS IN RELATIONSHIPS

Sample size (n) 916	Male	Female	Total
Respondents who are in relationships	228 56%	338 67%	566 62%
Respondents who are not in relationships	179 44%	171 33%	350 38%
Total	**407**	**509**	**916**

The results reveal that the majority (62%) of the respondents were in heterosexual relationships at the time. More girls (67%) than boys (56%) were involved in relationships. A smaller number of girls (33%) and boys (44%) indicated that they were not involved in heterosexual relationships. The fact that more girls than boys were involved in relationships can possibly be ascribed to girls' physical development and appearance during adolescence which tend to make them more attractive to boys while they are young.

4.2.2.2 Question 7: Are your parents aware that you are in a relationship? (see Table 4.7)

The aim of this question was to determine whether or not the respondents were having relationships with or without the knowledge of their parents. For the purpose of the study I assumed that many adolescents are in relationships even though parents may not always be aware of the fact, and that they may try to keep such relationships from their parents. The respondents who indicated that they were not involved in heterosexual relationships were excluded from the sample used in the analysis of this result.

TABLE 4.7: RESPONDENTS IN RELATIONSHIPS WITH OR WITHOUT THE KNOWLEDGE OF THE PARENTS

Sample size (n) 558	Male	Female	Total
Respondents in relationships with the knowledge of parents	149 65%	220 67%	369
Respondents in relationships without the knowledge of parents	79 35%	110 33%	189
Total	**228**	**330**	**558**

The results reveal that a larger number of girls (67%) than boys (65%) were in relationships *with* the knowledge of their parents. A smaller number of girls (35%) and boys (33%) indicated that they were having relationships *without* the knowledge of their parents. The fact that a large number of boys and girls indicated that their parents were aware of their

relationships can possibly be ascribed to the fact that parents may have open relationships with their children.

4.2.2.3 Question 8: Who should take the initiative to ask for a date? (see Table 4.8)

The aim of the question was to determine whether the respondents felt that a boy or girl should ask for a date. I assumed that boys should still take the responsibility in asking a girl out on a date.

TABLE 4.8: THE PERSON WHO HAS TO TAKE THE INITIATIVE TO ASK FOR A DATE

Sample size (n) 916 Should a boy or a girl ask to go out on a date?	Number of respondents	Percentage
Boy	479	52%
Girl	108	12%
Both	329	36%

The results reveal that a large number of the respondents (52%) were of the opinion that boys should ask girls out on a date. This indicates that adolescents hold specific views in terms of who should take the initiative when going on a date. Significant of the findings is that a small number of participants (12%) preferred girls to ask boys out on a date. It is interesting to note that 36% of the participants indicated that both boys and girls should take the initiative to ask someone on a date. This may be ascribed to the principle of equality that currently prevails between men and women.

4.2.2.4 Question 9: What do you do when you are out on a date? (see Table 4.9)

This question was asked to determine what the respondents do when they are out on a date. For the purpose of this study I included three possible answers from which the respondents could choose in order to determine how often sexual intercourse takes place when adolescents are out on a date.

TABLE 4.9: WHAT ADOLESCENTS DO WHEN OUT ON A DATE

Sample size (n) 916 What do adolescents do when they are out on a date?	Number of respondents	Percentage
Hold hands	806	88%
Kiss	816	89%
Sexual intercourse	249	27%

The results reveal that a large number of respondents (88%) held hands and a large number of participants (89%) indicated that they kissed when they were out on a date, at the time of the study. Significant of the results is that only 27% indicated that they had sexual intercourse when out on a date. This may be ascribed to the possibility that the majority of respondents may not yet have known their partners well enough or trusted them to engage in sexual intercourse. However, this is a mere hypothesis which requires further investigation. In addition, the question may be raised as to how honest the respondents were in answering this question, as adolescents are often not open about such sensitive issues.

4.2.2.5 Question 10: Do you feel worried or confused about how far you want to go sexually with your partner? (see Table 4.10)

Question 10 was asked to determine how far respondents would go sexually with their partners when they go out on a date. For the purpose of this question I anticipated that the participants might provide an indication of the sexual thoughts that are going through their minds when in the company of their partners.

TABLE 4.10: RESPONDENTS' WILLINGNESS TO HAVE SEXUAL INTERCOURSE

Sample size (n) 558	Number of respondents	Percentage
Respondents who do not worry how far they would go sexually with their partners.	348	62%
Respondents who do worry how far they would go sexually with their partners.	210	38%
Total	**558**	**100%**

Judging by the large number of respondents (62%) who indicated that they do not worry how far they would go sexually with their partners, the possibility exists that they could become sexually involved. This possibility may be ascribed to the insistence of one of the partners to have sexual intercourse. The respondents could also be immature or they might not immediately realise what the consequences of their action would be, thus making them vulnerable to HIV-infection, pregnancy and sexually transmitted diseases. These are, however, mere hypotheses that require further research.

4.2.3 SECTION C: KNOWLEDGE WITH REGARD TO HIV AND AIDS

The areas of knowledge with regard to HIV and AIDS as well as the areas where additional support is needed to curb the spreading of HIV-infection among adolescents were identified.

Results consist of the responses obtained to three questions in the questionnaire. The findings derived from the responses of the participants are hereby presented.

4.2.3.1 Question 11: Do you regard yourself as having basic knowledge[13] or do you think you need educational support[14] with regard to HIV and AIDS? (see Table 4.11)

This question was asked with the aim of determining the respondents' knowledge with regard to HIV and AIDS. For the purpose of the study respondents had to decide whether they possessed basic knowledge or whether they needed educational support with regard to HIV and AIDS by responding to the statements that are listed in Table 4.11.

TABLE 4.11: KNOWLEDGE AND SUPPORT NEEDED WITH REGARD TO HIV AND AIDS

Supply an answer to each of the following:	I have basic knowledge		I need support	
	Yes	No	Yes	No
1. Transmission of HIV and AIDS	824 90%	92 10%	384 42%	532 58%
2. I know how to protect myself against HIV Infection	861 94%	55 6%	357 39%	559 61%
3. The impact that HIV and AIDS will have on my life if I am infected	724 79%	192 21%	440 48%	476 52%
4. The consequence of premarital sex (engaging in sexual intercourse before getting married)	742 81%	174 19%	444 48%	472 52%
5. An understanding of the causes of HIV and AIDS	806 88%	110 12%	413 45%	503 55%
6. The kinds of risk that can lead to HIV-infection	780 85%	136 15%	426 47%	490 53%
7. The seriousness of HIV and AIDS in my community	687 75%	229 25%	514 56%	402 44%
8. Condom use	796 87%	120 13%	338 37%	578 63%
9. Knowing how to live by values (e.g. accountability)	862 94%	54 6%	395 43%	521 57%

The responses of the respondents who thought they possessed knowledge about HIV and AIDS overshadowed those who indicated that they needed support with regard to HIV and

[13] For the purpose of this question "basic knowledge" will mean knowledge that can effectively protect the participant to become HIV-infected.
[14] For the purpose of this question "support" refer to additional support provided to adolescents to acquire knowledge on HIV and AIDS.

AIDS. The resultant deduction is that a large number of the respondents indicated the need for more educational support about awareness and the spreading of HIV-infection.

The responses of the respondents to items 1 to 9 indicate that a large number thought they possessed sufficient knowledge with regard to HIV and AIDS, while a smaller number of respondents indicated that they needed more support. The respondents' responses to item 6 regarding the kinds of risk that could lead to HIV-infection reveal that 85% held the perception that they had basic knowledge and 47% indicated that they needed support in terms of more knowledge on HIV and AIDS. The need for HIV education seemingly existed, as almost half of the participants indicated that they required more information regarding possible risks that could lead to HIV-infection.

4.2.3.2 Question 12: Indicate whether you agree, are unsure or disagree with regard to the following statements (see Table 4.12)

With this question I aimed to determine the respondents' level of knowledge with regard to HIV and AIDS. For the purpose of this study I anticipated that the respondents might provide truthful answers to the statements and by doing so provide me with insight into their views and opinions on HIV and AIDS. The data are represented in Table 4.12.

TABLE 4.12: KNOWLEDGE WITH REGARD TO HIV AND AIDS

Indicate whether you agree, are unsure or disagree with regard to the following statements:	Agree	Unsure	Disagree
1. A person who is infected with HIV has no visible signs	403 44%	320 35%	193 21%
2. Kissing an HIV-positive person can be dangerous	192 21%	266 29%	458 50%
3. HIV is mainly caused by witchcraft	28 3%	91 10%	797 87%
4. People generally live by values	540 59%	311 34%	65 7%
5. There is no cure for HIV and AIDS	603 66%	211 23%	102 11%
6. You can become infected with HIV by having oral sex	459 50%	321 35%	132 14%
7. There is sufficient information in my community regarding HIV and AIDS	436 48%	235 25%	243 27%
8. Despite the wealth of information on HIV and AIDS there are young people who still contract the infection and die of AIDS	767 84%	121 13%	26 3%

Indicate whether you agree, are unsure or disagree with regard to the following statements:	Agree	Unsure	Disagree
9. People with many sexual partners are at risk of HIV-infection	793 87%	90 10%	31 3%
10. Condoms will prevent you from becoming infected with HIV	399 44%	336 37%	177 19%
11. I would tell my friends if I had a positive HIV test result	276 30%	328 36%	309 34%

The above responses support the fact that adolescents typically think they possess basic knowledge with regard to HIV and AIDS. The deduction is that people who think they know are often not open to learn. Prominent of the findings (item 1) is that only 44% of the respondents agreed while 21% of the respondents disagreed and 35% of the respondents were unsure whether or not a person with HIV would show any visible signs. This may be ascribed to the fact that adolescents are often inclined to judge a person's HIV status based on his or her appearance.

4.2.3.3 Question 13: What is your main source of information with regard to HIV and AIDS? (see Table 4.13)

This question was asked to determine the participants' main source of information with regard to HIV and AIDS.

TABLE 4.13: SOURCES OF INFORMATION

Sample size (n) 916 Resources	Number of respondents	Percentage
1. TV	369	41%
2. Teachers	179	21%
3. Parents	164	18%
4. Magazines	64	7%
5. Social workers	60	6%
6. Newspapers	44	4%
7. Friends	23	2%
8. Radio	13	1%
Total	**916**	**100%**

Table 4.13 provides a depiction of the respondents' main source of information with regard to HIV and AIDS. The results reveal that the largest number of participants (41%) obtained

information about HIV and AIDS from television programmes, followed by their teachers (19%) and parents (17%).

Findings show that respondents thus relied on audio-visual aids, for example television, to acquire information. The radio (1%) as a source of information proved to be less popular with adolescents. It should be noted that smaller numbers of respondents indicated that they acquired their information with regard to HIV and AIDS from the following sources: Social workers (6%), magazines (6%), newspapers (4%) and friends (2%). This may be ascribed to some of the respondents' limited reading skills, which is prevalent in the Eersterust community amongst adolescents.

4.2.4 SECTION D: INFORMATION WITH REGARD TO SKILLS OF ADOLESCENTS

Skills that adolescents may lack to curb the spreading of HIV-infection among young people in Eersterust were identified. The questionnaire contained two sections to elicit information from the respondents regarding the skills to protect themselves against HIV-infection.

4.2.4.1 Question 14: Indicate whether you agree, are unsure or disagree with regard to the following statements (see Table 4.14)

This question was asked to determine whether or not the respondents thought adolescents possessed sufficient skills to protect themselves against HIV-infection. The data are represented in Table 4.14.

TABLE 4.14: SKILLS OF RESPONDENTS WITH REGARD TO HIV AND AIDS PREVENTION

Sample size (n) 916 Adolescents (young people)	Agree	Unsure	Disagree	Total
1. should do whatever their friends tell them to do	54 6%	42 4%	820 90%	916 100%
2. should blame their friends for the wrong choices	88 10%	55 6%	773 84%	916 100%
3. know how to use a condom	605 66%	212 23%	99 11%	916 100%
4. have the skills to say NO if they are pressurised to have sex	732 80%	101 11%	83 9%	916 100%
5. are able to express positive and negative feelings	689 75%	174 19%	53 6%	916 100%
6. are able to prevent sexual threats and violence	519 57%	254 28%	143 16%	916 100%

Sample size (n) 916 Adolescents (young people)	Agree	Unsure	Disagree	Total
7. stand up for their rights without putting others down	653 71%	176 19%	87 10%	916 100%
8. talk about sex to adults (e.g. parents, teachers, nurses)	547 60%	200 22%	169 18%	916 100%
9. know how to act in order to delay sexual intercourse	541 59%	295 32%	80 9%	916 100%
10. know how to protect themselves from contracting HIV and AIDS	664 73%	159 17%	93 10%	916 100%

The responses of the respondents indicate that they were of the opinion that adolescents possessed sufficient skills to protect themselves against HIV-infection. Prominent findings are the following:

- A large number of the respondents (66%) indicated (item 3) that they thought adolescents knew how to use a condom, while 23% of the respondents were unsure and 11% of the respondents did not know how to use a condom.
- 57% of respondents indicated that they thought adolescents were able to prevent sexual threats and violence during sexual encounters, while 27% of the respondents (item 6) were unsure and 16% of the respondents unable to prevent sexual threats and violence.
- Only 59% of the respondents (item 9) were of the opinion that adolescents knew how to act in order to delay sexual intercourse while 32 % of the respondents were unsure and (9%) of the respondents unable to act in order to delay sexual intercourse.

These results provide an indication that the respondents were of the opinion that there was still a significant number of adolescents who lacked skills to protect themselves against HIV-infection.

4.2.4.2 Question 15: Indicate whether you have basic skills or whether you need support with regard to sexuality and HIV and AIDS (see Table 4.15)

In support of Question 14, the aim of this question was to determine whether or not the respondents possessed sufficient skills to protect themselves against HIV-infection. In addition, the need for support was determined.

TABLE 4.15: EXTENDED SKILLS OF RESPONDENTS WITH REGARD TO HIV AND AIDS PREVENTION

Sample size (n) 916 Indicate whether you have basic skills or whether you need support with regard to sexuality and HIV and AIDS	I have basic skills		I need support	
	Yes	No	Yes	No
1. Communication skills	784 86%	132 14%	440 48%	476 52%
2. Decision-making skills	808 89%	108 11%	417 45%	499 55%
3. Problem-solving skills	717 79%	199 21%	492 54%	424 46%
4. Negotiation skills	710 79%	206 21%	481 53%	435 47%
5. Assertiveness	737 81%	179 19%	448 49%	468 51%
6. Saying NO	864 95%	52 5%	323 34%	593 66%
7. Handling of emotions	743 82%	173 18%	450 49%	466 51%

It seems that a large number of respondents (on average 84%) were of the opinion that they possessed sufficient skills to protect themselves against the potential sexual threats with regard to HIV infection. A smaller number of respondents (on average 47%) indicated that they needed support to acquire the necessary skills to protect themselves against sexual threats with regard to HIV-infection.

The following findings are significant:

- 89% of the respondents (item 2) indicated that they had good decision-making skills while 45% of the respondents indicated that they needed educational support to develop decision-making skills;
- 79% of the respondents (item 3) indicated that they possessed problem-solving skills while 54% of the respondents needed educational support to develop problem-solving skills;
- 79% of the respondents (item 4) indicated that they possessed negotiating skills while 53% of the respondents needed educational support to develop negotiating skills.

Judging by the increasing HIV-infection rate among adolescents in Eersterust, these results indicate that the respondents did not possess sufficient skills to protect themselves against

HIV-infection at the time of the study. The results further reveal that half of the respondents in Eersterust needed support regarding decision-making, problem-solving and negotiation skills. A need for the development of skills among adolescents to be able to handle the problems and stresses with regard to HIV and AIDS was also indicated.

4.2.5 SECTION E: INFORMATION WITH REGARD TO THE SEXUAL BEHAVIOUR OF ADOLESCENTS

The findings with regard to the sexual behaviour of adolescents are presented below.

4.2.5.1 Question 16: Have you ever had sex? (see Table 4.16)

This question was asked to determine whether or not the respondents have had a sexual experience.

TABLE 4.16: NUMBER OF RESPONDENTS WHO HAVE HAD SEX

Sample size (n) 916	Gender				Total
	Male		Female		
Respondents who have had sex	261	64%	217	43%	478
Respondents who have never had sex	146	36%	292	57%	438
Total	**407**		**509**		**916**

These results reveal that more boys (64%) than girls (43%) have already had sexual intercourse at the time of the study. It is interesting to note that a larger number of girls (57%) than boys (36%) indicated that they had never had sexual intercourse. Therefore, the findings reveal that boys in Eersterust had a higher rate of sexual encounters than girls.

4.2.5.2 Question 17: If you have answered "yes" in question 16, how old were you when you had your first sexual experience? (see Table 4.17)

The aim of this question was to determine the age at which the respondents had their first sexual experience.

TABLE 4.17: AGE OF RESPONDENTS AT FIRST SEXUAL EXPERIENCE

Sample size (n) 460 Age	12	13	14	15	16	17	18	19	Total
Male	15 7%	26 11%	53 20%	67 26%	58 22%	20 8%	11 4%	5 2%	255
Female	2 2%	5 2%	17 8%	30 15%	74 35%	49 24%	24 12%	4 2%	205
Total	**17**	**31**	**70**	**97**	**132**	**69**	**35**	**9**	**460**

The results reveal that the highest concentration of respondents who have had sexual intercourse was between 15 years (26%) and 16 years (22%) of age for boys and between the ages 16 (35%) and 17 (24%) for girls for their first sexual encounter at the time. It seems as if this is also the age groups where adolescents in Eersterust typically start to develop an interest in heterosexual relationships.

4.2.5.3 Question 18: Indicate why adolescents become sexually active (see Table 4.18)

The aim of the question was to determine why adolescents become sexually active and to determine whether or not they wanted to gain experience, to please a boyfriend or girlfriend, or were being pressurised by friends to have sexual intercourse.

TABLE 4.18: REASONS WHY ADOLESCENTS BECOME SEXUALLY ACTIVE

Sample size (n) 916	Number of respondents	Percentage
To gain experience	699	76%
To please a boy-/ girlfriend	626	68%
Pressurised by friends	513	56%

The results reveal that a large number of respondents (76%) wanted to gain experience while 68% of the respondents wanted to please their partners and 56% of the respondents were pressurised by friends to become sexually active. The responses from respondents imply that although they were aware of the dangers of HIV and AIDS, sexual activity among adolescents occurred in high percentages at the time.

4.2.5.4 Question 19: How many sexual partners did you have in the past six months? (see Table 4.19)

The question was asked to determine the number of sexual partners that the respondents have had in the six months prior to the study.

TABLE 4.19: NUMBER OF SEXUAL PARTNERS IN THE LAST SIX MONTHS

Sample size (n) 435	Gender				Total
	Male		Female		
0 partner	22	9%	6	3%	28
1 partner	78	33%	137	69%	215
2 to 4 partners	101	43%	49	25%	150
5+ partners	36	15%	6	3%	42
Total	**237**		**198**		**435**

The results reveal that 33% of the boys and 69% of the girls have had one sexual partner in the six months prior to the study. Significant findings are that 43% of the boys and 25% of the girls have had more than one partner in the six months period. Boys had more sexual partners and nearly twice as often a STD history (Buga 1996).

4.2.5.5 Question 20: If you have answered "yes" to question 16, do you use a condom every time when having sex? (see Table 4.20)

I asked this question to determine whether or not the respondents used condoms when they engaged in sexual intercourse.

TABLE 4.20: PERSISTENT USE OF A CONDOM

Sample size (n) 476	Male and female	
	Number	Percentage
Respondents who use condoms every time when they have sex	305	64%
Respondents who sometimes use condoms when they have sex	124	26%
Respondents who never use condoms when they have sex	47	10%
Total	**476**	**100%**

The above results indicate that only 64% of the respondents used a condom every time when having sex while 26% did not use condoms regularly when they had sexual

intercourse and 10% never used condoms when they had sexual intercourse. This suggests that 36% of the participants were vulnerable to sexually transmitted diseases including HIV and AIDS.

4.2.5.6 Question 21: Have you ever been coerced to have sex? (see Table 4.21)

The aim of this question was to determine whether or not the respondents were being coerced.[15]

TABLE 4.21: THE NUMBER OF RESPONDENTS COERCED TO HAVE SEX

Sample size (n) 916	Male and female	
	Number	Percentage
Respondents who have been coerced into having sex	130	14%
Respondents who have never been coerced into having sex	786	86%
Total	**916**	**100%**

The results indicate that 14% of the respondents had been coerced into having sexual intercourse. This implies that despite the high HIV-infection rate, the majority of adolescents engaged in sexual intercourse out of their free will.

4.2.6 SECTION F: INFORMATION WITH REGARD TO THE ATTITUDES AND OPINIONS OF ADOLESCENTS

The attitude and opinions of respondents with regard to HIV and AIDS were investigated. The results consist of responses obtained from question 23 in the questionnaire.

4.2.6.1 Question 22: Indicate whether you agree, are unsure or disagree with regard to the statements in Table 24 (see Table 4.22)

The aim of the question was to determine the respondents' attitudes and opinions with regard to HIV and AIDS.

[15] For the purpose of the study, *coerced* means "being forced to have sex against your will".

TABLE 4.22: ATTITUDES AND OPINIONS OF ADOLESCENTS WITH REGARD TO HIV AND AIDS

Sample size(n) 916 **Do you agree, are unsure or disagree with regard to the following statements:**	**Agree**	**Unsure**	**Disagree**
1. Men are allowed to show their masculinity by having many sexual partners	119 13%	128 14%	669 73%
2. If you go on a date with a boy or a girl, you should have sex with him or her	64 7%	73 8%	779 85%
3. A person cannot get infected the first time he or she has sex	102 11%	256 28%	558 61%
4. You can be in love with several people at the same time	440 48%	156 16%	320 36%
5. If your partner hits you, it means that he loves you	119 13%	111 12%	686 75%
6. Young people engage in unprotected sex because of pressure from the partners	376 41%	275 30%	265 29%
7. Young people who submit to partners who insist on sex without a condom do so because they fear rejection	464 51%	269 29%	183 20%
8. You can only use a condom with someone you do not know well	311 34%	82 9%	523 57%
9. We are all destined to die – so if AIDS is the cause, that's the way it is	313 34%	137 15%	466 51%
10. Women should not initiate or discuss sex – that is the man's role	119 13%	171 19%	626 68%
11. It is not acceptable for girls to ask boys out on a date	237 26%	202 22%	477 52%
12. It is more acceptable for boys to drink and smoke than it is for girls	347 38%	146 16%	423 46%
13. Boys cannot rape their girlfriends – it is their right to have sex	164 18%	113 12%	639 70%
14. When a female says no to sex – she actually means yes	85 9%	92 10%	739 81%
15. Sexual intercourse by an older teenager with someone younger than 16 years is abusive, even if the younger person consents	602 66%	168 18%	146 16%
16. Young people who find it difficult to accept the use of a condom, can contract HIV and AIDS	712 78%	138 15%	66 7%
17. Having to engage in sexual activity under the influence of alcohol or drugs can hinder the use of a condom	625 68%	199 22%	92 10%
18. HIV and AIDS and substance abuse can be prevented by instilling a system of values (e.g. accountability) in young people	491 54%	355 38%	70 8%

Judging by the respondents' responses to the questionnaire items it seems that many adolescents adopted a laissez-faire attitude towards HIV and AIDS.

Significant findings include the following:

- From the responses of all respondents to item four, 48% agreed that one can be in love with several people at the same time, while 17% of the respondents were unsure and 35%of the respondents disagreed that it is possible to be in love with several people at the same time.
- With reference to item 6, only 40% of the respondents agreed that young people engaged in unprotected sex because of pressure from their partners, while 30% of the respondents were unsure and 30% of the respondents disagreed.
- Half of the respondents (item 7) agreed that young people giving in to partners who insist on sex without a condom did so because they feared rejection while 29% of the respondents were unsure, and 21% of the respondents disagreed.
- The majority (57%) of the respondents (item 8) disagreed that a condom can only be used with someone that they did not know well, while 34% of the respondents were unsure and 9% of the respondents agreed.
- The majority (51%) of the respondents (item 9) disagreed that when people die of AIDS it is the way it is, while 34% of the respondents agreed and 15% of the participants were unsure.

4.2.7 SECTION G: SEXUAL RIGHTS OF ADOLESCENTS

A few areas with regard to the knowledge of sexual rights of adolescents were identified. The results consist of responses obtained from question 27 of the questionnaire.

4.2.7.1 Question 23: Respond to the following statements as honestly as possible (see Table 4.23)

I asked this question to determine whether or not the respondents were aware of their sexual rights and responsibilities.

TABLE 4.23: SEXUAL RIGHTS OF ADOLESCENTS

Sample size (n) 916 **Sexual rights mean that you have the right to…**	**Number of respondents**	**Percentage**
1. have control over your body	890	97%
2. have sex when, with whom and how you want to	504	55%
3. be coerced by anyone to have sex or unprotected sex	112	12%

4. be protected from the risk of HIV-infection	846	92%
5. exercise the responsibilities that go with sexual rights	845	92%

It seems that 97% of the respondents were aware of their sexual rights because they could exercise control of their bodies. Fifty-five percent of the respondents indicated that they were not aware of their rights to have sex when, with whom and how they want to, and 45% of the respondents were unsure whether or not they could have sex when, with whom and how they wanted to.

4.3 RESULTS AND DISCUSSION OF OBJECTIVE 2: THE VIEWS OF ADOLESCENTS WITH REGARD TO THE MODE OF DELIVERY AND EFFECTIVENESS OF EXISTING EDUCATIONAL SUPPORT PROGRAMMES

In this section I present the findings based on qualitative data collection and analysis.

4.3.1 FOCUS GROUP INTERVIEWS

Focus group interviews were conducted with 11 learners who attended HIV and AIDS educational support programmes at YDO and COL (refer to Chapter 3, paragraph 3.5.3.4). These are two community-based organisations that operate in the Eersterust community (refer to Chapter 2, par. 2.7.1 and 2.7.2). The aim of the focus group interviews was to determine the views of the learners with regard to the mode of delivery and effectiveness of existing educational support programmes.

4.3.1.1 Question 1: Who do you think should be involved in the planning and implementation of educational support programmes with regard to HIV and AIDS?

The aim of this question was to determine who adolescents preferred to plan, implement and present HIV and AIDS educational support programmes at the community support structures. Participants indicated that they preferred young people to be part of the planning and presentation of HIV and AIDS educational support programmes. Participant 1 (focus group 1) responded as follows: "I think young people are better because they know where we come in. I am comfortable with young people" and Participant 2 (focus group 1) said: "Anyone who feels that he or she can make a positive contribution but I also prefer teenagers because we are at the same level". Participant 3 (focus group 2) responded as follows: "I think as young people we can be very creative if we are given a chance to do things". Involvement of adolescents could assume ownership if they are included as role-

players with adults (teachers, nurses and parents). Supplying adolescents with information could ensure effective HIV and AIDS education to them.

4.3.1.2 Question 2: Who are the presenters of the educational support programmes at the community-based support structures?

The aim of this question was to determine who presented the educational support programmes at the two community-based educational support structures at the time of the study. The presenters of educational support programmes at the two community-based organisations were young people who held specialised HIV and AIDS training. The participants' opinion was that young presenters who are open and trustworthy could relate to their educational needs with regard to sexually related matters. Participant 1 (focus group 1) responded as follows: "There are different presenters and they are all young". Participant 3 (focus group 2) said: "They are young and you can trust them because they are open about anything we want to know".

Participants from both organisations also added that, apart from young presenters, some HIV-positive presenters shared their experiences about being HIV-positive and what they had done to live productive lives. HIV-positive presenters seemed to be effective because adolescents are typically curious and want first-hand information. Participant 5 (focus group 1) responded as follows: "Nobody was listening to him (presenter) until he brought up the subject that he was HIV-positive".

Adolescents seemingly preferred young facilitators because they might be scared to talk to adults (teachers, health officials and parents) about sexually related issues. The responses of the participants indicate that they were however comfortable to ask questions regarding sexually related issues to young presenters.

4.3.1.3 Question 3: What is your view about the content of the educational support programme that you have attended?

The aim of this question was to determine the participants' views regarding the content of the existing educational support programmes at the community-based educational support structures under study. Participants were of the opinion that the content of the educational programmes was interesting, enjoyable and entertaining. Participants 3 and 4 (focus group 1) responded as follows: "The content is interesting and easy to understand. If you do not understand, you are free to ask" and "The content about the dangers of HIV and AIDS is enjoyable. I do not enjoy the long discussions about HIV and AIDS. I want to look at dramas about HIV and AIDS". Participants 1 and 5 (focus group 2) responded as follows: "It is good

because I learn how to protect myself against HIV-infection" and "I find the content truly enjoyable because I learn something new every time we take part in activities". The participants also indicated that they required more knowledge about sexually related matters, healthy lifestyles as well as HIV and AIDS education.

Participants reportedly did not enjoy long discussions about HIV and AIDS. They preferred to learn by looking at dramatisation of events about HIV-infection. I am of the opinion that it may be useful to include adolescents in activities as long as they acquire information with regard to HIV and AIDS. By performing dramas and role-play, adolescents could enjoy themselves and at the same time acquire knowledge with regard to HIV and AIDS.

4.3.1.4 Question 4: What is your view about the way in which the programme is presented to you?

The aim of this question was to determine the participants' views about the mode in which existing educational support programmes were offered. Participants were of the opinion that the educational programmes were presented in a variety of ways in order to make them interesting and enjoyable.

The programmes included activities such as discussions where adolescents could express their views, drama to demonstrate how HIV is transmitted and debates relating to HIV and AIDS. Participant 1 (focus group 1) responded : "The facilitators present the programmes in the form of dances and dramas and sometimes they hand out magazines and pamphlets about HIV and AIDS. I like the dramas because it is more interesting to look and learn instead of the discussions". Activities like poetry, role play and dances were are also reportedly included. Participant 2 (focus group 2) stated: "They have a variety of activities that are presented like drama, role play, discussions, debates and poetry. I even wrote a poem about HIV and AIDS and I am very proud about myself". The adolescents were apparently constantly involved in activities by young and energetic facilitators. Group discussions were promoted for adolescents to share their opinions and experiences regarding the given topics that were to be discussed.

Facilitators were reportedly patient and they made the participants comfortable before they started to present activities related to HIV and AIDS. Participant 1 (focus group 2) reported as follows: "The facilitators make us very comfortable before they have discussions about HIV and AIDS. We are free to ask questions". Adolescents who had questions on sexually related matters (which went unanswered at home and school) could be answered by the facilitators who had specialised training regarding HIV and AIDS.

4.3.1.5 Question 5: Do you think that the educational support programme was of any benefit to you?

The aim of this question was to determine whether or not the participants benefited from attending educational support programmes at the community-based educational support structures. The participants were all of the opinion that they had benefited from attending educational programmes at both community-based educational support structures. There was reportedly a change in the behaviour of participants who had attended educational support programmes. Participant 1 and 2 (focus group 1) responded: "Yes, I realised that HIV and AIDS is real and once you have it, there is no turning back" and "for me definitely, I was always having unprotected sex, but now I am using a condom". Participant 1 and 5 (focus group 2) stated: "I have learned things that I did not know about HIV and AIDS. I am now able to protect myself" and "yes they encouraged me to abstain from sexual intercourse".

The facilitators also utilised the services of HIV-positive presenters. This was seemingly an effective way to confront adolescents with the reality of HIV and AIDS. Participants 1 and 5 (focus group 1) responded: "Nobody was really listening or paying attention to him (HIV-positive presenter) until he said he was HIV-positive. There was a moment of silence because we realised the person is really HIV-positive" and "I realised that HIV and AIDS is real and once you have it, there is no turning back and you are going to die". I think adolescents should be encouraged to attend educational support programmes so that they can acquire information that may lead to safer sexual practices. If they were to attend educational support programmes they may be bound to become aware of the potential dangers that are posed by HIV and AIDS.

4.3.1.6 Question 6: Would you recommend the educational support programme to other adolescents?

The aim of this question was to determine whether or not the participants would recommend the educational programmes to other adolescents. The responses of the participants indicate that they would recommend the educational support programmes to other adolescents. Participants were open to discuss their educational needs with the facilitators at community-based educational support structures. Participant 1 (focus group 1) said: "Yes because our parents and even our Life Orientation teacher is scared to talk about sex. We never talk about sex or HIV and AIDS in the class. We only talk about physical health and substance abuse". In support, participant 5 (focus group 1) responded as follows: "Yes I will recommend the programme to other adolescents because we all need information about AIDS and other diseases. Most of us do not want to speak to our parents about sex".

Participant 4 (focus group 2) reported that: "Yes, I will recommend the programme because parents and teachers do not want to talk about sex and HIV and AIDS. The presenters are open about the problems with which we are confronted and the teach about HIV and AIDS". Participant 5 (focus group 2) confirmed this idea: "Yes, I will definitely recommend the programme because it is important for everyone to know about HIV and AIDS". Judging by the responses from the participants, it seems as if they realised the contribution of the educational programmes to young people for awareness and the curbing of HIV and AIDS.

4.3.2 SYNTHESIS OF QUALITATIVE RESULTS

I explored the views of adolescents with regard to the mode of delivery and effectiveness of educational support programmes by means of focus group interviews. The participants who attended the educational support programmes were seemingly pleased with the contribution that was made by the community-based educational support structures with regard to awareness and the curbing of HIV-infection. Participants indicated that they would like to be part of the preparation and planning of educational support programmes. They were of the opinion that the content of the educational programmes was interesting and user-friendly. They found the mode of delivery enjoyable and were pleased with the efforts by the young and energetic presenters to educate them about HIV and AIDS. They indicated that they would recommend the educational programmes to other adolescents to acquire knowledge about the potential threat of HIV-infection.

4.4 SUMMARY

In this chapter the results that were obtained from the empirical study were presented. This includes the results from the questionnaire survey (paragraph 4.2) and the focus group interviews (paragraph 4.3). The results were presented according to the two objectives of the study, namely: the educational needs of adolescents with regard to HIV and AIDS; and the views of adolescents with regard to the mode of delivery and effectiveness of existing community-based educational programmes.

A questionnaire survey (refer to Appendix D) was utilised in order to determine the educational needs of adolescents with regard to HIV and AIDS. The questionnaires were completed by learners from the two local secondary schools in the community under study (Eersterust).The findings with regard to the HIV and AIDS educational needs of adolescents are presented in Chapter 5, paragraph 5.2.3.

The views of the participants with regard to the mode of delivery and effectiveness of community-based educational support programmes were determined by means of focus group interviews with learners at the two community-based educational support structures (refer to Appendix E). Findings regarding the views of adolescents concerning the mode of delivery and effectiveness of educational support programmes are presented in Chapter 5, paragraph 5.2.4.

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CHAPTER 5
REVIEW, FINDINGS AND RECOMMENDATIONS

5.1 REVIEW

In this study titled: *Community-based educational programmes as support structures for adolescents within the context of HIV and AIDS,* the HIV and AIDS educational needs of adolescents were determined by means of a questionnaire survey. Secondly, the views of adolescents were explored pertaining to the mode of delivery and effectiveness of community-based educational support programmes. I concluded my research by investigating whether two existing community-based educational support programmes were addressing the educational needs of the adolescents, or not.

During the literature study several facts became apparent. I identified a shortfall in existing literature in terms of the contributions of community-based educational programmes with regard to HIV and AIDS (Chapter 2, paragraph 2.1). Despite efforts by government institutions (Department of Education and Department of Health), the number of HIV-infections among adolescents is increasing. It is estimated that more than five million people in South Africa are presently living with HIV and AIDS.

The main route of HIV-transmission in South Africa is by means of heterosexual intimate relationships, largely because of concurrent sexual relationships, particularly among adolescents (Chapter 2, paragraph 2.2.2). More than 50% of all new infections in South Africa occur among young people between the ages of 15 and 24 years (UNAIDS 2010) and life expectancy in South Africa will drop from a high of 68 years to less than 40 years within the next few years (Department of Health 2005).

Due to the socio-economic problems that prevail in South Africa, many people are still trapped in conditions of abject poverty and poor access to HIV and AIDS information and health services. The fact that the HIV and AIDS prevalence rate remains unacceptably high, despite many prevention strategies that have been in place for several years, is a cause for concern that necessitates ongoing research for solutions to curb the spread of HIV and AIDS. The most prominent prevention strategies appear to be education and positive changes in the sexual behaviour of adolescents (Van den Berg 2008).

It seems as if HIV and AIDS education programmes in schools may not be addressing awareness of HIV and AIDS effectively, as projected mortality rates among adolescents are

increasing (Chapter 1, paragraph 1.1). In the light of this reality, it seems necessary for school and community-based educational support structures to address the educational needs of adolescents with regard to HIV and AIDS. Effective community-based educational support programmes could be valuable in the sense that it can equip adolescents (also those not at school) with knowledge and skills to protect themselves against HIV-infection.

Two secondary research questions were deduced from the primary research question and by searching for answers to the two secondary questions, the primary research question could be answered. The formulation of the aims gave focus and direction to the study to such an extent that meaningful empirical research could be conducted.

Chapter 1 entails the background and orientation with regard to the research project. My area of interest was mentioned and I elucidated the rationale for undertaking the study. The aim and relevance of the study regarding certain choices that I had made during the planning phase were outlined. The main research question was formulated against the background of these choices and considerations. The formulation of the aim and primary research question of the study is descriptive by nature and focuses on exploring whether or not community-based educational support programmes are addressing the HIV and AIDS educational needs of adolescents.

After the research questions were formulated I identified the assumptions with which I approached the study. The key concepts of my study were clarified. I briefly stated the epistemology and paradigmatic perspective with which I approached the study and introduced the methodological choices and strategies, followed by a brief discussion on quality criteria. Finally, I presented a brief overview of my thesis in terms of its five chapters.

In Chapter 2, relevant literature on HIV and AIDS was explored that serves as a scientific background to the study. The literature study was utilised as a guide to structure the questions with regard to the educational needs of adolescents in the questionnaire. The investigation started with an analysis and discussion of the available literature on HIV and AIDS as theoretical backdrop of my study. I focused on the response of the government and the extent and impact of the epidemic on South Africans with special reference to the impact on families, the education sector, learners and educators. Also included in Chapter 2, are discussions on the vulnerability of adolescents to HIV-infection which entails contributing factors such as a lack of knowledge, lack of skills, laissez-faire attitude, risk behaviour, cultural perspectives, violence against women and children, the effects of poverty on children and families and the need for educational programmes with regard to HIV and AIDS.

Chapter 3 includes discussions and justifications regarding the methodological choices that I made with reference to designing and conducting the empirical part of my study. Firstly, I described the use of a questionnaire survey to identify the educational needs of adolescents with regard to HIV and AIDS. Secondly, I described the use of a reflective field journal and focus group interviews as qualitative data collection strategies in order to determine the views of adolescents with regard to the mode of delivery and effectiveness of existing community-based educational support programmes. The preferred methodology in terms of the research questions and purpose of the study was justified. I also described the manner in which I conducted data analysis and interpretation during the study.

This was followed by a discussion of the strengths and challenges of the selected methodology that I utilised during the empirical part of my research. The strategies that I employed to address these issues were highlighted. Chapter 3 is concluded with a discussion on the ethical guidelines that I adhered to during data collection and analysis, and on the manner in which I aimed to improve the quality of the research in the light of quantitative and qualitative quality criteria.

In Chapter 4, I reported on the results that I obtained during the empirical study. I provided a holistic view of the results by means of tables, figures and discussions in order to illustrate the responses of the participants as well as my interpretation thereof. The collected data were discussed in terms of the aims and responses of the various questions that were posed to the participants during the field work sessions. I used verbatim responses to supplement the discussions, with the aim of addressing the primary research question.

5.2 FINDINGS REGARDING THE RESEARCH QUESTIONS

In the following section I present the findings and conclusions in terms of the research questions that were formulated in Chapter 1 (refer to paragraph 1.3). The findings of the secondary research questions have contributed to answering the primary research question: *To what extent do community-based educational support programmes address the HIV and AIDS educational needs of adolescents?* Findings are categorised in terms of the two secondary research questions.

5.2.1 FINDINGS WITH REGARD TO THE LITERATURE STUDY

Findings with regard to the literature study are presented below.

Regarding the knowledge adolescents possess I found that –

(1) HIV and AIDS educational programmes in schools do not adequately address the needs and problems of adolescents (Chapter 1, paragraph 1.1);

(2) adolescents receive very little if any information from their parents or other adults with regard to HIV and AIDS or sexual and reproductive health issues (Chapter 1, paragraph 1.1);

(3) adolescents turn to their peers for information about sexually related matters and the possibility exists that they may acquire inaccurate or misleading information (Chapter 2, paragraph 2.3.1);

(4) adolescents receive conflicting messages with regard to sexual behaviour and are often faced with double standards calling for virginity in girls but early, active sexual behaviour in boys (Chapter 2, paragraph 2.3.1);

(5) adolescents are confronted with media images that portray sex, smoking and drinking as glamorous and risk-free (Chapter 2, paragraph 2.3.1);

(6) adolescents find it difficult to reach youth-friendly health services where they can discuss issues related to sexual health or obtain condoms and other protective devices (Chapter 2, paragraph 2.3.1);

(7) there is a relatively early departure of many young people from the educational system (Chapter 2, paragraph 2.5).

Regarding the skills adolescents possess I found that –

(8) young people generally lack confidence and the skills to negotiate sexual issues, contraception and the prevention of HIV-infection (Chapter 2, paragraph 2.3.2);

(9) adolescents face a series of important developmental decisions involving family and relationships, sexual expression and educational development (Chapter 2, paragraph 2.3.2);

(10) the high number of HIV infections is a consequence of a lack of prevention skills and poor developmental skills (Chapter 2, paragraph 2.3.2);

(11) adolescents lack skills to prevent sexual encounters and to engage in safe sexual practices (Chapter 2, paragraph 2.3.2);

(12) many adolescents do not have the ability to analyse situations and the behaviour of their peers (Chapter 2, paragraph 2.3.2);

(13) adolescents have little insight into the consequences of their own actions and the consequences of engaging in risky sexual behaviour (Chapter 2, paragraph 2.3.2).

Regarding the attitudes and opinions of adolescents I found that –

(14) adolescents often believe that they are impervious to disease, accidents and death (Chapter 2, paragraph 2.3.3);

(15) adolescents have an unfavourable perception of personal risk and do not immediately realise the threat of HIV and AIDS (Chapter 2, paragraph 2.3.3);

(16) a few adolescents perceive themselves to be at risk or take the need for safer sex seriously (Chapter 2, paragraph 2.3.3);

(17) adolescents are inclined to consider themselves not vulnerable or immortal to HIV and AIDS (Chapter 2, paragraph 2.3.3);

(18) adolescents think that HIV and AIDS infection only happens to older people and that they can judge a person's HIV-status based on his or her appearance (Chapter 2, paragraph 2.3.3);

(19) time has a different meaning for adolescents compared to time experienced by older individuals. For instance, when telling adolescents that if one is infected with HIV it may lead to death in ten to fifteen years, the time factor may not be meaningful for them (Chapter 2, paragraph 2.3.3).

Regarding the sexual behaviour of adolescents I found that –

(20) condom use is low among adolescents (Chapter 2, paragraph 2.3);

(21) many adolescents have unprotected sexual intercourse with a partner whose HIV status is unknown to them (Chapter 2, paragraph 2.3.4);

(22) many adolescents have multiple unprotected sexual partners and a lack of adherence to infection-control guidelines (Chapter 2, par 2.3.4);

(23) many adolescents engage in sexual activity, especially with casual partners when they are under the influence of alcohol or drugs (Chapter 2, paragraph 2.3.4);

(24) the abuse of alcohol and drugs is apt to make adolescents forgetful about safer sex practices and thus reduces the likelihood of condom use (Chapter 2, paragraph 2.3.4);

(25) messages aimed at gay men may go unheard by adolescent boys who have occasional homosexual experiences (Chapter 2, paragraph 2.3.4);

(26) young people become sexually active despite strong cultural values against premarital sex (Chapter 2, paragraph 2.3.5);

(27) same sex relations often occur among adolescent boys (Chapter 2, paragraph 2.3.4);

(28) adolescent boys hide their sexual orientation by having secretive affairs or rushed sexual encounters with little time for negotiating condom use (Chapter 2, paragraph 2.4.4).

5.2.2 CONCLUSION

The findings from the literature study in Chapter 1 and 2 indicate that adolescents do not possess sufficient knowledge of HIV and AIDS, and skills to protect themselves against HIV-infection. Many adolescents are sexually active from an early age and do not always practise safe sex (refer to Chapter 4, paragraph 4.2.4.1). Adolescents do not perceive themselves to be at risk and are vulnerable to HIV-infection in many ways due to e.g. alcohol and drug abuse, peer pressure, poverty and multiple unprotected sexual partners. Communities should not disregard the thread of HIV-infection posed to adolescents. More time should be devoted to HIV and AIDS education in schools and at community-based support structures.

5.2.3 FINDINGS IDENTIFIED FROM THE RESULTS OF THE QUESTIONNAIRE SURVEY

From the results obtained from the questionnaire survey, the following findings have been deduced:

Regarding the attitudes of adolescents I found that –

(29) 62% of the participants indicated that they do not worry how far they would go sexually with their partners (Chapter 4, paragraph 4.2.2.5). This may give rise to unplanned sexual intercourse.

Regarding the skills of adolescents I found that –

(30) 32% of the participants were unsure if they know how to act in order to delay sexual intercourse (Chapter 4, paragraph 4.2.4.1);

(31) 28% of the participants indicated that they are unsure how to protect themselves against sexual threats and violence (Chapter 4, paragraph 4.2.4.1).

Regarding risky sexual behaviour I found that –

(32) 64% of the participating boys and 43% of the girls (Chapter 4, paragraph 4.2.5.1) already had a sexual experience prior to my study. If adolescents had already had sexual intercourse they seemed likely to continue with this behaviour;

(33) the age group at which participants had their first sexual experience was between 15 and 16 years (Chapter 4, paragraph 4.2.5.2). This seems to be the age group where adolescents start to form relationships. They are immature and probably do not realise the danger of being infected with HIV;

(34) 43% of the boys and 25% of the girls (Chapter 4, paragraph 4.2.5.4) have had two to four sexual partners in the six months prior to my study.

Regarding the knowledge adolescents possess I found that –

(35) 25% of the participants did not realise the seriousness of HIV and AIDS within the community (Chapter 4, paragraph 4.2.3.1);

(36) 25% of the participants were unsure and 27% of the participants disagreed that there are sufficient information available regarding HIV and AIDS in the community (Chapter 4, paragraph 4.2.3.2);

(37) 47% of the participants indicated that they needed educational support to protect themselves against HIV-infection (Chapter 4, paragraph 4.2.4.2).

Regarding the use of condoms I found that –

(38) adolescents (87%) think that they have sufficient knowledge regarding the use of a condom (Chapter 4, paragraph 4.2.3.1);

(39) 37% of the participants were unsure whether or not condoms will prevent them from becoming infected with HIV (Chapter 4, paragraph 4.2.3.2);

(40) 23% of the participants were unsure and 11% of the participants did not know how to use a condom (Chapter 4, paragraph 4.2.4.1);

(41) 26% of the participants did not use condoms regularly when they had sex and 10% of the participants never used condoms when they had sex (Chapter 4, paragraph 4.2.5.5);

(42) 19% of the participants were unsure of their rights and 10% of the participants did not know how to stand up for their rights (Chapter 4, paragraph 4.2.4.1).

(43) 51% of the participants agreed that young people submitted to partners who insisted on sex without a condom for fear of rejection while 29% of the participants were unsure (Chapter 4, par. 4.2.6.1);

Regarding peer pressure I found that –

(44) 68% of the participants indicated that adolescents become sexually active to please a boyfriend or girlfriend (Chapter 4, paragraph 4.2.5.3);

(45) 56% of the participants indicated that adolescents become sexually active because they are pressurised by friends (Chapter 4, paragraph 4.2.5.3).

5.2.4 EDUCATIONAL NEEDS DEDUCED FROM THE FINDINGS OF THE QUESTIONNAIRE SURVEY

The under mentioned educational needs with regard to HIV and AIDS have been deduced from the findings of the questionnaire survey.

Adolescents need:

- knowledge on HIV and AIDS awareness and prevention (29, 31, 32, 33, 34, 35, 36);

- negotiation skills to delay sexual intercourse and to protect themselves against HIV-infection (30, 37);
- decision-making skills to make well informed decisions about engaging in relationships and sexual activities (42);
- communication skills to express themselves when they are in relationships with people e.g. peer group (43);
- to be educated regarding the use of condoms to prevent HIV-infection (38, 39, 40, 41);
- education to deal with peer pressure (43, 44, 45);
- education to change the attitude of adolescents about the seriousness and consequences of HIV and AIDS;
- education with regard to risky sexual behaviour in order to abstain or to practise safe sex;
- education with regard to human rights (43).

5.2.5 FINDINGS REGARDING THE VIEWS OF ADOLESCENTS REGARDING THE MODE OF DELIVERY AND EFFECTIVENESS OF COMMUNITY-BASED EDUCATIONAL SUPPORT PROGRAMMES

The findings regarding the mode of delivery and effectiveness of educational programmes (secondary research question 2) are as follows:

(46) Participants wanted to be included in the planning and preparation of educational support programmes to ensure that their educational needs are addressed (Chapter 4, paragraph 4.3.1.1);

(47) Participants wanted peer education to be promoted (Chapter 4, paragraph 4.3.1.1);

(48) Participants preferred young presenters to present the educational programmes with regard to HIV and AIDS (Chapter 4, paragraph 4.3.1.2);

(49) Participants felt free to talk to young people about sexually related issues without feeling embarrassed (Chapter 4, paragraph 4.3.1.2);

(50) Participants enjoyed the presentations made by HIV-positive people (Chapter 4, paragraph 4.3.1.2);

(51) Participants enjoyed dramatic presentations rather than long discussions regarding HIV and AIDS (Chapter 4, paragraph 4.3.1.3);

(52) The content of the educational support programmes was perceived as youth friendly, interesting and entertaining (Chapter 4, paragraph 4.3.1.3);

(53) Participants did seemingly not possess sufficient knowledge regarding sexually related matters and healthy lifestyles (Chapter 4, paragraph 4.3.1.3);

(54) The mode of delivery included discussions, drama, debates, poetry, role-play, dances and art (Chapter 4, paragraph 4.3.1.4);

(55) Participants found the programmes to be interesting and enriching (Chapter 4, paragraph 4.3.1.4);

(56) Participants seemingly benefitted educationally with regard to HIV and AIDS by attending the educational support programmes (Chapter 4, paragraph 4.3.1.5).

The following core findings support secondary research question 1, namely *What are the knowledge, skills, attitudes and sexual behaviour of adolescents?*

- Adolescents receive very little if any information from their parents or other adults with regard to HIV and AIDS or sexual and reproductive health issues;
- Participants did not report to possess sufficient knowledge regarding sexually related matters and healthy lifestyles;
- Young people seemed to lack confidence and skills to negotiate sexual issues, contraception and the prevention of HIV-infection;
- Many adolescents reportedly had multiple unprotected sexual partners and a lack of adherence to infection control guidelines;
- 43% of all the participants did not realise the seriousness of HIV and AIDS within the community.

The following core findings support secondary research question 2, namely *What are the views of the adolescents regarding the mode of delivery and effectiveness of HIV and AIDS educational programmes?*:

- The content of the educational support programmes was perceived as youth-friendly, interesting and entertaining;
- Participants preferred young presenters to present the educational programmes on HIV and AIDS;
- Participants wanted to be included in the planning and preparation of educational support programmes to ensure that their educational needs are addressed;
- Participants found the programmes interesting and enriching;
- Participants benefitted educationally with regard to HIV and AIDS by attending educational support programmes;
- Participants enjoyed the presentations made by HIV-positive people.

With regard to the primary research question, namely: *To what extent do community-based educational support programmes address the HIV and AIDS educational needs of adolescents?*, the following findings were deducted:

- Participants felt free to talk to young people about sexually related issues without feeling embarrassed;
- The content of the educational support programmes was perceived as youth-friendly, interesting and entertaining;
- The mode of delivery included discussions, drama, debates, poetry, role-play, dances and art;
- Participants enjoyed the dramatic presentations more than long discussions regarding HIV and AIDS;
- Participants benefitted educationally with regard to HIV and AIDS by attending educational support programmes.

5.2.6 CONCLUSION

Findings indicate that the participants found the programmes to be interesting and enriching. They enjoyed the interactive way in which the programmes were presented such as dramas, debates, role-play and group discussions.

Participants were in favour of young presenters as well as presentations made by HIV-positive people. They were of the opinion that young presenters are more approachable than their teachers and parents. It seems as if the participants enjoyed the presentations at community-based educational support programmes that were less formal more than the HIV and AIDS presentations at schools.

5.3 COMPARING THE EDUCATIONAL SUPPORT PROGRAMMES WITH THE EDUCATIONAL NEEDS OF ADOLESCENTS

The educational support structures under study, namely *Youth Development Outreach* (YDO) and *Circle of Life* (COL) are organisations that have been established due to the high HIV-infection rate and AIDS-related deaths among residents, including young people in the community of Eersterust. This study aims at determining how the community-based educational programmes of these community-based educational support structures address the educational needs of adolescents (or not), against the background of the high HIV and AIDS prevalence in Eersterust. In order to answer the primary research question the HIV and AIDS educational needs of adolescents were identified by means of a questionnaire survey. Focus group interviews were utilised to determine the participants' views with regard to the mode of delivery and effectiveness of HIV and AIDS educational programmes. In this section the participants' identified needs are compared with the content in two existing educational support programmes to determine whether or not the adolescents' educational needs are addressed in the said programmes.

The adolescents under study seemingly needed education that deals with relationships (Chapter 4, paragraph 4.2.6.2). The educational support programmes at both support structures addressed issues on relationships. Adolescents were namely educated on how to conduct themselves responsibly when they are in relationships (Chapter 2, paragraph 2.3.1.4 nos: 5.1, 5.2, 5.3, 7.5 and paragraph 2.3.2.4 nos: 7.1, 7.2, 7.3, 7.4).

The adolescents under study also displayed a laissez-faire attitude with regard to sexually related matters and therefore needed education regarding the invulnerability and consequences of HIV and AIDS (Chapter 4, paragraph 4.2.2.5). Both educational support programmes addressed the attitudes of adolescents with regard to HIV and AIDS in an effort to enhance behaviour change (Chapter 2, paragraph 2.3.2.4 no 2.1).

The adolescents seemingly became sexually active at an early age (around 12 years). They therefore allegedly needed detailed education on HIV and AIDS at an early age (Chapter 4, 4.2.5.2). The educational support programmes of both educational support structures did not specify a particular age at which adolescents could attend educational programmes. All adolescents from as young as 12 years of age were free to attend the programmes (Chapter 2, paragraph 2.3.1.4 nos: 9.1.1, 9.1.2, 10.1 to 10.7 and paragraph 2.3.2.4 nos: 11.1 to 11.8).

Adolescents needed skills such as decision-making, negotiation and communication skills to protect themselves against HIV-infection (Chapter 4, paragraph 4.2.4.2). Both educational support programmes did not include specific education with regard to these skills. It seemed as if the educational support programmes placed emphasis on the knowledge regarding HIV and AIDS with little focus on skills.

Adolescents also needed education to handle peer pressure (Chapter 4, paragraph 4.2.5.3). The educational support programmes at the community-based support structures made detailed provision for education regarding the influence of peer pressure on adolescents (refer to Chapter 2, paragraph 2.3.1.4 no. 1.9 and paragraph 2.3.2.4 nos: 8.1, 8.2).

Adolescents also needed education on risky sexual behaviour from an early age (Chapter 4, paragraph 4.2.5.1 and paragraph 4.2.5.4). Both educational support programmes included education with regard to risky sexual behaviour that may lead to HIV-infection (Chapter 2, paragraph 1.6, 6.3, 7.6, 9.1.1, 9.1.2, 10.1-10.7).

Adolescents needed to be educated about the use of male and female condoms (Chapter 4, paragraph 4.2.5.5). Both educational support programmes at the two community-based support structures did address the importance of condom use to enhance safer sexual

intercourse and to curb the spread of HIV infection (refer to Chapter 2, paragraph 2.3.1.4 no. 7.3, 10.5 and paragraph 2.3.2.4 no. 9.3). The use of male condoms during sexual intercourse was more emphasised than the use of female condoms.

Adolescents needed education with regard to human rights to speak up when their rights are being violated e.g sexual abuse, (Chapter 4, paragraph 4.2.6.2). The educational support programmes did address issues on human rights (Chapter 2, paragraph 2.3.2.4, no 1.10). Adolescents had to be educated to resist being sexually abused by family members or other people in the community.

The community-based educational support structures in Eersterust were thus seemingly striving towards a common goal (awareness and the curbing of HIV-infection among adolescents), although they functioned independently.

5.3.1 CONCLUSION

The above comparisons reveal that the community-based educational support programmes did address the HIV and AIDS educational needs of adolescents to a large extent. However, no specific provision was made in any one of the educational programmes to address skills needed to prevent HIV-infection. Yet the programmes might have indirectly addressed these skills through drama, debates, role-play and group discussions. This is viewed as a gap in the community-based educational support programmes that needs to be addressed in future. The community-based educational support programmes should also address the use of female condoms which could prevent adolescent girls from infection, for example during coercive sex and when men prefer unprotected sex.

The programmes are presented in the form of edutainment. Adolescents indicated that they enjoyed presentations by young presenters and the informal way of presentation of educational programmes. The fact that the adolescents mentioned that they would recommend the programmes to other peers is an indication that they benefitted educationally from the programmes.

It is unfortunate that only a few adolescents in Eersterust with such a high HIV-infection rate regularly attend the educational programmes. It seems as if one of the contributing factors for the high HIV-infections in Eersterust is not because of inadequate or insufficient community-based educational programmes, but rather because only a few adolescents attend the educational programmes.

5.4 FINDINGS BASED ON BRONFENBRENNERS ECOLOGICAL MODEL

Bronfenbrenner's ecological model contributes to an understanding of the socio-cultural environment of the developing adolescent by identifying five major structural systems and describing the nature of their interactions. The ecological model offers a useful framework for identifying appropriate interventions for adolescents with regard to awareness and the reduction of HIV-infection among adolescents.

The microsystem focuses on the developing adolescent's environment where a great deal of time is spent engaging in various activities and interactions. According to Bronfenbrenner, adolescents live in an interactive flow with their microsystem which includes family, school, peers and neighbourhood (Abrams *et al.* 2005). Adolescents are at a period of sexual awakening, learning and experimentation and need extensive help and support in making constructive use of their new-found powers (Kelly 2000). The study revealed that adolescents receive very little if any information from their parents or other adults with regard to HIV and AIDS or sexual and reproductive health issues. When the role of the parent in the socialisation of adolescents is diminished, they turn to their peers for information about sexually related matters. The peer group becomes increasingly central in guiding the further development of the adolescent. The possibility exists that adolescents may acquire inaccurate or misleading information. The study further revealed that large numbers of respondents were involved in hetero-sexual relationships at the age of sixteen with the knowledge of their parents. This can possibly be ascribed to the fact that parents may have open or don't care relationships with their children. Adolescents face the possibility that such relationships may become sexually related. Many of the respondents indicated that they do not worry how far they would go sexually with their partners which may give rise to unplanned sexual intercourse without realising the consequences of premature intimacy and HIV and AIDS.

The mesosystem provides the connection between the structures of the adolescent's microsystem, which includes the relation to family experiences, educational experiences, peer experiences and the experience with social institutions (Bronfenbrenner 1994). The academic relevance of institutions and how it impacts on the academic adjustment of the adolescent emerges from a particular academic background. The study revealed that HIV and AIDS educational programmes in schools do not adequately address the needs and problems of adolescents. Young people are not sufficiently educated to develop the necessary educational needs to manage their emerging sexuality responsibly. The adolescent's development regarding knowledge, skills, attitude and risky sexual behaviour is further affected by educators who are experiencing anxiety with regard to the possible

violation of sexual taboos and consequently offending parents. It seems as if the educational needs of adolescents are not being fulfilled or that the learners do not benefit from the educational opportunities offered in schools. In my view, it is necessary for schools and community-based educational support structures to collectively address the educational needs of adolescents with regard to HIV and AIDS. Effective community-based educational support programmes could be valuable in the sense that it can equip adolescents (including the out-of-school youth) with knowledge and skills to protect themselves against HIV-infection. The content of the community-based educational support programmes at both organisations includes interesting and entertaining activities that appeals to young people. It seems as if one of the contributing factors for the high HIV-infections in Eersterust is not because of inadequate or insufficient community-based educational programmes, but rather because only a few adolescents attend the educational programmes.

The exosystem focuses on how the adolescent and his microsystem are affected by the settings that although perhaps not directly involving the adolescent, have an impact on the adolescent's life (Abrams *et al*. 2005). The exosystem emphasises the context in which adolescents live with or without the support of the family with regard to relevant HIV and AIDS education or reproductive health information. The community and peer groups becomes the main source of information and an additional influence during adolescence. There is a relatively early departure of many young people from the educational system due to poverty and a lack of social and financial support. Adolescents become sexually active at an early age (around twelve years). Adolescents therefore need detailed education on HIV and AIDS at an early age. Lower levels of education can contribute to little or no knowledge with regard to awareness of effective measures to prevent HIV-infection. Due to the complexity of HIV and AIDS, the community under study should take ownership and create a sense of mutual responsibility in the fight against the further spread of HIV-infection particularly among the adolescents. The study revealed that the entire community (family, friends, school) does not play a pro-active role to encourage the adolescents to attend the educational programmes at community-based educational support structures. Adolescents who attend educational programmes are equipped with knowledge and decision-making, negotiation and communication skills to protect themselves against HIV-infection.

The macrosystem involves the broader cultural influences on the developing individual such as ethnic or religious values and peer group norms (Bronfenbrenner 1994). The macrosystem embraces the social interactions in relation to the adolescents' perceptions, thoughts, beliefs, attitudes and behaviour in response to the actions and feelings of others. Adolescents often believe that they are impervious to disease, accidents and death. According to UNAIDS 2000:40) *peer group norms gain relative power over familial norms*

during adolescence. Adolescents have an unfavourable perception of personal risk and do not immediately realise the threat of HIV and AIDS. The study revealed that adolescents displayed a laissez-faire attitude with regard to sexually related matters and therefore needed education regarding the invulnerability and consequences of HIV and AIDS. Adolescents have little insight into the consequences of their own actions and the consequences of engaging in risky sexual behaviour. They are inclined to consider themselves not vulnerable or immortal to HIV and AIDS. Adolescents in the study think that HIV and AIDS only happens to older people and that they can judge a person's HIV status based on his or her appearance. Social development pertains to the development of the adolescents' knowledge, skills, attitude and sexual behaviour for awareness and the reduction of HIV and AIDS. I am of the opinion that the educational programmes of community-based educational support structures can play an active role in educating young people, particularly the out-of-school youth. Based on how to conduct oneself in risky situations, adolescents can develop a self-protective attitude towards their peers. The study revealed that community-based educational support programmes do address the educational needs of adolescents to a large extent.

According to Bronfenbrenner (1994:40) a chronosystem *entails developmental timeframes pertaining to family structure, socio-economic status and living conditions in everyday life.* This study focused on the contemporary adolescents within the community of Eersterust. Many parents in Eersterust are subjected to long working hours on a daily basis. They often leave their homes very early in the morning and return late from their workplace in the evenings, leaving the children without supervision. This creates opportunities for adolescents to bunk school and host house parties with friends. These house parties are characterised by immoral behaviour such as excessive alcohol and drug abuse. Some adolescents may engage in sexual activities and in some instances, girls having consensual sex with more than one partner without the use of contraceptives. This behaviour of adolescents in the community under study makes them vulnerable to HIV-infection.

5.5 RECOMMENDATIONS

Based on the findings summarised in paragraph 5.2, I present the following recommendations concerning the existing community-based educational support structures:

5.5.1 Based on findings 6, 7, 27, 32, 34, 35, 36, 49, 50, 55 and 56, I recommend that adolescents attend educational support programmes to equip themselves with knowledge and skills to protect themselves against the potential dangers of HIV and AIDS. Community-based educational support structures as well as schools in

the community should make special efforts to encourage adolescents to attend educational support programmes.

5.5.2 Based on findings 1, 2, 3, 4, 5, 7 and 39, I recommend that successful educational preventative efforts must start early (e.g. 12 years) with HIV education being presented before the average adolescent encounters a first sexual experience.

5.5.3 Based on findings 8, 9, 10, 11, 12, 37, 38, 39, 40, 43 and 45, I recommend that adolescents should be taught skills to develop relevant competencies and to handle peer pressure and the prevention of HIV-infection.

5.5.4 Based on findings 13, 15, 16, 20, 21, 22, 23, 24, 25, 26, 28, 29, 33, 41 and 42, I recommend that adolescents be taught to understand what risky sexual behaviour entails and how to manage and avoid risky situations.

5.5.5 Based on findings 30, 31, 44, 48 and 52, I recommend that HIV and AIDS programmes in both schools and community-based organisations must place a greater focus on adolescence as a developmental phase and on a developmentally sensitive approach to sexuality education.

5.5.6 Based on findings 46 and 47, I recommend that young people become involved in programme design and delivery, including the promotion of peer education.

5.5.7 Based on findings 14, 17, 18 and 19, I recommend that adolescents be educated to develop a change in attitude with regard to the potential threat and consequences of HIV and AIDS.

5.5.8 Based on findings 8, 33, 34, 36, 37, 51, 53 and 54, I recommend that adolescents be educated on human rights issues.

5.5.9 Based on findings 20, 23, 38, 39, 40 and 41, I recommend that educational programmes educate adolescents on how to use condoms, particularly female condoms, to prevent HIV-infection.

5.6 RECOMMENDATIONS FOR FURTHER RESEARCH

In light of the findings in paragraph 5.2 and the recommendations in paragraph 5.4, I suggest that further research be undertaken in the following areas:

5.6.1 The determinants of sexual behaviour of adolescents and the influence of social and other community-related factors.

5.6.2 The potential effects of peer education on the knowledge, attitudes and behaviour of adolescents with regard to HIV and AIDS.

5.6.3 The consequences of early sexual involvement among adolescents/the implications of early sexual activity among adolescents /effects of premature sexual relationships among adolescents.

5.6.4 Factors influencing adolescents to become sexually active/reasons why adolescents become sexually involved.

5.7 POSSIBLE CONTRIBUTIONS OF THE STUDY

Community-based educational support programmes can play a pro-active role with regard to creating awareness and curbing HIV-infection among adolescents. In answering the primary research question, this study adds to the growing body of literature on how educational support programmes may contribute to and address the educational needs of adolescents with regard to HIV and AIDS.

In this study, HIV and AIDS-related educational needs of adolescents were determined, discussed and compared with two community-based educational support structures. In addition, I investigated the views of adolescents on their preference with regard to the mode of delivery and effectiveness of the two educational programmes. The interpretation of the experiences of the participants shed light on aspects surrounding the implementation of effective HIV and AIDS educational programmes. This study indicates that active involvement of adolescents in the preparation and planning of HIV and AIDS educational programmes could have a positive effect on the adolescents' views and understanding of HIV and AIDS.

It is my view that awareness of the HIV and AIDS educational needs of adolescents can aid effective educational programmes to curb the spread of HIV-infection among adolescents to a large extent. The views of adolescents with regard to the mode of delivery and effectiveness of educational programmes helped me to explore the potential efficiency of the programmes as well as the hindrances that may negatively influence programme delivery to adolescents.

I am also of the opinion that this study could contribute to the improvement of existing HIV and AIDS educational programmes at community-based educational support structures and may add value to the existing HIV and AIDS curriculum in schools. I am of the opinion that the outcomes of my study may directly appeal to prominent community members to become involved and enhance the effectiveness of community-based intervention initiatives.

5.8 POSSIBLE LIMITATIONS OF THE STUDY

Based on the fact that I entered the research field as an educator, I experienced distinct challenges. It was challenging to conduct research among learners and facilitating group discussions on a topic that is sensitive in nature and often avoided during discussions. Being aware that participants might not want to reveal information concerning sexually related matters, I spent much time in establishing rapport and building sound relationships of trust, prior to commencing with data collection.

To address the potential limitation of being influenced toward personal and biased findings, I constantly remained aware of the likelihood thereof by reflecting and asking myself: “Am I interpreting what the participants are telling me in an unbiased manner?” Upon completion of the interviews, I returned to the participants to confirm the outcomes in order to limit any subjectivity on my part and enhance the trustworthiness of the study. This served the purpose of member checking.

Another challenge and possibly a limitation with regard to the outcomes of the study is that the findings cannot be generalised to other communities since it is based on two case studies only. However, following the interpretivist stance I took, I did not aim to generalise my findings but rather to gain an in-depth view of the contribution of two educational programmes to awareness and the curbing of HIV-infection among adolescents in a specific community (Eersterust). The findings might possibly be transferred to communities characterised by similar circumstances, based on the knowledge of such communities and against the background of my description of the research context.

5.9 A FINAL WORD

At present, the challenge to curb the spread of HIV and AIDS among adolescents is relevant not only globally, but also on local ground and in local communities. I believe that continuous efforts must be made by communities in this area by for example relying on educational support programmes, especially in schools and at community-based educational support structures.

In this study I identified the educational needs of adolescents with regard to HIV and AIDS and investigated the adolescents' views with regard to the mode of delivery and effectives of existing educational support programmes in an attempt to curb the spreading of HIV-infection. By doing so, I believe that the study can contribute to the existing knowledge with regard to HIV and AIDS prevention.

My study demonstrates the potential value of educational support programmes at community-based educational support structures when facing the challenge of HIV-infection among adolescents. The views and opinions of adolescents may add value when attempting to improve such programme implementation at community-based educational support structures. As such, I believe that the findings of my study may result in a more effective implementation of the educational support programmes and positive behaviour change among adolescents.

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LIST OF APPENDIXES

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APPENDIX A

Permission to conduct research and informed consent

1. **Gauteng Department of Education**
2. **Principals of schools**
3. **Community-based educational support structures**

APPENDIX B

Covering letter and informed consent from the participants

APPENDIX C

Permission: Ethics Committee

APPENDIX D

Questionnaire

APPENDIX E

Transcripts of focus group 1 and 2

APPENDIX F

Excerpts from field journal