GRADE 12 LEARNERS’ PERCEPTIONS OF THEIR VULNERABILITY TO HIV-INFECTIONS: A STUDY IN THE EASTERN CAPE

by

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- All the participants for their cooperative responses and valuable comments towards the research.
DECLARATION

Student number: 4612-061-0

I declare that GRADE 12 LEARNERS’ PERCEPTIONS OF THEIR VULNERABILITY TO HIV INFECTIONS: A STUDY IN THE EASTERN CAPE is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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(Dr N Nyembezi) DATE

...............................................

06/04/2015
SUMMARY

The purpose of the study was to investigate Grade 12 learners' perceptions of their vulnerability to HIV infections in order to gain insight of their experiences on HIV and AIDS at schools in the Eastern Cape.

This was done by using a mixed method approach where focus-group discussions and questionnaires were used to gather data.

This study found that the teaching of HIV and AIDS or Life Skills is not adequate. It is possible that the lack of learner involvement in the design and implementation of the programmes could be one of the reasons why there is low participation by learners in intervention programmes in schools, as noted in this study.

There is need for strong advocacy on the use of condoms as a preventive measure against unwanted pregnancies, and sexually transmitted diseases (STIs) including HIV. More involvement in extra-curricular activities would help learners to develop self-esteem and the ability to resist drugs and other risky sexual behaviours.

Key terms

Grade 12 learners; perceptions; vulnerability; HIV-infections; adolescents.
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<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>AMD</td>
<td>Amathole Municipal District</td>
</tr>
<tr>
<td>DoE</td>
<td>Department of Education</td>
</tr>
<tr>
<td>ECDoe</td>
<td>Eastern Cape Department of Education</td>
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<tr>
<td>ECDSd</td>
<td>Eastern Cape Department of Social Development</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HIVvs</td>
<td>HIV Vulnerability Scale</td>
</tr>
<tr>
<td>HSRC</td>
<td>Human Sciences Research Council</td>
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<tr>
<td>LO</td>
<td>Life Orientation</td>
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<tr>
<td>NAC</td>
<td>National Aids Council</td>
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<td>NDoH</td>
<td>National Department of Health</td>
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<td>Unicef</td>
<td>United Nations International Children’s Emergency Fund</td>
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<td>UNISA</td>
<td>University of South Africa</td>
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CHAPTER 1

BACKGROUND AND RESEARCH PROBLEM

1.0 Introduction

HIV and AIDS are life-threatening diseases which are not curable yet, hence there is an urgent need for preventive measures to curb this pandemic. Getting to zero, new infections will require effective combination prevention: using behavioural, biomedical and structural strategies in combination, both intensively in specific populations in concentrated epidemics and across the whole population in generalised epidemics. Critical programmatic elements of prevention of the sexual transmission of HIV include behaviour change, condom provision, male circumcision, focused programmes for sex workers and men who have sex with men and access to antiretroviral therapy (UNAIDS 2012).

Young people are the most vulnerable globally (accounting for half of the new cases of HIV) and the greatest hope for turning the tide against HIV and AIDS (UNAIDS 2012). Therefore, their social and sexual behaviours will determine the future direction of the AIDS pandemic. These behaviours will depend largely on accurate knowledge regarding preventive measures, perceptions and attitudes towards HIV and AIDS.

(a) Worldwide programmes on HIV and AIDS

Worldwide Programmes on HIV and AIDS have been introduced in various countries including the following: In India, there is a Better Life Options Programme, which focuses on adolescent girls and empowers them through a holistic approach using life skills education that includes reproductive health, livelihoods and education (CEDPA 2001). Peru found a significant positive effect on knowledge in secondary school learners about HIV and sexuality from their skills based education programme on sexuality and HIV and AIDS prevention facilitated by trained teachers (Mangham & Hanson 2010).
(b) HIV and AIDS programmes in Africa

In Africa, Uganda’s life skills programme for both secondary and primary schools implemented in 1994 showed a reported fall of almost 50% in new infections in 15 to 19 year-old learners. In Zimbabwe, the AIDS Action Programme for Schools was initiated in 1992 with UNICEF (WHO 2006). The programme that targeted primary and secondary learners did not yield impressive results. Teachers were unfamiliar with participatory techniques and found it embarrassing to discuss HIV and sex.

Zambia, which is one of the affected countries, implemented the National AIDS Control Programme in 1992. This programme was introduced for all school children, teachers, and trainee teachers. It also covered peer-led education and anti-AIDS clubs. Increased awareness in Zambia of HIV and AIDS led to a decrease of HIV infections from 52% to 35% in 15 to 19 year-old learners from 1992 to 1998, in the number of sexual partners and in the proportion of young, unmarried women who are sexually active (WHO 2006).

In South Africa, the government’s Curriculum 2005 strategy includes the Life Orientation learning area programme that focuses on sexuality and relationships as well as improving life skills and general confidence (DoE 2007). Although there are numerous HIV and AIDS programmes in place, much still needs to be done as the youth still engage in risky sexual behaviour that exposes them to HIV infections.

1.1 Background to the study

As the world commemorates the 31st World AIDS day on 1st December 2013, South Africa is humbled by the sad reality that almost one third of pregnant women in South Africa are infected with HIV. About 11% of all South Africans are estimated to be infected with HIV (Karim 2013). Despite these sobering statistics, over the past few years South Africa had several commendable achievements that one could be proud of, in the fight against HIV and AIDS.

The past few years saw the completion of clinical trials that examined a range of new prevention strategies, including male circumcision, vaginal microbicides, vaginal diaphragms, and behavioural interventions. Unfortunately, only male circumcision showed effectiveness in preventing HIV infections (Navarro, Bekker, Darkoh, &
The recent rollout of circumcision services in KwaZulu Natal supported by the Zulu King is potentially important depending upon demand and any adverse impact it may have on male sexual behaviour (moral hazard), which could negate its benefits (Navarro et al 2010).

One of the prominent conclusions in South Africa from the Nelson Mandela Foundation/Human Sciences Research Council (NMF/HSRC) 2004/5 HIV prevalence survey was that, prevention programmes are not working well as expected (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste and Pillay 2008). The report found a high level of exposure to HIV and AIDS prevention campaigns, and concerning HIV prevalence and behavioural response it was clear that, in spite of massive investment, there has been insufficient progress in addressing HIV (Shisana et al 2008). Contrary to Shisana et al’s report, another research showed an incredible 60% decrease in HIV infections between 2005 and 2008 among women aged 15 to 24, offering hope for a big change in the South African epidemic. Still with an estimated 2.2 infections per 100 people a year in that same group, there is work to be done (Navarro et al 2010).

1.1.1 Conclusions drawn from the South African findings

According to the National Department of Health (2011) the estimated national HIV prevalence increased from 17.8 to 17.9% between 2009 and 2010, projected from the 15 to 49 year-old members of the general population. The antenatal 1st visit before 20 weeks rate has increased steadily since 2007/08, reaching 46.2% in 2013/14 which was close to the national average of 50%. However, it was still below the national target of 60%. The 2012 Antenatal Sero-prevalence Survey showed a fluctuation in HIV prevalence among antenatal clients over the past five years and was 31.5% in 2012, above the national average of 29.5%. The antenatal client initiated on ART rate improved significantly from 61.9% in 2012/13 to 89.4% in 2013/14, well above the national rate of 76.3%. Based on the National Health Laboratory Services data, the early infant HIV diagnosis coverage had increased from 79.2 % in 2012/13 to 110.9% in 2013/14. The value over 100% might have occurred because babies born in another district were tested in the Amathole District (Broumels 2014).
The HIV prevalence is increasing among women aged 30 and above, although the Millennium Development Goal 6, Target 7, indicator 18, states that countries should aim to halve the HIV prevalence among pregnant women in the 15 to 24 years age group. The HIV testing coverage of the population in the Amathole District municipality from age 15–49 years, at 33.8%, was the second best provincially and was above the national average of 22.8%. The male condom distribution coverage, which had been relatively static since 2009/10, grew to 17.1 condoms per male 15 years and older, but was still well below the national average of 27.9 condoms and the national target of 50 (Broumels 2014).

1.2 Problem statement

It is widely held that prevention programmes are not working as expected (Shisana et al 2005:136). Karim (2013) supports this view by arguing that, lack of knowledge of HIV status or denial of HIV status is a consequence of discrimination and social marginalisation, which continues to be experienced daily by people who are the most affected by HIV. Stigma contributes substantially through reluctance to test for HIV. HIV programmes are known to be concentrated in the cities and may not have reached rural settlements in many parts of Africa because of the limited access to radio and television, the main organs of publicity. Most of the vulnerable groups, except probably the city dwellers, may not have benefited from the enlightenment programmes. The wide publicity given to the use of condom has compromised traditional and religious values of promoting ‘no sex before marriage’ (i.e. virginity), ‘chastity in marriage’, and the role of the community and religious formations in the moral upbringing of the youths. The press that has presented abstinence as an impossible proposition has also not helped matters either. The pre-eminent premium placed on the use of condoms, therefore, appears misplaced and misleading. The current thinking that circumcision and minimization of concurrent relationships are keys to stemming the spread of HIV in Africa, while still promoting abstinence, faithfulness, and consistent and correct use of condom appears to be the way to go.

The high level of HIV infection in Africa, particularly Southern Africa, and the high cost of treatment mean that the rates of infection will increase unless effective prevention measures are employed. Any destruction of youths in schools by HIV infection constitutes a waste of investment in education and a challenge to the drive
to develop future manpower base for Africa and the society. There is no tertiary institution that would not have every sector of the society represented, either as students or workers.

In Nigeria, every graduate undertakes a compulsory one-year National Youth Service (NYSC) that takes each graduate away from his/her state of origin. If already infected while at school, s/he carries the infection along to wherever s/he serves. There is confounding evidence that university students are involved in unsafe sexual activities within a concurrent relationship and with very low perception of their vulnerability to STI and HIV infections. Okafor and Duru (2010) reported high level of sexual promiscuity among students of tertiary institutions in Imo State of Nigeria.

A study conducted by the Fort Hare Institute of Social and Economic Research (FHISER) (2007) showed an alarming report that many young people in the Buffalo City of Eastern Cape are engaged in risky lifestyle by choice. Their engagement in risky behaviour irrespective of their perceptions, peer pressure, and economic conditions might be the driver. The latter study revealed that a large percentage of youth continue to engage in risky behaviours like unprotected sex and having multiple sexual partners, despite the known threats posed by HIV and AIDS and other sexually transmitted diseases. This indicates that, despite high levels of awareness in the modes of HIV transmission and prevention among teenage learners, the majority of teenagers do not think that they are personally at risk.

The problem here is that, underlying factors are not known, which influence Grade 12 learners’ choice of indulging in risky behaviours that expose them to HIV infections. The researcher expects the findings of the current study to shed light on what can be done to reduce the Grade 12 learners’ vulnerability to HIV infections in the selected area in the Eastern Cape. Hence the study was set out to investigate the perceptions of Grade 12 learners of their vulnerability to HIV infections in order to gain insight and understanding of their experiences on HIV and AIDS in selected schools in the Eastern Cape.
1.3 Significance of the study

Knowledge gained from the current study could be used as a tool to make recommendations about HIV and AIDS. It could also enable Eastern Cape schools to implement policies, strategies and programmes that might help to reduce the prevalence of HIV and AIDS among Grade 12 learners. The findings of the current study could also provide a basis for implementing responsible sexual behaviour programmes in schools, and could serve to review the current health behaviour programmes offered in schools in the Eastern Cape.

The results of this study could influence behaviour changes among adolescents by advocating inclusion of AIDS messages in initiation ceremonies. The results of the current study could lead to the development of programmes to revitalise sex education, sensitisation, redirection, strengthening, and provision of sexual information to sustain the motivation of the secondary school health programmes in Butterworth.

The findings of this study will be made available to the Eastern Cape DoE. Policymakers may use knowledge gained from the current study in order to come up with policies that will encourage young people to practise safer sex. The results may also help training institutions for health care providers to incorporate the findings in their training curriculum.

1.4 The Purpose of the study

The aim of this study was to investigate the perceptions among Grade 12 learners of their vulnerability to HIV infections and to gain insight into their experiences of HIV and AIDS in selected schools in the Eastern Cape.

1.4.1 Objectives of the study

To realise the aforementioned aim of the study, the following research objectives were addressed:
- To examine the Grade 12 learners’ knowledge on HIV and AIDS.
- To explore the perceptions of Grade 12 learners, of their vulnerability to HIV infections.
• To determine the attitudes of Grade 12 learners, towards the vulnerability of contracting HIV.
• To identify the perceptions of Grade 12 learners on the effectiveness of the available intervention strategies in school in reducing HIV infections.
• To establish the perceptions of Grade 12 learners, on what needs to be done to reduce their vulnerability to HIV infections.

1.4.2 Research questions

Drawing on the objectives of the study, the key research questions were formulated as follows:
• What do the Grade 12 learners know about HIV and AIDS?
• What are the perceptions of Grade 12 learners of their vulnerability to HIV infections?
• What are the attitudes of Grade 12 learners towards the vulnerability of contracting HIV?
• How do the Grade 12 learners perceive the effectiveness of the available intervention strategies at school in reducing HIV infections?
• What are the perceptions of Grade 12 learners on what needs to be done to reduce their vulnerability to HIV infections?

1.5 Area of the study

The study was undertaken in the townships of Butterworth in the Eastern Cape, where Grade 12 learners’ perceptions of their vulnerability to HIV infections were studied. The two schools targeted were township Senior Secondary Schools that had HIV intervention programmes in place. Butterworth is a diverse town with diverse cultures living side by side, but it has not always been like that. The local economy faces high unemployment and the principal employer in the area is the Government sector, while manufacturing is identified as a steadily declining employment sector (Mnquma Municipality 2013). In Butterworth, there are about half a million people living in the area. Differences in economy, gender, and class are clearly visible. On quality of Life, Mnquma scores well below the Provincial average in terms of access to water, electricity, sanitation and refuse services, as well as to health services.
The city spreads from homeless people via townships to rural areas and one shopping mall for the community opened in November 2012. The participants in the study come from such diverse backgrounds and both schools where the study was done cater for all these types of learners. The researcher has lived all his life in the area since 1972 until now, and has experienced staying there as a person.

1.6 Definition of central terms

(a) Vulnerability to HIV

Swartz, de la Rey and Duncan (2004:409) define vulnerability as “susceptibility to negative outcomes under conditions of risk.” The concept of vulnerability, as used in this study, is similar to what De Guzman (2001:665) describes as “social vulnerability”. De Guzman recognises that individuals are at risk due to their social positions and not simply as a result of sexual behaviour. Furthermore, De Guzman posits that social vulnerability recognises that individual behaviour is governed by societal and cultural norms and that, while individual knowledge, attitudes, and beliefs may affect behaviour, these are mediated by relationships with others.

(d) HIV intervention

At the root of all preventative programmes is the saying that “prevention is better than cure”. Prevention is a construct related to intervention. Gibson and Mitchell (2003:367) define prevention as “an effort that seeks to avoid the occurrence of something undesirable - the prevention of that which threatens life or healthy living”. NAC (2003:23) defines interventions as “any approach or strategy used to support an individual’s ability to adopt or maintain new behaviour”.

(e) Semi-urban area

A semi-urban area is a community that has some characteristics of a town or city, but dominated by a rural economy and population (AMD 2007).
(f) Grade 12

The Grade 12 class refers to the class of 16 and 17 year-old learners in the Further Education and Training Phase. It is regarded as the last grade before Higher Education (DoE 1995).

(g) Perceptions

Lewis (2001) refers to perceptions as the process by which individuals organise and interpret their sensory impressions in order to give meaning to their environment. Because each person gives his or her own meaning to stimuli, different individuals will 'see' things in different ways.

1.7 Chapter outline

1.7.1 Chapter 1

Background and Research Problem

Chapter 1 provided a historical background to the study, the statement of the problem, an indication of the objectives, research questions, and significance of the study, assumptions and the scope of the study. A section dealing with terminology concludes the chapter.

1.7.2 Chapter 2

Literature Review and Theoretical Framework

Chapter 2 provides an overview of the literature study, the theoretical framework on which the study is based and the concepts that are used in the research are investigated in order to assess where we stand in relation to local and international trends.

1.7.3 Chapter 3

Research Methodology

Chapter 3 contains a discussion of the methodology used in this study in order to determine Grade 12 learners’ perceptions of their vulnerability to HIV infections in two Eastern Cape schools. The methodology, the research instrument, the research
process, issues of trustworthiness and ethical considerations are also described in this chapter.

1.7.4 Chapter 4

Data Analysis and Discussions

Chapter 4 focuses on the analysis of the research results from the interviews and questionnaires. The findings from the interviews are explored according to the major themes, which emerged, in which the research participants’ descriptions are central. The psychological challenges connected to daily problems experienced by the interviewees in their daily lives are discussed. In addition, the Likert scale results are analysed using frequencies and percentages. The social challenges resulting from moral pressure and the impact of the psychosocial challenges among Grade 12 learners concerning their vulnerability to HIV infections are examined. The coping mechanisms established or needed are explored.

1.7.5 Chapter 5

Summary of Findings, Conclusions and Recommendations

Chapter 5 contains a reflection on the completed research process, giving a summary of the main facts found in the literature review and the main findings of the empirical study. Conclusions are drawn and the limitations of the study are pointed out. Recommendations are made based on analysed and interpreted data, which is helpful to the learners in preventing HIV infections.

1.8 Summary

This chapter outlined the general orientation of the study. The introduction and background to the problem together with the problem statement, the purpose, significance, and objectives of this study were presented. The research questions were stated, and operational definitions were provided so that clear demarcations are set for the study. In the next chapter, a more in-depth discussion of the literature and theoretical framework follow.
CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Introduction

The aim of this chapter is to describe the context in which the movement towards the development of HIV intervention programmes in South African schools has taken place. This chapter also looks at the literature and the theory that informed the shift from a biomedical to the societal context of sexual behaviours versus HIV and AIDS.

2.1 Context of HIV and AIDS in the Eastern Cape

The Eastern Cape Province has a population size of approximately 7 million, representing 16% (third largest) of the South African population (ECSECC 2012). The non-urban population amounts to nearly 4 100 000, and dense concentrations of rural and peri-urban settlements occur in other districts and areas (ECSECC 2012). The Eastern Cape is one of the provinces with the highest levels of poverty, underdeveloped infrastructure, and unemployment (Eastern Cape Department of Social Development 2004). In 2010 The Eastern Cape provincial HIV prevalence amongst women was 29.9% (95% CI: 28.2–31.7). The estimated overall HIV provincial prevalence in this province has increased by 2.3% from 27.6% in 2008 to 29.9% in 2010 (NDoH 2011).

In 2010 there were four districts in the Eastern Cape that recorded HIV prevalence above 30%. Only one district i.e. Cacadu where the HIV prevalence decreased from 24.3% in 2009 to 20.7% in 2010. The decreased HIV prevalence in Cacadu district is encouraging; however the sample size is too small to draw any statistical conclusions in the trends recorded in Table 1.
Table 1: HIV prevalence among antenatal women by district in the Eastern Cape, 2008 – 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>95% CI</td>
</tr>
<tr>
<td>Alfred Nzo</td>
<td>201</td>
<td>29.8</td>
<td>22.3 – 38.6</td>
</tr>
<tr>
<td>Amathole</td>
<td>1,128</td>
<td>26.5</td>
<td>23.0 – 30.3</td>
</tr>
<tr>
<td>Cacadu</td>
<td>281</td>
<td>23.8</td>
<td>17.7 – 31.2</td>
</tr>
<tr>
<td>Chris Hani</td>
<td>529</td>
<td>27.0</td>
<td>22.9 – 31.5</td>
</tr>
<tr>
<td>N.M.M.</td>
<td>795</td>
<td>29.0</td>
<td>23.4 – 35.4</td>
</tr>
<tr>
<td>ORTambo</td>
<td>1,063</td>
<td>29.6</td>
<td>26.2 – 33.2</td>
</tr>
<tr>
<td>Joe Gqabi</td>
<td>219</td>
<td>21.9</td>
<td>15.2 – 30.5</td>
</tr>
</tbody>
</table>

Source: Antenatal Sentinel HIV Survey, National Department of Health

N = Realised sample; CI = Confidence Interval.

The HIV prevalence in Joe Gqabi district significantly increased, by 8.3%, from 21.9% in 2008 to 30.2% in 2010. The O.R. Tambo district HIV prevalence rate slightly increased from 29.6% in 2008 to 31.5% in 2010, and for Chris Hani it increased from 27.0% in 2008 to 30.1% in 2010, which is nearly equal to the national overall prevalence of 30.2%. Alfred Nzo, Amatole and Nelson Mandela Metro recorded increased HIV prevalence in 2010 than 2009 (Table 1).

The high levels of people who take Nevirapines in Butterworth where the research took place might also be a contributing factor to a lesser number of AIDS related deaths as illustrated on Table 1. In 2009, the Eastern Cape provincial HIV prevalence amongst 15 to 49 antenatal women was 28.1%. The overall HIV provincial prevalence in this province has increased from 27.6% in 2008 to 28.1% in 2009. In 2010, the Nelson Mandela Metro was the highest municipal district to record HIV prevalence at 31.6%, see Table 1 (NDoH 2011).
Figure 1: HIV prevalence by district, South Africa 2012

The statistics in Table 1 and Figure 1, portray a picture of what has been happening in the Eastern Cape particularly the high levels of vulnerability of the youth within the province compared to the national average. In Figure 1, the HIV prevalence is between 10 - 12 percent in the Amathole district where the study was conducted. These levels are due to poor socio-economic conditions that prevail in the province and that makes the youth to be vulnerable to HIV infections (ECSECC 2012).
2.1.1 Risk behaviour among the Grade 12 learners in the Eastern Cape

The national household study conducted by the National Department of Health (NDoH 2007:25) found that in South Africa, the Eastern Cape youth indulge in the following risk behaviours:

### 2.1.1.1 Concurrent partnerships

Sexual partnerships, which overlap, or are conducted over the same period, greatly increase the risk of HIV infection. Nine percent of young women reported concurrent partnerships in the preceding month, compared to 4% nationally. Concurrency among young men was similar to national levels (13%).

### 2.1.1.2 Sexual debut

Delaying the age at which young people start sex is an important factor in HIV prevention. However, young people in the Eastern Cape were discovered to have sex at a younger age than their national counterparts, with the mean age of sexual debut for males around 16.4 years and of females, 17 years. Sexual debut is at an earlier age (15 years) in urban informal areas than other areas.

### 2.1.1.3 Condom use

Similar to the other provinces, condom use was highest among the 15 to 24 year-old youth (88% of males and 78% of females), and declined with increasing age. Both women and men in all age groups reported higher condom use (69% and 76% respectively) than the national average (65% and 57% respectively). However, fewer young women used condoms specifically to prevent HIV (35%) than young women nationally, (38%) did.

### 2.1.1.4 Exposure to AIDS communication programmes

There were high levels of exposure to AIDS communication programmes on television: Soul City television series (65%), Tsha Tsha (46%), and loveLife adverts (67%). Exposure to radio programmes was slightly higher than the national average, especially for Soul City radio (46% compared to 36%), and loveLife radio adverts (59% compared to 57%). Forty percent of listeners were exposed to Khomanani
adverts, which was lower than the national average of 47%. Despite the low reach of newspapers and low education levels, one third of the population had access to Khomanani pamphlets.

This study sought to explore how the Grade 12 learners perceive their vulnerability to HIV-infections. This was done by exploring their perceptions on HIV and AIDS and their vulnerability to HIV infections through their everyday experiences. The study was conducted in the semi-urban area of Mquma Municipality in a town called Butterworth. This municipality falls under the bigger Amathole Municipal District (AMD), which is made up of five local municipalities (Mquma, Buffalo City, Mbhashe, Amahlathi and Nkonkobe). Table 2 paints a picture of what the HIV prevalence rate was in Amathole Municipal District in 2007.

**Table 2. HIV Prevalence in Amathole Municipal District (2007)**

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>AMAHLATI</th>
<th>BUFFALO CITY</th>
<th>MBHASHE</th>
<th>MNQUMA</th>
<th>NKONKOBE</th>
<th>AMD TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV test rate</td>
<td>58.97</td>
<td>87.03</td>
<td>69.18</td>
<td>85.16</td>
<td>82.28</td>
<td>79.84</td>
</tr>
<tr>
<td>People living with HIV</td>
<td>21.89</td>
<td>34.83</td>
<td>26.74</td>
<td>26.10</td>
<td>23.96</td>
<td>29.96</td>
</tr>
<tr>
<td>Nevirapine Uptake</td>
<td>27.50</td>
<td>13.74</td>
<td>51.96</td>
<td>63.68</td>
<td>29.41</td>
<td>43.68</td>
</tr>
<tr>
<td>Transmission Rate</td>
<td>14.14</td>
<td>15.27</td>
<td>8.22</td>
<td>18.37</td>
<td>23.36</td>
<td>15.95</td>
</tr>
</tbody>
</table>

**Source:** District Health Information System (2007) (Amathole Health District)

From Table 2, one could notice that the Mquma municipality where the study took place had the highest nevirapine uptake and the second highest transmission rate in the region. As an intervention method to reduce the impact rate of HIV and AIDS, awareness programmes are being undertaken on an on-going basis. There are programmes such as integrated nutrition programme, community based care and capacity building for community health workers. The HIV control programmes include coordination of HIV and AIDS activities, production and dissemination of information, distribution of nutritional and therapeutic supplements and replenishing of community health worker home-care kits. If HIV intervention programmes could be intensified at
senior secondary school level including grade 12 learners, the HIV transmission rate and nevirapine uptake in Table 2 would decrease.

Some efforts were initiated by health care providers to create awareness on voluntary testing and counselling. Mbhashe Local Service Area launched a community based voluntary counselling and testing programme. Generally, the HIV test rate has improved and this indicates that communities have adopted more of a health-seeking behaviour (AMD 2007).

In relation to the study, the above background gives a foundation on which to build and strengthen support for secondary school learners. The learners’ mind-set (in terms of knowledge, attitudes, and perceptions) still needs to be changed if one wants to reduce the high levels of HIV prevalence in the Eastern Cape Province.

2.2 Contextual factors and learners’ vulnerability

The following subsections discuss several factors that contribute to Grade 12 learners’ vulnerability to HIV infections, i.e. emerging sexuality and lack of control, learners’ perceived invulnerability to HIV, peer pressure, economic and social contextual factors, cultural practices, gender disparities in sexual activities, gender-based violence, the influence of alcohol and drug use, the influence of the media and unreliable sources of information like peers on social networks. These are discussed drawing on literature from both South Africa and other countries.

2.2.1 Emerging sexuality and lack of control

In this study, the adolescents are at the centre of the exploration of vulnerability to HIV infections. For adolescents whose sexuality is still developing, self-control often becomes a problem; causing them to indulge in unplanned sexual activities, perhaps due to being excited (Kadzamira, Maluwa-Banda, Kamlongera, and Swainson 2001). For example, in Malawi Kadzamira et al (2001) found that lack of restraint was one of the factors causing adolescent learners to engage in high risk sexual activities. In Zimbabwe, Wekwete and Madzingira (2005) found that most girls engaged in unintended or unplanned sex and cited reasons such as that ‘it just happened’, or that ‘I was forced’ or that ‘it was to show love to a partner’. The study further found
that girls who had never had sex before were more likely to have high self-efficacy in refusing sex compared with the sexually experienced. However, this spontaneous sexual activity is not a universal phenomenon.

2.2.2 Learners’ perceived invulnerability to HIV

In South Africa, Hartell (2005) conducted a comprehensive analytical review of available research concerning sexual behaviour of adolescents. He, among others, concluded that few adolescents perceive themselves to be at risk and, consequently, few take the need for safer sex seriously because they do not see AIDS as a personal threat, even though most adolescents acknowledged the severity of the disease. Another qualitative study in South Africa done by Steyn, Myburgh and Poggenpoel (2005) involves male learners from grades 9 to 11 between the ages of 15 and 17; who come from a multi-cultural school in South Africa; and who have been exposed to a life skills programme including HIV and AIDS awareness. The study found that while these learners were aware of the consequences of unsafe sex; they were noncommittal about susceptibility to the disease and shifted the blame onto girls.

However, some studies, as noted by Rodham (2002) and cited in Lerner (2005) have dispelled the notion of adolescent invulnerability as the cause of risk-taking behaviour. They argue that there is little empirical evidence to support the role played by feeling invulnerable in the relatively high level of adolescent risk-taking. Moreover, it is further argued that a feeling of invulnerability is not unique to adolescents alone, many adults harbour similar feelings (Bishop-Sambrook, 2003).

2.2.3 Peer pressure

The influence of peers during adolescence is so great that youths conform to group norms to become part of a group even if such behaviour is detrimental to their well-being. Zwane, Mngadi and Nxumalo (2004) conducted a study in Swaziland to explore adolescents’ views regarding risky behaviours. Among other things, their study established that adolescents have low risk perceptions of the disease and engaged in risky sexual behaviours, which they also attributed to peer pressure. In relation to condom use, participants believed that condoms are for prostitutes or
those who have casual sex partners or engage in extramarital sex. Their study further found that the participants, whose friends had sexual intercourse and never used condoms, were three times more likely than their peers to demonstrate risky behaviour.

In the United Kingdom, Rodham, Brewer, Mistral, and Stallard (2006), did a qualitative study in selected schools in the Bath and North East Somerset Local Education Authority to identify what adolescents perceived to be risky behaviour and to explore factors they felt influenced their decisions to engage in or avoid risky health behaviours. Using focus group discussions (FCDs) with single sex groups, the study established that adolescents believed they had control over their decisions whether or not to take part in risky behaviour, but that, sometimes, situations in which they found themselves made them decide to engage in a particular risky behaviour because of lifestyle choices. They mentioned the need to fit in with a group and be accepted by them, hence the risky behaviour even if they did not want to engage in it.

While most qualitative studies have reported peer pressure, the research of Sieving, Eisenberg, Pettingell and Skay (2006) yielded very different findings. They conducted a longitudinal study in the US between 1994 and 1995 involving approximately 90,000 learners of grade 7 to 12 to examine forms and pathways of friends’ influence on adolescents’ sexual debuts. The assumption of the study was that individuals are especially motivated to adopt attitudes and behaviours of others with whom they have strong social bonds; such as their immediate circle of friends. A questionnaire was administered to respondents and the data analysed using multivariate models and chisquare tests. The results indicated that there was no significant relationship between friend variables (proportion of friends who were sexually experienced, friends’ attitudes about sex, and perceived respect from friends for having sex) and adolescent sexual initiation. The study concluded that peer influence on adolescent sexual debut was insignificant.

2.2.4 Economic and social environment

The practice of transactional sex does not take place between girls and “sugar daddies or mummies” only; it also takes place among adolescents themselves. In a multi-country study that involved Malawi, Burkina Faso, Ghana, and Uganda,
transitional sex between girls and sugar daddies and among adolescents as well has been noted (Amuyunzu-Nyamongo, Biddlecom, and Ouedraogo 2005). The expectation of transactional sex is that once a girl receives money or gifts from a man or boy, she owes him something in return, normally sex or the promise of having sex in the future. Girls, in turn, expect money or material goods from their male partners for having sex with them. The practice of transactional sex puts all parties involved at risk of contracting HIV, because, as was observed in the same study when a girl has received money or gifts from her partner, she finds it difficult to negotiate condom use (Amuyunzu-Nyamongo et al 2005).

2.2.5 Cultural practices and beliefs

Cultural practices have been seen to render people of all ages vulnerable to HIV infections but as the discussion that follows illustrates, Grade 12 learners are specifically vulnerable. Learners in South Africa get a great deal of sexual knowledge, including knowledge about sexual practices, through various cultural practices. However, some cultural practices and beliefs have been blamed for the spread of HIV. Mugambe (2006:73) defines culture as “the totality of socially transmitted behavioural patterns, arts, beliefs, institutions and all other products of human work and thought”. In South Africa, initiation rites, polygamy, the use of a surrogate husband, wife inheritance, and funeral cleansing have been blamed for promoting the spread of HIV.

Research seems to point to the fact that the circumcision of males reduces their chances of HIV infection. For example, it has been observed that in cultures with high rates of circumcision, HIV infection rates are low (Navarro et al 2010). Voluntary Medical Male Circumcision (VMMC) is being scaled up in the country because it has been shown to be partially effective in reducing HIV infection among males. The South African government introduced the VMMC policy and programme in 2010 with a target of reaching 80 per cent of HIV-negative men aged 15–49 years by 2015 or 1.6 million men as recommended in the 2012–2016 NSP (SANAC 2011a). However, it has been estimated through mathematical modelling that 4.3 million VMMCs are needed in South Africa to achieve 80% male circumcision by 2015 which could avert more than 1 million HIV infections between 2011 and 2015 (HSRC 2014).
Furthermore, studies carried out in Uganda and Kenya support this proposition (Mugambe 2006). However, they caution that further studies should be done before this practice can be used universally. Initiation rites are meant to build character but as Munthali, Chimbiri, and Zulu (2004) have observed, they are also known to encourage early sexual debut. For example, among the Xhosa tribe of the Eastern Cape, young men from the initiation school are encouraged to experiment with sexual intercourse through a practice known as “Ukosula” (removing dust).

Graduating from girl’s initiation schools called “Intonjane” also poses its own problems as new initiates are seen to be elevated on the social ladder and are expected to be women who are ready to marry, yet they are still at school. This, as Kuthemba-Mwale, Hauya, and Tizifa (1996) observed, works in sharp contrast to the schools’ expectations, where they are still treated as children. This newly found social status encourages early marriages and premarital sexual practices to reinforce lessons learnt at the ceremonies, all of which put learners at high risk of contracting HIV.

However, if properly handled, initiation rites can be used as a vehicle to introduce behavioural change. Initiation rites offer a useful opportunity for intervention programmes, where not only information about HIV and AIDS can be introduced, but also sexual negotiation skills can be imparted. Groce, Mawar, and Macnamara (2006) argue that it is possible to influence behaviour changes among adolescents by including AIDS messages in initiation ceremonies.

### 2.2.6 Gender disparities in sexual activities

Unequal power relations between men and women render women, especially young women, vulnerable to coerced or unwanted sex and consequently to HIV infections. Extra-marital and multiple sexual partners are considered the norm for men but not for women. Society accepts multiple sex partners as an expression of male sexuality and masculinity (Ntata 2005, as cited in Tiessen 2005).

Some initiation rites tend to encourage sexual activities in adolescents. In South Africa and Swaziland, the stress is in ensuring the virginity of girls’ readiness for marriage. This practice has its own drawbacks. The practice of virginity testing of
young women, particularly in KwaZulu-Natal (also known as the “reed dance” in Swaziland) which is in part a response to the high rates of teenage pregnancies, STIs and HIV and AIDS, may increase young women’s vulnerability to HIV. Girls identified to be virgins may fall prey to sexual assault by men and boys who falsely believe that having sex with a virgin can cure AIDS. It is further argued that the practice reinforces gender inequalities, as there is no parallel practice for their male counterparts (Karim 2005).

2.2.7 Gender-based violence

Gender-based violence is a universal problem manifested in various ways. It remains an additional challenge in the efforts to stop the spread of HIV and AIDS throughout Africa and in South Africa, and accounts for a large proportion of HIV infections (UNAIDS 2004, as cited in Tiessen 2005). In a number of studies gender disparities noted in the preceding section have been associated with gender violence where a girl child has been the victim of rape or coerced sex.

It has further been observed that long distances between the home and school, which learners cover every day, is another contributing factor. Learners risk sexual harassment on their way to and from school. Kelly (2003) further argues that boarding schools, which are meant to solve the problem of distances from schools, do not seem to offer a solution either as learners find opportunities to have sex with residents from the surrounding areas, fellow students, or even teachers.

In the school context, the following were highlighted: girls having sexual relationships with teachers under coercion; teachers and peers raping school girls; and parents encouraging or forcing their daughters to have sex with teachers in the hope that teachers would marry them once they become pregnant or financially compensate them.

2.2.8 The influence of alcohol and drug use

The issue of risky sexual behaviour which is linked to drugs and alcohol is argumentative as some research indicate a link and others not. Risky sexual behaviour by Grade 12 learners has been associated with the use of alcohol or drugs because excessive consumption of the latter leads to distorting of
consciousness and poor judgement in decision-making. It can also lead to a lower level of ability to negotiate condom use. For example, in Sri Lanka, Pereira and Reece (2006) did a study of secondary school learners, which aimed to explore the relationship between alcohol and drug use and risk-taking behaviour. Among other findings, the study showed that alcohol and drug use were predictors of unplanned sexual activities and pregnancies.

The findings by Christofides et al. (2014) suggest that behavioural factors may be important in the increased risk of incident HIV, adding to the results of earlier studies that suggest that higher transmission in pregnancy is biological and the result of hormonal changes during pregnancy. Early adolescent pregnancy was associated with higher lifetime partner numbers and subsequently having a partner who was four or more years older. Although this analysis was exploratory, these findings suggest that early adolescent pregnancies were followed by different risk behaviour than that among young women who had a pregnancy between the ages of 16 and 18 years and the younger adolescents. Further research is required to investigate the pathways through which early adolescent pregnancy increases the risk of subsequent HIV infection.

2.2.9 The influence of the media

In South Africa, the TV soap opera Soul City, which dealt with HIV and AIDS and issues of domestic violence, has brought about social policy change. Another initiative is the “Love-life” series, a national HIV and AIDS prevention programme which targeted youth between 12 and 17 years through television, radio, and print to bring about awareness. It had reached about 85% of the young people but whether or not the South African initiatives have had any positive impact remains to be seen (Global AIDS Link 2007:8).

The role of the media in addressing HIV and AIDS issues has however, received mixed reactions from the public. While the literature on the media and adolescent sexual behaviour indicate that the media, especially television, plays a powerful role in influencing teenage sexual attitudes, values and beliefs, its actual impact raises serious doubts. These media are often associated with sex, humour, and excitement, but the dangers of unprotected sex are rarely illuminated on television, especially soap operas, sex between unmarried partners is commonly portrayed, but the virtues
of abstinence rarely encouraged (Steven & Miriam 1995). This observation is shared by WHO (1993) which states that adolescents are, enticed by the mass media, under constant social pressure to experiment with sex which is in complete conflict with the traditional religious and societal expectations for chastity (cited in Zwane et al 2004).

However research shows that not all adolescents interpret the media in the same way, nor are they equally susceptible to sexual suggestiveness. WHO (2006) argues that, if properly utilised, the mass media has the potential for reaching Grade 12 learners with educational HIV and AIDS messages, since they are attuned to the mass media for information.

2.2.10 Unreliable sources of information

While life skills lessons emphasise skills in self-awareness and self-control, initiation rites encourage experimentation with sex. They also get conflicting messages about condom use as a means of practising safe sex; some sources say the condom is not 100% perfect, while others say it is better than having unprotected sex (Kadzamira et al 2001). In South Africa too, Hartell (2005) found that learners received conflicting messages about sex and sexuality and that they lack the knowledge, confidence, and skills to discuss sexual issues, including contraception and prevention of infections. Hartell further argues that most learners make decisions about sex in the absence of accurate information.

Condoms, both male and female, are currently the only available and most effective technology to prevent HIV and other sexually transmitted infections (STIs), as well as unintended pregnancies, among sexually active people. They are inexpensive, costeffective, their use does not require assistance of medical or healthcare personnel, and they can be utilised by anyone who is sexually active (HSRC 2014). Correct and consistent use of condoms is an integral component of combination HIV-prevention strategies that individuals can choose at any time in their lives to reduce risks of sexual exposure to HIV and other STIs, or as a dual protective method used for also preventing pregnancy among women.
2.2.10.1 Learners’ perceptions and their knowledge about HIV and AIDS

According to Moodley and Phillips (2011), HIV and AIDS education at schools has increased the knowledge base of learners who now appear to be more sympathetic to those learners infected with HIV and/or affected by AIDS. The study demonstrates an increase in responsible sexual behaviour like safer sex, abstinence, and increased condom use by learners Moodley and Phillips (2011). It concludes by saying that the implementation of the Grade 8 HIV and AIDS education programmes has substantially increased the acquisition of the necessary knowledge of learners to prevent HIV infections, which has influenced learners’ attitudes toward risk behaviour in a positive way. What is unknown is how long such attitudes can be sustained.

Taylor, Jinabhai, Dladla, Rangongo & Connelly (2000) conducted research with a group of learners and concluded that learners generally experience negative feelings towards fellow learners infected with HIV, whom they believe could be identified by the visual presence of lesions or sores. Fear of contracting HIV could result in negative attitude towards persons who are perceived as HIV positive and thus capable of transmitting the virus. Once again, an educator as a facilitator of learning has an important role to play in developing positive attitudes to HIV and AIDS and in establishing a learning environment that is free of discrimination, prejudice, and stigma. Therefore, educators have to move beyond the four walls of the classroom in order to ensure that ‘caring’ is not just a verbal exercise but indeed a visible performance.

Robertson and Richards (2003) argue that it is impossible to think about how people can have an identity without being excluded or marginalised among certain groups with different identities. Racial, religious, cultural and gendered biasness need to be addressed as issues of significance since these are factors that reinforce the concept of ‘other’ and which could lead to prejudice and discrimination of those People Living with HIV and AIDS (PLHIV). Thus, educators play an important role in imparting unbiased and correct information to learners.

2.3 Theoretical framework

This study is informed by the Theory of Planned Behaviour (TPB).
While there are several versions of the Social Learning Theory (SLT) to which researchers currently subscribe, they all share three basic tenets (Jones 1989).

**Tenet 1:** Response consequences (such as rewards or punishments) influence the likelihood that a person will perform a particular behaviour again in a given situation.

**Tenet 2:** Humans can learn by observing others, in addition to learning by participating in an act personally.

**Tenet 3:** Individuals are most likely to model behaviour observed by others they identify with.

### 2.3.1 Theory of Planned Behaviour

Ajzen (1991) proposed the Theory of Planned Behaviour by adding perceived behavioural control (PBC) to the theory of reasoned action in an effort to account for factors outside a person’s control that may affect his/her intentions and behaviour. The extension was based on the idea that behavioural performance is determined by motivation (intention) and ability (behavioural control). According to Ajzen, actual behavioural control should be distinguished from perceived behavioural control. The latter, which is what distinguishes the theory of planned behaviour from the theory of reasoned action, refers to people’s perception of the ease or difficulty of performing a given behaviour.

Montano and Kaspyzyk (2002) regard perceived behavioural control as being similar to Bandura’s concept of self-efficacy, which refers to an individual’s judgement of how well he can perform a behaviour under various conditions. While Azjen (1985) and Ajzen and Madden (1986) do not make a conceptual distinction between perceived behavioural control and self-efficacy, Terry and O’Leary (1995) do. Their view is that people’s perception of how much control they have over whether they perform a behaviour (a measure of perceived control) is different from their assessment of how easy or difficult it will be for them to perform that behaviour (a measure of self-efficacy). Terry and O’Leary draw heavily from Bandura’s (1977; 1982) social cognitive theory of behaviour change, which advocated for a distinction between the notions of self-efficacy and perceived control.
Bandura (1977; 1982) proposed that there are two types of expectancies that influence people’s decisions to engage in a particular behaviour. These are efficacy expectancies and outcome expectancies. Efficacy expectancies refer to people’s confidence in their ability to perform a behaviour. Thus, people have positive efficacy expectancies if they are confident in their ability to perform a behaviour, which, in turn, motivates them to carry out the behaviour. On the other hand, people may be reluctant to engage in a behaviour if they doubt their ability to perform it (a negative expectancy scenario). Outcome expectancies refer to people’s perception that the performance of a behaviour will lead to a desired outcome. Thus, people will be reluctant to perform a behaviour if they believe that the performance will not result in a desired outcome (a negative outcome expectancy). A positive outcome expectancy will result in motivation to engage in a behaviour. Using Bandura’s conceptualisation, Terry and O’Leary (1995) propose that perceived behavioural control and self-efficacy be measured separately in research on the relationship between intentions and behaviour.

Ajzen (1985), in an attempt to emphasise the distinction between the theory of reasoned action and the theory of planned behaviour, suggests that intentions can only be expected to predict a person’s attempt to perform a behaviour, not necessarily its actual performance. In trying to predict behaviour, one would have to not only assess intentions, but also obtain an estimate of the extent to which individuals are apt to exercise control over the behaviour in question. This implies that the harder the person tries, and the greater his/her control over personal and external factors that may interfere with his/her behavioural goal, the greater the likelihood that he/she will achieve his/her behavioural goal.

According to Ajzen (1991), performance of a behaviour is a function of both intentions and perceived behavioural control. For accurate prediction, three conditions have to be met:

(a) Measures of intention and perceived behavioural control must correspond with the behaviour that is to be predicted. In other words, intentions and perceived behavioural control must only be related to the behaviour in question, and the context must be the same as that in which the behaviour is to occur. For example,
the behaviour could be “to use a condom every time I have sex”, not “to prevent myself from contracting HIV”.

(b) Intention and perceived behavioural control must remain stable in the interval between their assessment and observation of the behaviour. Intervening events must be minimised; and

(c) Perceptions of behavioural control must realistically reflect actual behaviour. The relative importance of intention and perceived behavioural control in predicting behaviour varies across situations and behaviours. When the behavioural situation is within a person’s control, intentions alone can predict behaviour. When control decreases, both intention and perception of control are needed (Ajzen 1985; 1991).

2.3.1.1 Relevance of the Theory of Planned Behaviour to the study

In the discussion on the TPB, it is argued that its application is based on the assumption that when making behavioural decisions people consider the information available to them Reddy (2002). Unfortunately, the theory assumes that individuals are rational in their decision-making, an assumption possibly not accurate as HIV and AIDS-related behaviour is influenced by emotions originating from both the individual and society at large. Moreover, most adolescents, and indeed many adults, do not seem to approach HIV and AIDS issues from such a logical perspective Ross & Deverell (2004). Besides, adolescents are under intense influence from peers, which makes individual adolescents susceptible to HIV and AIDS infections because they tend to rely heavily on their friends’ knowledge about the dangers of HIV and AIDS (Vanlandingham Superset, Grandjean, and Sittitrai 1995).

The researcher drew on this model to understand how reference peer group norms influence behaviours that put adolescents at risk of contracting HIV. Despite these shortfalls in ensuring rapid behaviour change among Grade 12 learners, the TPB has facilitated the development of interventions that have made an impact on knowledge and awareness of the HIV and AIDS pandemic and has, in some way, contributed to HIV risk reduction (Kelly, Parker, & Lewis 2001).
In this study the researcher drew on the psychological and health behaviour model in an attempt to understand Grade 12 learners’ perceptions of their vulnerability to HIV-infections, especially how they affect their lifestyle choices. Almost all psychological models tend to emphasise common aspects, such as the role of modelling, peers, a supportive environment, self-efficacy and attitudes, and the determining of goals as paramount in adolescent risk taking behaviours. Since most interventions have been based on health behaviour models, they might also help the researcher to understand and appreciate Grade 12 learners’ experiences with the various intervention programmes that are available in schools and their responses to them.

2.3.2 Behavioural beliefs and attitudes towards behaviour

Behavioural beliefs are beliefs a person holds about the outcome of a behaviour. Each belief links behaviour to a certain outcome or attribute. Since attributes that are linked to behaviour are either positively or negatively valued, people acquire an attitude towards the behaviour in question. Behaviours that have desirable consequences are favoured over those that have less favourable consequences. Thus, an attitude towards a behaviour is developed.

2.3.3 Normative beliefs and subjective norms

Normative beliefs are concerned with the likelihood that significant referents approve or disapprove of a given behaviour. The strength of each normative belief is multiplied by the person’s motivation to comply with the referent in question (Taylor and Todd 1995).

2.3.4 Control beliefs and perceived behavioural control

Control beliefs refer to the perception of factors likely to facilitate or inhibit the performance of a behaviour. Taylor and Todd 1995 believes that, these factors include both internal factors (for example, information, personal deficiencies, skills, abilities and emotions) and external factors (for example, opportunities, dependence on others and barriers). People who perceive that they have access to the necessary resources and that there are opportunities to perform a behaviour – that is, people
who have positive control beliefs will have a high degree of perceived behavioural control.

2.4 Summary

This chapter reviewed the literature and discussed the theoretical framework that guides this study; justifying its application in the study. The next chapter focuses on the research methodology that was adopted in order to accomplish the purpose of the study.
CHAPTER 3
RESEARCH METHODOLOGY

3.0 Introduction

The focus of this study is to understand how Grade 12 learners perceive their own vulnerability to HIV infections by exploring their understanding and experiences with regard to the pandemic. To achieve this aim the researcher decided to use a triangulation method to collect data. The chapter begins by discussing the research paradigm that guided this research and its design. The process of sampling the schools and participants is discussed. This chapter also details how research techniques and their related tools were used, including problems and ethical issues that arose in the use of these techniques.

3.1 Mixed method approach

It is important to note that although the qualitative method (Focus Group Interviews) was used in this study, a quantitative approach was also applied whereby a structured questionnaire was administered to twenty Grade 12 learners in the selected schools. Denzin (2002) asserts, that an important technique to strengthen the reliability and validity of a research design is by combining qualitative and quantitative methodologies through triangulation, which is characterised by the use of multiple methods of sampling, research instruments, and statistical analyses.

Denzin (1970) extended the idea of triangulation beyond its conventional association with research methods and designs. He distinguished four forms of triangulation:

*Data triangulation*, which entails gathering data through several sampling strategies, so that slices of data at different times and social situations, as well as on a variety of people, are gathered.

*Investigator triangulation*, which refers to the use of more than one researcher in the field to gather and interpret data.

*Theoretical triangulation*, which refers to the use of more than one theoretical position in interpreting data.
**Methodological triangulation**, which refers to the use of more than one method for gathering data.

To address the objectives of the study, the researcher used a combination of methods of data generation known as method “triangulation” (Babbie & Mouton, 2001). Kelly (2006:287) describes triangulation as “collecting material in as many different ways and from as many diverse sources as possible”. The authors argue that triangulation can help the researcher “home in” on a better understanding of a phenomenon by approaching it from several angles. Greene and Hogan (2005) concur with this view arguing that triangulation of theoretical orientation, methods and perspectives enhance understanding of a phenomenon. They further argue that triangulation is useful in field research for verification and that it strengthens the case for trustworthiness of the study, as various data sets are able to support each other. This study employed a mixed method approach, which combined both qualitative and quantitative methods.

A qualitative method guided by phenomenological theory approaches was chosen to provide in-depth data about the participants’ attitudes, knowledge, behaviours, and perceptions about HIV infection. With qualitative studies, only small samples of individuals, groups, or events are invariably chosen, in view of the in-depth nature of the study. In such studies, one cannot engage in intensive examination of all the factors, as it would entail huge costs and energy expenditure. For the above reason, qualitative studies use small samples as this study has done so (Sekaran 2003).

The quantitative approach generates numbers, which are analysed statistically, making comparisons and correlations possible (Descombe 2000). Saunders, Lewis & Thornhill (2009) explain that, in conducting a descriptive research, it is necessary to have a clear picture of the phenomena on which you wish to collect data prior to the collection of the data. An exploratory research method was used in this study, because it is particularly useful if one wishes to clarify his/her understanding of a problem, when one is unsure of the precise nature of the problem.

For this study, a combination of quantitative and the qualitative approaches was considered the most appropriate and effective means of data collection as this approach allowed the researcher to get a comprehensive overview of the issues pertinent to the objectives of the study.
3.2 Research design

Borrowing from the qualitative design, the researcher used phenomenology (focus group interviews) which is mainly a real-life method of studying people. The researcher analysed his conversations and interaction with the participants using the strategy of interpretative inquiry (De Vos 2000). Data were systematically collected and analysed within a school context.

On the other hand, the study employed a survey (quantitative design) in collecting, processing, and analysing data. A survey involves acquiring information about one or more groups of people, perhaps about their characteristics, opinions, attitudes, or previous experiences, by asking questions and tabulating their answers. The ultimate goal is to learn about a large population by surveying a sample of that population (Leedy and Ormrod 2005: 183). The researcher posed a series of questions to willing participants; summarised their responses in percentages, and frequency counts; and then drew inferences about a particular population from the responses of the sample.

All the questions asked had something to do with the research objectives, which sought to investigate Grade 12 learners’ perceptions of their vulnerability to HIV-infections.

3.3 Target population

Gray (2004) defines a population as the total number of possible units or elements that are included in the study. The population of the study were Grade 12 learners who are 17 years old, drawn from two senior secondary schools in the Eastern Cape. Two secondary schools were considered appropriate for this study due to their existence for more than ten years as senior secondary schools with Grade 10 to 12.

The reason for targeting the Grade 12 learners who are 17 years old was that, they were considered suitable sources of information for the study as they were considered to be relatively knowledgeable about HIV and AIDS since they have been exposed to such information through Life Orientation. Secondly, they had been exposed to various programmes that were offered in their schools to curb the spread of HIV infections.
3.3.1 Sampling

For the focus group discussions, non-probability sampling was used because the study targeted 17 year-old Grade 12 learners who were readily accessible at the time of the study. The researcher selected schools within the Amathole Municipal District. These were two senior secondary schools, which were easily accessible to the researcher, and were classified as previously disadvantaged schools, which are meant to serve both township and rural children from the surrounding areas including the informal settlements.

In order to accommodate the use of questionnaires, proportional stratified sampling was also used. All the respondents were from schools situated in semi-urban areas. The process of selection was done by the Life Orientation teacher according to guidelines given by the researcher. The guidelines were; grade 12 boys and girls learners who are 17 years old, and should be equally represented in the study. The respondents’ sample had to be in accordance with the proportions of each residential group in the school enrolment. This ensured that the respondents were willing and motivated to participate. Boys and girls were selected in order to explore learners’ perceptions from both genders’ perspectives.

3.3.1.1 Non-probability sampling

Non-probability sampling provides a range of alternative techniques to select samples based on subjective judgment and is also very useful when the resources available for conducting the research are limited (Saunders et al. 2009). The participants were selected on the basis of their knowledge of the subject investigated, which was based on HIV and AIDS prevention strategies. The study also took into consideration the self-selection sampling (Saunders and Thornhill 2003). Self-selection sampling occurred when the Life Orientation teachers identified individuals who expressed their desire to take part in the research.

3.3.1.2 Proportional stratified sampling

In a simple stratified random sampling design; all the strata of the population are essentially equal in size (Leedy and Ormrod 2005). But it was a different situation in
this study. This study's target population was 17 year-old learners, 4 learners were from rural areas, 8 from squatter camps, and 28 from the townships. Based on the proportional stratified sampling criteria, for every rural learner, there had to be two learners from squatter camps and seven learners from the townships. This sampling technique was applied in both schools because of the age constraint (small number of respondents available within the required age of 17). In other words the sample was more of a convenience sample than a scientifically representative sample.

3.3.2 Sample size

The participants for focus groups were only from Grade 12 (six boys and six girls who were 17 years old) in each school. These participants were targeted because the researcher assumed they had knowledge of HIV infections. Twenty respondents aged 17 from grade 12 were used for the questionnaire. It was 10 boys and 10 girls in each school. Selection was based on proportional stratified sampling (see Section 3.3.1.2). Out of the population of about 200 Grade 12 learners in each school, not all the respondents were within the required strata of 17 years old, therefore only a sample size of (10 girls and 10 boys) per school was selected. A sample size of 20 learners in each school was manageable and also a reasonable number for a dissertation of limited scope. The researcher chose this sample in accordance with the proportions of each group (gender, and residential area). This sampling technique was used for the purpose of triangulation, and to allow the respondents to answer some questions that they felt uncomfortable with when asked in a group.

3.4 Data collection instruments

Data refer to information obtained during the course of an investigation or study (Polit & Hungler 1999). In any study, the development of a formal instrument ensures that similar data are collected from all the participants and this also ensures that objectivity is maintained throughout the data collection process.

Focus-group interviews and self-administered questionnaire were therefore used as methods of data collection for this study.
Since the population also consisted of female participants, the researcher collected data with the help of one female research assistant who interviewed female participants in two focus groups at the two selected schools. A female research assistant interviewed the female participants, because of the sensitivity of the topic, and to enhance openness among the participants during the interviews. Although the study was not costly in terms of travel, it enabled the researcher to collect enough data using a standardised questionnaire (see Appendix F) and the interview schedule (see Appendix G) in both schools. The participants were given an hour to fill in the questionnaire and return it to the researcher afterwards. All the questionnaires were returned within the allocated time and the longest was within 10 minutes. The focus group discussions, which took about thirty minutes each, were done with the selected participants the same day during study time from 3 o’clock as agreed by the principal. The FGDs were conducted in both English and Xhosa since the participants’ home language is Xhosa. The fieldwork was conducted between 07 May and 25 May 2012. There was a week in between the interview in school A and the second interview in School B.

3.4.1 Questionnaires

A questionnaire is an instrument with open or closed questions or statements to which a respondent must react. Different kinds of questionnaires can be distinguished, such as mailed questionnaires, telephonic questionnaires, or the group questionnaire (McMillan & Schumacher 1997).

For the purpose of triangulation, a standardised questionnaire written in English was administered with twenty Grade 12 learners in each school, to validate the information obtained from the interviews. Twenty respondents per school (20 + 20 = 40) were considered a reasonable number in order to explore Grade 12 learners’ perceptions regarding HIV-infections. A Self-efficacy Scale (SES; Appendix F) assessing self-efficacy regarding performance of the specific self-protective behaviours of discussing condom use and HIV-antibody testing with potential sex partners and plans for future adherence to safer sex practices was developed during Phase 1. The SES used a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree) with higher scores corresponding with a greater level of self-protective self-efficacy. Sample statements included “I have discussed safer sex with
my past sex partner(s)” and “I have discussed HIV testing with my current sex partner(s)”.

The HIV Vulnerability Scale (HIVVS; Appendix F) had four subscales to assess four components of the HBM: perceived susceptibility, severity, benefits of condom use and barriers to condom use. Each subscale of the HIVVS is a 4-item measurement using a 5-point Likert-type scale with higher scores indicating a higher degree of agreement or belief. Perceived severity subscale statements include “I would rather have any other terminal illness than AIDS”, and perceived benefits to condom use subscale statements include “I think it is worth the effort to have condoms readily available”. Each subscale of the HIVVS was used in data analysis.

The response rate was 100% since all the 40 questionnaires were distributed and filled in under the supervision of the researcher. This strategy was helpful in ensuring that no incomplete and unusable questionnaires were returned.

3.4.2 A justification of the use of a questionnaire

Despite the criticism that surveys lack imagination the following are the qualities of the survey design that influenced the researcher to integrate it into his methodology:

3.4.2.1 Uniqueness

A survey gathers information not available from other sources. Thus, the survey design enables the researcher to acquire original data to produce original information.

3.4.2.2 Non-probability and probability sampling

A survey has unbiased representation of population of interest as most subjects are given equal chances to participate (Trochim 2006). It is also flexible in that a researcher can still use the non-probability sampling if the sample is big.
3.4.2.3 Standardization of measurement

Surveys gather the same information collected from all respondents making it easy for the researcher to deduce information. Surveys collect data from different points but all respondents respond to the same question using the same instrument making it easy for the researcher to be guaranteed of getting standard information.

3.4.2.4 Analysis needs

Surveys use data to complement existing data from secondary sources. Theories can be tested or verified using surveys. By virtue of being able to assess human behaviour in a large sample or population, what writers have said or hypothesised can be verified or tested within a short space of time.

3.4.2.5 Convenient sample size

This type of design which allows the researcher to use his/her discretion can enable the researcher to deal with big sample sizes within a short time (Creswell 2003). Leedy and Ormrod (2005) also agree that surveys can be sent to a large number of people, including those who live thousands of miles away. Thus they may save the researcher travel expenses, and postage is typically cheaper than a lengthy long-distance telephone call. From the perspective of survey, this distance becomes an additional advantage.

3.4.2.6 Anonymity of respondents

Participants can respond to questions with assurance that their responses will be anonymous, and so they may be more truthful than they would be in a personal interview. Particularly when they are talking about sensitive or controversial issues (Leedy and Ormrod 2005).

3.5 Focus group interviews

Traditionally, focus group research is “a way of collecting qualitative data, which basically involves engaging a small number of people in an informal group discussion (or discussions), ‘focused’ around a particular topic or set of issues”
(Wilkinson 2004:177). Social science researchers in general and qualitative researchers in particular often rely on focus groups to collect data from multiple individuals simultaneously.

An area such as HIV and AIDS, which deals with human behaviour that can be mysterious and is multi-dimensional, can therefore be best understood through the use of multiple methods. Leedy and Ormrod (2005) concur with this view, saying qualitative researchers recognise that the issue they are studying has many dimensions or layers, and so try to portray it in its multifaceted form. The use of multiple methods, a common feature of interpretivist research, helped the researcher to gain a deeper and more holistic understanding of the phenomenon of Grade 12 learners’ vulnerability to HIV infections.

One important method of generating data in qualitative research is the focus group discussion which provided the researcher with the opportunity to generate data from the participants in their own words. The researcher therefore triangulated methods of data generation and sources of data, as this process enhanced his understanding of learners’ vulnerability to HIV infections.

The researcher interviewed six participants simultaneously in a focus group. These participants were selected by their Life Orientation teachers, based on their willingness to participate, and purposely 17 year-old learners in Grade 12. The researcher gathered six boys and six girls in two schools to discuss the knowledge, attitudes, and perceptions that the Grade 12 learners have about their vulnerability to HIV infections. The interview schedule was employed during the discussion to ensure that the same open questions were asked to all the participants. The discussions were recorded through a digital voice recorder and the researcher also took field notes while observing the participants’ behaviour during the interviews. In both schools, the focus group interviews took place in the computer laboratory, and the questionnaires were filled in before the interviews started. Both the interviews and the filling in of questionnaires took place after the official contact time in compliance with the DoE’s requirements, and the whole process took about 45 minutes.
3.5.1 A justification of the use of focus group interviews

The open-ended nature of focus group interviews was expected to aid exploration through the interaction of the participants as they debated, engaged in self-reflection and even contradicted each other regarding socio-cultural practices and factors causing HIV and AIDS. As targeted, the participants chosen represented the age group of 17 years in order to capture all pertinent issues as viewed from the lens of the same age group. Focus groups were useful in the following way (Creswell 2003):

- The researcher had limited time at school since he could only conduct the research after the normal teaching time.
- The participants felt more comfortable talking in a group than alone.
- Interaction among the participants was more informative than it would be on individual interviews.

3.6 Pilot study

The researcher conducted a pilot study to establish how long it takes to conduct the interviews and whether there were any offensive, ambiguous, or inadequately worded questions so that adjustments could be made where necessary. The researcher conducted a pilot with five participants who did not take part in the actual study. The participants consisted of one focus group made up of boys who were purposely selected from Grade 12 (in school A) where the main study was conducted. The same participants were required to fill in a questionnaire with close-ended questions.

With the permission of the interviewees, the researcher recorded all the interviews since the preservation of participants’ words ensured original data and in the event of a query, the researcher can play back and check. The recorded interviews were kept for three years so that they could be available when points of clarity or complaints are raised from the findings. The respondents had similar characteristics to those used in the main study. The pilot sample enabled validation of the instrument by identifying possible ambiguities in both content and language in preparation for the data collection of the main sample. It also helped the researcher to form an idea of the time required to complete the questionnaire and to anticipate any problems likely
to be encountered during the main data collection. No changes were made after the pilot study, as the respondents understood the questions. The questionnaire was also given to expert researchers, including the researcher's study supervisors, to scrutinise for validity and reliability.

3.7 Ethical considerations

Ethical clearance was obtained from the Higher Degrees Committee of the Department of Sociology at the University of South Africa to conduct research (Appendix A). Further permission was sought and granted from the Eastern Cape Department of Education (ECDoe), to conduct the study at the schools (see Appendix B). In order to gain access to the participants, permission was sought and granted from the school principals (see Appendix D). Saunders, Lewis and Thornhill (2007: 95) emphasise that consent to participate in research is not a straightforward matter; hence in this study informed consent was applied. The participants were informed in a letter about their option to or not to participate (see Appendix E). In addition, the rationale for their being sampled was explained. The purpose of the study was explained to the respondents before completion of the questionnaire and the commencement of the focus groups discussions.

3.8 Data analysis and interpretation

Data analysis is the process of transforming raw data into usable information, often presented in the form of a published analytical article, in order to add value to the statistical output (Statistics Canada 2009).

3.8.1 Qualitative data

The researcher analysed the data according to the following steps as described by Creswell (2002):

- Organised the data, to break down large bodies of text into smaller units in the form of stories, sentences, and individual words.
- Perused the entire data set several times to get a sense of what it contained as a whole.
• Identified general categories or themes, and subcategories or subthemes as well, and then classified each piece of data accordingly.

• Integrated and summarised the data for the readers. This step included offering propositions.

3.8.2 Quantitative data

The quantitative information has been analysed using frequency counts, percentage scores, and pie charts.

3.9 Ensuring trustworthiness of this study

To enhance validity of the findings, the study used a mixed method approach in the form of a questionnaire and focus group discussions. In this study, the researcher used Guba’s model of describing the credibility of qualitative research. Guba (1990), prefers to describe the rigour of qualitative research in terms of trustworthiness, and uses criteria like credibility, dependability, and confirmability in the following way:

3.9.1 Credibility

Credibility relates to the truth-value of research findings. According to Ulin, Robinson, Tolley and McNeill (2002), credibility in qualitative research focuses on the truth of the findings of a study, including an accurate understanding of the context. This prolonged engagement with participant also allowed the researcher to identify patterns and check the participants’ perceptions regarding their vulnerability to HIV infections. During the data production, process the researcher kept detailed field diary of events. These notes, were fed into the researcher's thick description, and added to the credibility of the results obtained. The researcher also validated the findings through literature review and quotations of participants. After the data generation, the researcher transcribed the recorded interviews and took the transcripts back to the participants to check whether what was summarised is what they actually said.
3.9.2 Dependability

Guba’s (1990) notes that dependability criterion relates to the consistency of findings and refers to the degree to which the reader can be convinced that the findings did indeed occur (cited in Van der Riet & Durrheim 2006:93). This was achieved through rich and detailed description, which showed how the participants’ behaviour and actions are rooted and developed out of contextual interactions. This has been reflected in their quotations.

3.9.3 Confirmability

Guba’s criterion of confirmability is through follow up interviews with two participants to validate the transcription of interviews. This was done with two participants and the transcripts were bracketed in order to obtain an honest and objective view of the study findings.

3.9.4 Validity and reliability

The researcher tried to maximise the validity and reliability of the data collected by making use of the following: close ended questions in the questionnaire, using clear and simple language in the questionnaire, by clearly explaining the purpose of the questionnaire, and the completion of a pilot study which resulted in minor adjustments of the original questionnaire.

3.10 Ethical considerations

The researcher adhered to the UNISA policy on research ethics (2007) as follows:

(a) **Voluntary participation**

Participants were informed that participation in the study was voluntary and that failure to participate in the study or a withdrawal of consent would not result in any penalty or loss of benefits to which the participants were otherwise entitled.

(b) **Informed consent**
After informing the participants of the purpose of the study, the type of information needed and how the information would be used; the participants voluntarily confirmed orally to participate. The representatives of the SGB signed a consent form for all the participants in the study.

(c) Avoidance of harm

The researcher did not put participants in a situation where they might be at risk of harm (physically, emotionally, socially, politically, economically, and psychologically) as a result of their participation.

(d) Protection of privacy

Confidentiality was ensured by not divulging the participants’ information to anyone who was not directly involved in the study. Anonymity of participants was ensured by not revealing their identity.

3.11 Summary

This chapter presented a detailed description of the research methodology and research design of the study. The chapter focused on the theoretical purpose and justification of the methodology chosen, ethical considerations, informal and formal data gathering techniques and an explanation of the data analysis method used. Both quantitative and qualitative research approaches were indicated. Issues of sampling and trustworthiness were described and explained with focus on credibility, dependability, and confirmability. The data analysis methods for both quantitative and qualitative data for the study were explained.

The next chapter (Chapter 4) analyses and interprets data collected from the field.
CHAPTER 4
DATA ANALYSIS AND DISCUSSION

4.0 Introduction

This chapter presents the results of the study and data was analysed according to the structure of the questionnaire as follows: Biographical information, Self-efficacy scale, and HIV vulnerability scale. A summary of the respondents’ responses to the questionnaire is arranged and presented in a tabular form. On the other hand, the participants’ responses to focus group discussions are presented word for word as translated from Xhosa into English and analysed according to the research themes.

4.1 Demographic profile of respondents

The study targeted equal proportions of (20; 50%) females, and (20; 50%) males (see Table 3). All the respondents 40 (100%) were Xhosa speakers. They were also asked to indicate their residential areas which were townships (28, 70%), squatter camps (8, 20%) and rural areas (4, 10%). All the respondents were purposely selected from Grade 12 and were 17 years old only. School names have been falsified and the actual names of the respondents and the residential areas have not been mentioned in order to ensure confidentiality.

Figure 2, illustrates that (20; 50%) of the respondents belonged to School A, and another (20; 50%) of the respondents belonged to School B. When the figures are combined, they constitute the 100% response rate received in this study.

4.1.1 Response rate

The study targeted 40 respondents and all of them (40; 100%) completed and returned questionnaires as presented on Figure 2.
4.1.2 Details of respondents

The respondents were asked to provide their details according to gender, school, residential area, Grade, and age and Table 3 represents their details.

Table 3: Details of respondents (n = 40)

<table>
<thead>
<tr>
<th>School A</th>
<th>Residential Area</th>
<th>Grade</th>
<th>Gender</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learner 1</td>
<td>Township</td>
<td>12</td>
<td>Female</td>
<td>17</td>
</tr>
<tr>
<td>Learner 2</td>
<td>Township</td>
<td>12</td>
<td>Female</td>
<td>17</td>
</tr>
<tr>
<td>Learner 3</td>
<td>Township</td>
<td>12</td>
<td>Female</td>
<td>17</td>
</tr>
<tr>
<td>Learner 4</td>
<td>Squatter Camp</td>
<td>12</td>
<td>Female</td>
<td>17</td>
</tr>
<tr>
<td>Learner 5</td>
<td>Squatter Camp</td>
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<td>Female</td>
<td>17</td>
</tr>
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<td>Female</td>
<td>17</td>
</tr>
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<td>17</td>
</tr>
<tr>
<td>Learner 8</td>
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<td>17</td>
</tr>
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</table>

<table>
<thead>
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<th>Residential Area</th>
<th>Grade</th>
<th>Gender</th>
<th>Age</th>
</tr>
</thead>
<tbody>
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<td>Learner 1</td>
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<td>Female</td>
<td>17</td>
</tr>
<tr>
<td>Learner 2</td>
<td>Township</td>
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<td>Female</td>
<td>17</td>
</tr>
<tr>
<td>Learner 3</td>
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<td>17</td>
</tr>
<tr>
<td>Learner 4</td>
<td>Township</td>
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<td>Female</td>
<td>17</td>
</tr>
<tr>
<td>Learner 5</td>
<td>Township</td>
<td>12</td>
<td>Female</td>
<td>17</td>
</tr>
<tr>
<td>Learner 6</td>
<td>Rural area</td>
<td>12</td>
<td>Female</td>
<td>17</td>
</tr>
<tr>
<td>Learner 7</td>
<td>Rural area</td>
<td>12</td>
<td>Female</td>
<td>17</td>
</tr>
<tr>
<td>Learner 8</td>
<td>Rural area</td>
<td>12</td>
<td>Female</td>
<td>17</td>
</tr>
<tr>
<td>Learner 9</td>
<td>Township</td>
<td>12</td>
<td>Female</td>
<td>17</td>
</tr>
<tr>
<td>Learner 10</td>
<td>Squatter Camp</td>
<td>12</td>
<td>Female</td>
<td>17</td>
</tr>
<tr>
<td>Learner 11</td>
<td>Township</td>
<td>12</td>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>Learner 12</td>
<td>Squatter Camp</td>
<td>12</td>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>Learner 13</td>
<td>Township</td>
<td>12</td>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>Learner 14</td>
<td>Township</td>
<td>12</td>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>Learner 15</td>
<td>Squatter Camp</td>
<td>12</td>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>Learner 16</td>
<td>Township</td>
<td>12</td>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>Learner 17</td>
<td>Township</td>
<td>12</td>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>Learner 18</td>
<td>Township</td>
<td>12</td>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>Learner 19</td>
<td>Township</td>
<td>12</td>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>Learner 20</td>
<td>Squatter Camp</td>
<td>12</td>
<td>Male</td>
<td>17</td>
</tr>
</tbody>
</table>

In **School A**, six female participants (learner 1 to learner 6) were asked to fill in the questionnaire and also participate in focus group interviews. Learner 7 to learner 10 only filled in the questionnaire without being interviewed, as they did not form part of the focus group interviews. Six male participants (learner 11 to learner 16) were asked to fill in the questionnaire and also participate in a focus group discussion. Learners 17 to 20 were not assigned to a focus group discussion hence they only filled in a questionnaire. The same procedure was followed in **School B**.
4.2 Presentation of quantitative results of the study

The following table is a descriptive statistics computed regarding Grade 12 learners’ vulnerability to HIV infections. By increasing the public’s awareness and knowledge of health risks associated with ignoring preventive behaviours, the Grade 12 learners may be prompted to examine their own behaviour. Once the idea of vulnerability to HIV infections has become incorporated at the personal level, the focus is on development of self-regulative skills to translate concern or fear into self-protective behaviour.

Respondents were asked to indicate their self-efficacy and perceptions on their vulnerability to HIV-infections. Respondents were given a list of possible options on a 5-point Likert scale to choose from as was applicable to their situations. SA = Strongly Agree, A = Agree, N = Neither agree nor disagree, D = Disagree, SD = Strongly Disagree. Table 4 summarises their responses.

Table 4: Learners’ self-efficacy and perceptions on their vulnerability to HIV infections (n = 40)

<table>
<thead>
<tr>
<th>Items</th>
<th>SA</th>
<th>A</th>
<th>N</th>
<th>D</th>
<th>SD</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
</tr>
<tr>
<td>1. I think that when two 17-year old learners are considering having sex, it would be wise for them to discuss safer sex.</td>
<td>18</td>
<td>45</td>
<td>11</td>
<td>27.5</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>30</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>2. I shall discuss safer sex with my partner before we have sexual intercourse.</td>
<td>25</td>
<td>62.5</td>
<td>12</td>
<td>30</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. My friends think it is a good idea to practise safer sex.</td>
<td>16</td>
<td>40</td>
<td>14</td>
<td>35</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>4. I think it is a good idea to get an HIV test.</td>
<td>31</td>
<td>77.5</td>
<td>6</td>
<td>15</td>
<td>1</td>
<td>2.5</td>
</tr>
</tbody>
</table>
5. I think that when two 17-year old learners are considering having sex, they should discuss HIV testing.

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>15</td>
<td>12</td>
<td>30</td>
<td>2</td>
<td>5</td>
<td>6</td>
<td>15</td>
</tr>
</tbody>
</table>

6. I shall consider discussing HIV-testing with a sexual partner.

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16</td>
<td>14</td>
<td>35</td>
<td>7</td>
<td>17.5</td>
<td>1</td>
<td>2.5</td>
</tr>
</tbody>
</table>

7. Condoms help prevent the spread of HIV.

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>19</td>
<td>17</td>
<td>42.5</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

8. My family thinks it is a good idea to practise safer sex.

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<tbody>
<tr>
<td></td>
<td>15</td>
<td>11</td>
<td>27.5</td>
<td>3</td>
<td>7.5</td>
<td>7</td>
<td>17.5</td>
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</tbody>
</table>

9. I plan to get an HIV test in future.

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<tbody>
<tr>
<td></td>
<td>16</td>
<td>11</td>
<td>27.5</td>
<td>3</td>
<td>7.5</td>
<td>8</td>
<td>20</td>
</tr>
</tbody>
</table>

10. I feel that the chances are good that I can contract HIV.

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<tbody>
<tr>
<td></td>
<td>8</td>
<td>20</td>
<td>8</td>
<td>20</td>
<td>12.5</td>
<td>5</td>
<td>12.5</td>
</tr>
</tbody>
</table>

11. I am afraid that I might contract HIV.

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<tbody>
<tr>
<td></td>
<td>12</td>
<td>14</td>
<td>35</td>
<td>5</td>
<td>12.5</td>
<td>5</td>
<td>12.5</td>
</tr>
</tbody>
</table>

12. I believe that I can be exposed to HIV infection if my sex partner is heterosexual.

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<thead>
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</thead>
<tbody>
<tr>
<td></td>
<td>9</td>
<td>22.5</td>
<td>5</td>
<td>12.5</td>
<td>10</td>
<td>25</td>
<td>6</td>
</tr>
</tbody>
</table>

13. I believe that I can get HIV even if I am only having sex with one partner.

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<tbody>
<tr>
<td></td>
<td>18</td>
<td>45</td>
<td>10</td>
<td>25</td>
<td>5</td>
<td>12.5</td>
<td>5</td>
</tr>
</tbody>
</table>

14. AIDS causes death.

<p>| | | | | | | | |</p>
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<thead>
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<tbody>
<tr>
<td></td>
<td>23</td>
<td>57.5</td>
<td>10</td>
<td>25</td>
<td>3</td>
<td>7.5</td>
<td>2</td>
</tr>
</tbody>
</table>

15. I would rather have any other terminal illness than AIDS.

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<tbody>
<tr>
<td></td>
<td>11</td>
<td>27.5</td>
<td>8</td>
<td>20</td>
<td>9</td>
<td>22.5</td>
<td>7</td>
</tr>
</tbody>
</table>

16. I would rather die from a violent death than from AIDS.

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<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>6</td>
<td>15</td>
<td>15</td>
<td>37.5</td>
<td>3</td>
<td>7.5</td>
<td>8</td>
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</tbody>
</table>

17. AIDS is probably the worst disease a person can get.

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<tr>
<td></td>
<td>11</td>
<td>27.5</td>
<td>10</td>
<td>25</td>
<td>5</td>
<td>12.5</td>
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</tbody>
</table>

18. I believe that the chances of contracting HIV can be significantly reduced by using a condom.

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<tbody>
<tr>
<td></td>
<td>12</td>
<td>30</td>
<td>17</td>
<td>42.5</td>
<td>7</td>
<td>17.5</td>
<td>1</td>
</tr>
</tbody>
</table>

19. I think it is worth the effort to have condoms readily available.

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</thead>
<tbody>
<tr>
<td></td>
<td>17</td>
<td>42.5</td>
<td>20</td>
<td>50</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
Some of the response frequencies and percentages to items 1 to 23 in Table 4 are summarised as follows:

4.2.1 I shall discuss safer sex with my partner before we have sexual intercourse

Table 4 shows that 25 (62.5%) of the respondents strongly agreed to discussing safer sex with their partners before having sexual intercourse, and 12 (30%) of the respondents agreed. These results are in line with the Theory of Planned Behaviour (TPB) which is based on the idea that behavioural performance is determined by motivation (intention) and ability (behavioural control).

This means, where there is will on the learners’ side to discuss safer sex with their partners before sexual intercourse, that behaviour stands a good chance of becoming a habit.

4.2.2 I think it is a good idea to get an HIV test

It can be seen on Table 4 that 31 (77.5%) of the respondents strongly agreed to an idea of getting an HIV test, and this was the highest frequency response rate compared to other items in the questionnaire. None (0%) of the respondents strongly
disagreed, except for 2 (5%) of the respondents that disagreed with the above statement. This perception is based on Bandura’s (1982) theory of outcome expectancies which refer to people’s perception that the performance of a behaviour will lead to a desired outcome.

This means that, people will be keen to perform a behaviour (test for HIV) if they believe that the performance will result in a desired outcome (knowing their HIV status). The high percentage of learners that acknowledged the idea of getting an HIV test is a step towards the right direction (behavioural change).

4.2.3 I shall consider discussing HIV-testing with a sexual partner

The majority of respondents 16 (40%) strongly agreed to considering an HIV-testing discussion with a sexual partner, and 14 (35%) agreed. Only one respondent 1 (2.5%) disagreed with the statement and 2 (5%) strongly disagreed.

As the TPB outlines, efficacy expectancies boost people’s confidence in their ability to perform a behaviour. Thus, people have positive efficacy expectancies if they are confident in their ability to perform a behaviour (discussing HIV-testing), which, in turn, motivates them to carry out the behaviour (getting tested for HIV). On the other hand, people may be reluctant to engage in a behaviour if they doubt their ability to perform it (a negative expectancy scenario).

This is the kind of behaviour expected from the respondents (considering to discuss HIV-testing with their partners) if they want to see a reduction in the spread of HIV. More discussions about HIV-testing should be encouraged so that it becomes the mutual responsibility in a relationship.

4.2.4 Condoms help prevent the spread of HIV

It can be seen from Table 4 that the majority of respondents 19 (47.5%) strongly agreed that condoms help prevent the spread of HIV, and 17 (42.5%) agreed. None (0%) of the respondents disagreed to the statement.
Based on the theoretical framework of this study, normative beliefs are concerned with the likelihood that significant referents approve or disapprove of a given behaviour. Reading from their responses, the respondents approve of condom use in preventing the spread of HIV. The strength of each normative belief is increased by the person’s motivation to comply with the referent in question.

These results demonstrate that the respondents have knowledge on how to prevent HIV infections and are prepared to use condoms as a norm in preventing the spread of HIV.

4.2.5 My family thinks it is a good idea to practice safer sex

A significant number of respondents 15 (37.5%) strongly agreed that their families approve safer sex practices, while 11 (27.5%) of the respondents agreed. Interestingly, only 7 (17.5%) respondents disagreed with the above statement and 4 (10%) strongly disagreed.

Tenet 3 of the Social Learning Theory states that individuals are most likely to model behaviour observed by others they identify with and in this case the family plays a big role in influencing learners to practice safer sex.

It is important to note that this (17.5%) could be attributed to the fact that, their families were not vocal about sex matters since in some African cultures it is taboo to talk about sex to children.

4.2.6 I plan to get an HIV test in the future

Interestingly, a significant number of the respondents 16 (40%) strongly agreed to get an HIV test in the future, and 11 (27.5%) agreed, while 8 (20%) of the respondents disagreed.

According to Ajzen (1991), performance of a behaviour is a function of both intentions and perceived behavioural control. Measures of intention must correspond with the behaviour that is to be predicted. In other words, actions should speak louder than just mere intention to test in the future with no time limits.
For example, in this case the behaviour is to get an HIV test in the future. In this study, the resistance from 8 respondents to get an HIV test in the future might be an attitude problem towards the vulnerability of contracting HIV.

4.2.7 I feel that the chances are good that I can contract HIV

Table 4 demonstrates that 8 (20%) of the respondents strongly agreed that the chances are good that they can contract HIV, and 8 (20%) of the respondents agreed, while 14 (35%) strongly disagreed.

The Theory of Planned behaviour talks of control beliefs which are perceptions of factors that are likely to facilitate or inhibit the performance of behaviour. These factors include both internal factors (for example, information, personal deficiencies, and emotions) and external factors (for example, opportunities, dependence on others and barriers). People who perceive that they have access to the necessary resources and that there are opportunities to perform a behaviour – that is, people who have positive control beliefs – will have a high degree of perceived behavioural control.

Despite high levels of awareness towards the modes of HIV transmission and prevention among teenage learners, the results show that the majority of the respondents did not think that they are personally at risk. This is an indication that some of the respondents did not perceive themselves as vulnerable to HIV infections though they confessed to not always using condoms.

4.2.8 I believe that I can be exposed to HIV infection if my sex partner is heterosexual

The study established that 10 (25%) of the respondents neither agreed nor disagreed to being exposed to HIV infection if their sex partners are heterosexuals, while 10 (25%) strongly disagreed.

In the TPB, the behavioural beliefs are beliefs a person holds about the outcome of a behaviour. Each belief links behaviour to a certain attribute. Since attributes that are linked to behaviour are either positively or negatively valued, people acquire an
attitude towards the behaviour in question. Behaviours that have desirable consequences are favoured over those that have less favourable consequences.

Thus, an attitude towards a behaviour is developed. These results might confirm the concept of ‘othering’ where the respondents believe that the heterosexuals are insusceptible to HIV and attribute HIV infections to homosexuals.

4.2.9 I think it is worth the effort to have condoms readily available

The results show that 17 (42.5%) of the respondents strongly agreed that it is worth the effort to have condoms readily available, and 20 (50%) of the respondents agreed. Perceptions of behavioural control must realistically reflect actual behaviour.

In the TPB the relative importance of intention and perceived behavioural control in predicting behaviour varies across situations and behaviours. When the behavioural situation is within a person’s control, intentions alone can predict behaviour. In other words, when learners perceive a situation that might lead to risky sexual behaviour, then condoms should always be readily available in order to stay in control of the situation. When control decreases, both intention and perception of control are needed (Ajzen 1985; 1991).

These high levels of agreement to the statement are an indication of the respondents’ perceptions on what needs to be done to reduce HIV-infections.

4.2.10 I feel that the chances of contracting HIV can be reduced by having sex with only one partner

Interestingly, the majority of respondents 11 (27.5%) strongly agreed that chances of contracting HIV can be reduced by having sex with only one partner, and 9 (22.5%) of the respondents agreed with the statement as indicated in Table 4. Only 6 (15%) of the respondents were undecided on the matter, while 7 (17.5%) of the respondents disagreed and 7 (17.5%) strongly disagreed. Tenet 2 of the SLT states that humans can learn by observing others, in addition to learning by participating in an act personally and that will definitely reduce the spread of HIV.

Reading from the results, a lot still needs to be done by intensifying HIV and AIDS awareness programmes in schools where the ABC strategy is emphasised (in this case being faithful to one partner).
4.3 Presentation of qualitative results of the study

The researcher structured the presentation of the qualitative results of this study according to seven themes, categories, and sub categories that emerged from the analysis (see Table 5 and Table 6). The seven themes are:

- Grade 12 learners’ awareness of their vulnerability to HIV infections.
- Grade 12 learners’ perceptions of HIV and AIDS risky situations.
- Some controversies regarding what constitutes risky situations.
- Voices of participants regarding what could and should be done to reduce the risk of Grade 12 learners’ vulnerability to HIV infections.
- Awareness of various HIV and AIDS programmes offered to learners.
- Learners’ experiences of HIV and AIDS programmes.
- Participants’ voices of what could and should be done about the programmes.

Table 5: Themes and categories relating to Grade 12 learners' perceptions of their vulnerability to HIV infections

<table>
<thead>
<tr>
<th>Theme 1: Grade 12 learners’ awareness of their vulnerability to HIV infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories</td>
</tr>
<tr>
<td>• Awareness that Grade 12 learners are a more vulnerable group than others</td>
</tr>
<tr>
<td>• Awareness of how one can contract or avoid contracting HIV</td>
</tr>
<tr>
<td>• Awareness of what constitutes a safe or unsafe/risky environment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 2: Grade 12 learners’ perceptions of HIV and AIDS risky situations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 2.1: Internal Factors</td>
</tr>
<tr>
<td>Sub-category</td>
</tr>
<tr>
<td>• Sexuality development</td>
</tr>
<tr>
<td></td>
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</table>
**Theme 3: Some controversies regarding what constitutes risky situations**

**Categories**
- Condom promotion and use

**Theme 4: Voices of participants regarding what could and should be done to reduce the risk of Grade 12 learners’ vulnerability to HIV infections**

**Categories**
- To fellow learners
- To parents
- To school management and government
- The ABC strategy

**Table 6: Themes and categories relating to Grade 12 learners' experiences with HIV and AIDS intervention programmes in schools**

**Theme 5: Awareness of various HIV and AIDS programmes offered to learners**

**Categories**
- School-based programmes
- Non-school-based programmes

**Theme 6: Learners’ experiences of HIV and AIDS programmes**

**Categories**
- Positive experiences
- Negative experiences

**Theme 7: Participants’ voices of what could and should be done about the programmes**
The findings concerning the above themes are presented, and analysed under the research questions as follows.

4.3.1 Grade 12 learners’ knowledge on HIV and AIDS

4.3.1.1 Theme 2: Grade 12 learners’ perceptions of HIV and AIDS risky situations
(a) Internal factors

- **Adolescent sexuality development**

Grade 12 learners realise that their sexual development exposes them to risk of contracting HIV, and at the same time acknowledge that sexual feelings are a natural part of their development. They consider failure to control their sexual feelings and attraction to people of the opposite sex as contributing factors to their risk of contracting HIV. The following are some statements about how the participants regard the development of their sexuality in relation to HIV and AIDS risk.

(b) School related factors

- **Peer pressure/influence**

Learner participants expressed varying degrees of peer influence, ranging from mere imitation of what others say and do, to being forced or coerced to conform to the demands of the peer group. Girls were the most susceptible to peer influence, reporting that they are influenced by what their friends tell them to do and hence try to imitate their behaviours. Boys, on the other hand, reported intense pressure from their peers to conform to the latter’s behaviour. The pressure takes the form of teasing or ridicule. Girls reported pleasing a friend as a motivating reason for conformity. Deliberate imitation seems to be more influential among girls than boys. Participants also spoke of the pressure that girls from poor families have from their counterparts from rich families to engage in sexual relationships in order to obtain material goods. The following extracts illustrate the impact of peer pressure on learners’ risky sexual behaviours.

(F2) Kukumamela kwiitshomi kakhulu ungathathi iingcebiso zabazali.

(It is listening to friends mostly and not taking parents’ advices).
(F5) Eem… zilboyfriends because thina girls siyathanda ukupliza like wenze izinto like ungenzi kuba ufuna but uyenze for the benefit ye boyfriend yakho so zezinye zezinto nje ezisibeka emngciphekweni.

(Eem…it is the boyfriends because, we girls like to please them; we tend to do things we do not want to do just for the sake of our boyfriends and in that way put our lives at risk).

(M5) …so I think even ilfriends kwazona that is the peer pressure nabo banokumislidana ukuba no masambe ngoku siyokwenza le nale. So I think yi entertainment ne peer pressure.

…so I think even friends themselves can mislead you to go and do this and that, so I think it is entertainment and peer pressure.)

(G4) Okwesibini umntu xa efika e high school ndizothetha ngabase high school ufike abeneshomi njengokuba sele etshilo u G2 then xa eneetshomi uzobona ukuba uyashiyeka yena nhe enze le nto yenziwayo.

(Secondly I will talk about high school learners, when a person arrives at high school she/he meets new friends as G2 said and finds out that she/he is lagging behind and start doing what everyone else is doing.)

(B6) Ndicinga ukuba mna yi influence yeetshomi esikolweni umntu xa ebona iitshomi zakhe ziheva isex neecouples zazo naye azibone ahlekwe zitshomi zakhe so then aqonde ukuba naye makade ayiheve isex ngoku ingezozigqibo zakhe nezo.

(I think it is peer pressure at school, when one sees friends having sex as couples she/he tends to have unplanned sex in order to avoid being a laughed at by friends.)

(B3) Mna ndingathi umntu xa efika apha ehigh school uye azibone ukuba ok mdala then adibane neetshomi nabantu ekudala befunda apha abantu ekudala bezenza ezi zinto zokuheva isex afumane ke
ngoku la peer pressure ukuba naye ngaske afane nabanye abantwana angabingathi uyashiyeka.

(I would say when a person arrives here at high school she/he views herself/himself as mature and make friends with older learners in the school who have been having sex and get influenced by that peer pressure to start having sex so as to conform to their standards.)

- **Inter-school meetings**

Schools organise inter-school meetings for a variety of reasons, such as sports, entertainment and educational visits. Often these are organised during weekends. Learners travel either by hired transport or walk. While these meetings are initiated with good intentions, learner participants reported that at times these events present HIV risks. Learner participants for example reported walking back home late from sports gatherings as risky since they may be tempted to engage in sexual activities on the way under cover of darkness. Learners are worried that such sexual encounters tend to be unplanned and mostly occur without protection. Participants had the following to say:

(M3) *Singatsho sithi mhlawumbi zikhe zibekhona ngalo maxesha abantu xa bephumile mos xa kufuneka kubuyiwe mos soze kungaditywana yilo group ithile kuthengwe ezo drinks uyabo ezodrink kuselewwe mos once usele ingqondo iyaphazamiseka, ukuphazamiseka kwayo uqonde ikuba eish kudala ndambawela unantsika man, nonantsika naye abe eqonda uba mhmm ngoku nibethe ezo quick quick uyabo ngapha endaweni ethile aninaprotection nitumane iHIV kanjalo.*

(We could say maybe sometimes we have some drinks when we go out as the school, and when we come back we drink alcohol and the mind gets disturbed. After that, you think of a girl that you have been lusting for and that girl will also be in the same mood and you go for a quick unprotected sex.)
(G3) Xa kaphunywe imatch siye sinxile pha ndizakuthi siyanxila emveni kokuba sinxile silale nabantu ebesingaziplenanga ukuba sizolala nabo umntu ongamaziyo nestatus sakhe.

(When we go out for a match we get drunk there. I will say we drink alcohol and after that we have unplanned sex with girls we do not even know their HIV status.)

- Sexual harassment/abuse

Generally, sexual harassment appears to be under-reported. Participants indicated that not much sexual harassment takes place within the school premises but away from school. However, what has been reported tends to point to a deep-rooted problem. Indications are that girls are the main victims of sexual harassment from boys and male teachers. Sexual harassment by boys takes the form of touching body parts of girls and using obscene language, while that of teachers includes sexual acts of some sort.

Other forms of sexual harassment reported by participants include pressure to have sexual intercourse with boyfriends in order to provide food for the family. In most cases it is not a boyfriend from the same school, and such encounters take place during the holidays at their homes. The following is what Grade 12 learners said about their experiences of sexual harassment or abuse:

(M2) Ezinye izinto ulutsha lona lulonke luyathanda ukuhamba ebusuku okanye lubuye late like ungazifaka ezingozini yokuba mhlawumbi badibane nootsotsi okanye bareythswe okanye like loonto ingakhoza iAIDS, ibe loo nto isenzeka kungxamekile ke ngoku loo mntu ureypha loo mntu like angasebenzisi kwacondom atsho loo mntana ululutsha afumane iHIV and AIDS.

(On the other hand, the youth like going out at night and during that time, they could be in danger of being raped and that could lead to HIV infection and AIDS because the rapist might not use a condom.)
(B2)...abantwana besikolo baykwazi ukuba bametshe nootitshala besikolo so into eyenzekayo ibe yiloo nto.

(...learners are able to have sex with teachers and it just happens like that.) They all agreed to this statement.

(c) Home and society providing unsafe environment

- **Home environment perceived as unsafe space**

While on the issue of awareness of what constitutes a safe environment, participants reported parents as providing a supportive and guiding role in HIV and AIDS prevention, but the location of their homes and lack of good role models around their homes were perceived as risk factors. Participants claim that youth like to imitate what they see as significant to others. This is what they said about their experiences in the home environment:

(G3) *Mna ndicinga ukuba xa ukowenu ukhuseleke kakhulu kunangaphandle especially ukuba ungamazi ukuba ukhona umntu oposite apha kowenu ngaphandle kokuba ke awumazi.*

(I think you are safer at home than when you are outside especially if you know that there is a person living with HIV at home, unless you do not know that.)

(G2) *Ndiyaphikisa mna kula mcimbi ka G5 ngokolwam ulwazi ndiva kusithiwa zizinto ezidibene negazi ukuba kwaklatshana amagazi enu ukuze nibe niyesulelana. And naxa ukowenu andinakuthi ungosuleleka etoilet but etoilet uyakwazi ukufumana ii STDs into ezinjalo, but akude kuthiwe ufumene iAIDS etoilet andiyazi.*

(I disagree with G5, according to my knowledge; it is blood related issues that lead to HIV transmission. Although you are at home but still I cannot say you can get infected in the toilet except for sexually transmitted infections and things like that, but you cannot contract AIDS from the toilet.)
(M4) Yea! they are safe but on the other hand homes are not safe, you know there has been this myth that has been going around about the people who say whenever an HIV male sleeps with a virgin, HIV becomes healed. So we know there are ladies, who live with their uncles, or they live with whoever, someone related to them, due to the mere fact that they have to stay close to school, their parents end up sending them to stay with their uncles or whoever. So those people end up sleeping with those children. This is something that is proven statistically, and it is increasing. So I think it is not always safe at home than outside, except for those staying with their parents. The problem is if you stay with uncles, step parents, yea! Step parents have got a problem staying with other children because of the myth and belief that HIV infected males get healed when sleeping with a virgin.

- **Poverty as a risk factor**

Participants reported that girls, especially those who come from poor families, engage in transactional sex with boys or men to get money for their needs at school. It becomes worse when they mix with girls from rich families who have good clothes. The poor girls feel envious of the other well to do girls and decide to emulate them. This drives them to look for men. Yet even those who come from rich families have their own desires for more and better clothes. They, too, turn to having sex with rich men for money. The following reports by participants demonstrate their understanding of poverty as a risk factor to HIV infections.

(F6) Kulanto yentlupheko, we girls tend to prostitution and xa sifika phaya kwiprostitution sometimes we do not even use condoms so lanto ingamfaka emngciphekweni umntu.

(Because of poverty, we tend to prostitution and when we arrive in that field we do not always use condoms; so that puts us at risk.)

(F4) Mna ndingathi kwabanye kukuthanda imali…

(I would say with some it is the love of money…)
The rate of unemployment in South Africa is specifically just being blown out. We know that people are being unemployed. Our parents are being unemployed and are facing the reality. Some parents out there are forcing their children to engage in relationships, specifically talking of girls. They are being forced by their parents to be engaged in relationships with people older than them, people who are working so that those children can be breadwinners of their homes since they are learners. Therefore, it is becoming some sort of a challenge to the learners because when they get out there, their parents force them to get into relationships. This might be done in different ways not that parents talk with their children that they have to be engaged, but through their actions. For the mere fact that parents are suffering and they end up saying we are suffering and you are sitting doing nothing. Therefore, they end up being in that kind of a situation, which is more dangerous for their lives at home.

Sometimes they want to benefit from these men in that they get into relationships with men because of their good looks without knowing their HIV status).

- **Cultural practices and beliefs as risk factors**

Participants acknowledge that these practices are harmful. One female participant was concerned with the lack of HIV and AIDS education in the villages where some cultural practices and church beliefs are followed. What follows are their voices concerning these practices:

Eee... to add more on what F1 has said like kwezinye ireligion goes a long way like kwezinye iinkonzo there are iipractices ezenziwayo ezenza uba abantu babe exposed like ukusuleleka like yi HIV and AIDS so I believe like ukubana there are 50% chances zokuba ungangasuleleki and 50% chances zokuba ungasuleleka. I had my friend one time endibaliswa eh ukhonza eh! there is enye into andazi
ukuba kuthiwa yintoni, uhlatywa ngenaliti here apha eqatheni then nifola iline kuqalwa kowokuqala like ayirinswa or what like uba kuqalwe ekuqaleni it’s like gqu gqu kuye wonke umntu and abantu abaninzi phana wayendibilisela that they got infected but bengazazi because kuqalwa kowokuqala umntu because they had la belief yoba apha ndizohilishwa.

(Eee… to add more on what F1 has said, religion goes a long way like in other churches there are practices which expose people to HIV infections, so I believe there is 50% chance of contracting HIV and 50% chance of not contracting HIV. One day my friend told me about this thing they do, I do not know what it is called, you get pricked by a straight pin on the ankle and as you are in a queue they start with the first one and the pin is not sterilised or anything until the last person. She told me that many people were infected through this without knowing since they had a belief that this was done for their healing.)

(M4) Yea! I also agree that it does reduce the rate of HIV and AIDS considering specifically quoting one of the religions eem… taking it back to Kwazulu Natal eee… there is this tendency of eem… or a season whereby ladies from Kwazulu Natal get tested which is a religion that has been going on since then. They are being tested whether they are virgins or not and obviously for those who are not virgins they are being punished for the mere fact that they have to abide by the rules that have been set in that particular country or that particular place.

(F3) … in most churches akuthiwa sukuzisebenzisa iipilisi okanye like sukuzisebenzisa iimedicines zakho but they believe that if you trust God, if you believe, if you have faith uzakuphila…

(…in most churches they do not say do not use your medicines but they believe that if you trust God, if you believe, if you have faith you shall be healed…)

- **Media as risk factor**
While the media is renowned for its power to facilitate behavioural change among the youth, it also has the power to institute or reinforce risky habits. Participants reported that watching pornographic films, viewing images on cell phones, internet and TV soap operas could influence learners to engage in risky sexual behaviour. Adolescents like to imitate and practise what their idols are doing. The following demonstrate how Grade 12 learners view the negative influence of the media:

(M5) …it is because of the things we watch, it is because of the thing esi more exposed kuzo. Zisenza nje ngokunokwethu sibe more sexually active sibe izinto ezikude sikhawuleze sikwazi ukuzi aksesa. If sijonga abantu bakudala babengazenzi bona izinto zocaca ukuba bayaphuzana more intimately like in our days we do ezinye izinto nje kubo babengekho they did not know of them they were not taught mhlawumbi nee TV ezi zidlale indima enkulu ekusiboniseni izinto ezinjeyya.

(… it is because of the things we watch, it is because of the things we are exposed to which make us to be sexually active since we can easily access things which are far from us. If we look at people in the olden days, they would not kiss intimately as we do in our days because they were not exposed to them, so television has played a role in showing us such things.)

4.3.2 Grade 12 learners’ perceptions of their vulnerability to HIV infections

4.3.2.1 Grade 12 learners’ understanding of their vulnerability to HIV-infections

The Grade 12 learners’ discourse around perceptions of their vulnerability to HIV infections is interesting. Although the interview questions were directed to them, so that they would talk about themselves, some participants preferred to talk about adolescents as if they themselves were not part of the category. Statements like “adolescents are…” or “they do this because….” Or “many youth…” are signs of “othering” (Squire 2007:117) the disease or the situation and distancing themselves from adolescents who encounter the problems discussed. This denial of their own
vulnerability is also a reflection of deep-rooted cultural norms in rural South Africa where issues of sex and sexuality, and consequently HIV and AIDS, are still taboo.

HIV and AIDS are still covered in mystery and stigma and people who are infected believed to be responsible for their fate resulting from carelessness and promiscuity. Sometimes the infection is considered punishment from God or ancestral spirits, or witchcraft at work. If someone dies, even if it is obvious that he or she might have died of AIDS, it is uncommon for people to accept it, they prefer to look at other causes of death, for example, “he has died of diarrhoea”, “he died of pneumonia or he has been bewitched” indicating blame and othering. Consequently, these learners do not want to be associated with the disease of shame. This attitude puts adolescents at increased risk of HIV and AIDS because they are shy to seek services such as voluntary counselling and testing for fear of being associated with the disease and stigmatisation. However, with more advocacy programmes, and also as each family is affected in one way or another, these perceptions are gradually changing.

In this study, some participants discussed the issue with reference to themselves, accepting that they are part of the learners who are vulnerable and who experience the problem being discussed. Statements like “…we as learners are in a deeper and very wide possibility of contracting HIV” exemplified this.

4.3.2.1.1 Theme 1: Grade 12 learners’ awareness of their vulnerability to HIV Infections

(a) Awareness that Grade 12 learners are a more vulnerable group than others

The level of awareness of their vulnerability to HIV infections is relatively high among Grade 12 learners in secondary schools in Butterworth. The participants singled themselves out as more vulnerable to HIV than any other group in society. This is positive because, as Blake (1990:9) indicates, “by accepting our vulnerability and understanding realities about AIDS, we then take the first steps to prevent it”. This self-awareness could be attributed to many factors such as the massive campaigns that government has put in place both in school and out of school. Participants clearly articulated an understanding of their vulnerability to HIV infections as demonstrated in the extracts below.
(F3) Ee… basengozini kakhulu because okokuqala kule mihla yethu iinto zobumnandi, iinto zokuthandana aziseyontloni it’s almost like a fashion so sisengozini kakhulu because iinto zoheva isex aziseyonto ifihlakeleyo, then when you have sex ingathi mhlawumbi yinto engcono, yinto entle, yinto emnandi, so I would say that basengozini kakhulu because ayisafihlakelanga wonke umntu ufuna ukwenza njee ukuzibonakalisa nokuzicacisa.

(Ee… they are at risk because firstly, in our days having a good time, being in love and having sex is not a secret but a fashion; so we are at risk. When you have sex it is like you are doing something better. It is something nice; it is enjoyable, so I would say that we are at risk because there is no secret. Everyone wants to do it just to show off that they can also do it.)

(F5) Ee… ndicinga ukuba basengozini kakhulu because if you today like iiinight clubs, iindawo ekuselwa kuzo like zifull of abantu abantu abatsha like imost yabantu abaphaya ngabantu abatsha, and there is also if uyaafumanisa uba abantwana ab… like iiteenagers ziyathanda ukuba… like ukwenza izinto like umzekelo ndizawuthini na ndizoybeka kanjani? Ukwenza izinto like ezi zinto bazenzayo bazenze but bengekho aware ukuba baziekspowza engozini. Umzekelo uya eklabhini like wenze lento ufuna ukuyenza like awukho aware of into yokuba mandibhiheyve kanjani etc.

(Ee… I think they are so much at risk because today nightclubs and all places that sell alcohol are full of youth and you will also find that teenagers like to do things, like how am I going to put it? To do things and not being aware that what they do expose them to HIV. For instance, you go to a club and do what you want to do and not being aware of how to behave etc.)

(M4) Well I would say with a clear conscience that we as learners are in a deeper and very wide possibility of contracting HIV. Ee… as we know that it is not only with sexual intercourse that people get infected
with HIV but there are certain ways which make people end up being HIV positive. One of those ways is that in South Africa there is high rate of road accidents and we as people like to travel. Being involved in an accident might lead to HIV infection because of the blood of the people you travel with. Then once again I would like to consider another point which is the rate of sexual intercourse that grows within learners at school... trying to answer your question. I would say that yes we are because the rate of sexual intercourse that grows in South Africa and rate of pregnancy that grows in South Africa it grows with teenagers... saying that it is possible for people to be infected. One of the reasons that make people to be infected is because there is a social grant in South Africa that leads learners to be so greedy and end up being involved in sexual intercourses. When they are involved in sexual intercourses, they do not know their partners they slept with before they come and sleep with them. Now I would suggest and say that it is possible for people to be infected with HIV because of the mere reason that, the society of South Africa is so involved in such things like sexual intercourses and the high rate of accidents in South Africa and that might put people in a risk of contracting HIV.

(B1) Hayi mna ndibona sisebungozini uninzi lwethu thina asikuthandi ukusebenzisa icondom so singayifumana lula ke ngoku.

(No I see myself as at risk, a lot of us do not like to use a condom so in that way we can easily contract HIV.)

(b) Awareness of how one can contract or avoid contracting HIV

Participants were asked if they perceived themselves vulnerable to HIV infections and, if so, how? They were also asked how they could avoid contracting the disease. Learner participants demonstrated considerable knowledge about the modes of HIV transmission and how they can avoid contracting the disease. This knowledge is presumably acquired from the formal programmes in school, such as Life Skills and HIV and AIDS clubs, but also from informal sources such as peers, the media and significant people to them like relatives and religious leaders. Learner participants showed awareness that having unprotected sex with an infected person is the main
mode of HIV transmission. In this regard, having multiple sex partners was particularly regarded as a sure way of contracting HIV.

Girls were concerned that they would contract HIV from their boyfriends, especially if the latter insisted or forced them to have unprotected sex. Participants also expressed knowledge of other modes of transmission namely blood-contaminated needles and syringes. However, it appeared from responses that most of this knowledge had been repeated from class work on HIV and AIDS because in most cases participants seemed to be recalling facts from somewhere else. In terms of knowledge of how one can avoid contracting HIV, learner participants felt that abstinence from sex is the surest way to avoid AIDS. They also felt that if one has an intense sexual drive, the best thing to do is to engage in alternative activities, such as playing ball games and taking or attending debate classes to suppress the drives. Participants had the following to say regarding how they might contract or avoid contracting HIV:

(F3) Eee I think mna enye into enokwenziwa kukugxininisa kulendawo ithi abstain, meaning that ok fine it’s either you don’t have sex or it’s either you use a condom if you have sex okanye you use gloves xa uphatha igazi lomntu qha that’s all there is nothing else.

(F5) Eh! to add more on what F1 has said like kwezinye ireligion goes a long way like kwezinye iinkonzo there is iipractices ezenziwayo ezenza uba abantu babe exposed like ukusuleleka like yi HIV and AIDS so I believe like ukubana there are 50% chances zokuba ungangasuleleki and 50% chances zokuba ungasuleleka. I had my friend one time endibalisela eh ukhonza eh! there is enye into andazi ukuba kuthiwa yintoni, uhlatywa ngenaliti here apha eqatheni then nifola iline kuqalwa kowokuqala like ayirinswa or what like uba kuqalwe ekuqaleni it’s like ggu ggu kuye wonke umntu and abantu abaninzi phana wayendibalisa that they got infected but bengazazi because kuqalwa kowokuqala umntu because they had la belief yoba apha ndizohilishwa.
(c) Awareness of what constitutes a safe or unsafe/risky environment

Grade 12 learners are capable of distinguishing a risky environment from a safe one when it comes to vulnerability to HIV. They believe that school itself provides a safe environment as school work and extra-curricular activities tend to keep them too busy to contemplate risky behaviours. Sports have been particularly singled out as providing a safe space for them at school. Learners also acknowledge that supportive parents, teachers, and religious institutions all provide a safe environment for them. Religion, especially reading and sharing the word of God from the Bible, was mentioned as the most inspiring in providing a safe environment. However, learner participants view the physical location of certain schools and the presence of nightclubs and bars in the vicinity of the school and their homes as providing risky environments to contract HIV.

An interesting observation is that Grade 12 learners seem to appreciate the role that they themselves can play as peers in providing safe environments for themselves. They believe that talking about HIV among themselves can provide a healthy environment for them. Participants’ statements below demonstrate their level of awareness of what constitutes risky or safe environments.

(F1) Eh drinking a lot, going to nightclubs ndiyacinga uba zezo.

(Eee… drinking a lot, going to nightclubs I think those are the things.)

(F3)Kukungafuni ukulawulwa nokungafuni ukumamela then umntu aendaphe sesysithi yena uyancama nekhaya lakhe then abanye kwezo zinto umntu uqqibela mhlawumbi seyohlala naloo mntu athandana naye and all that stuff then kengoku xa sekunjalo ufumanise uba naphaya uyahethisheka and then aphele selengasenandawo yokuncama mhlawumbi aphele selezijwil’ eziwil’ ezijwila because most of the time singamantrambezana sifuna ukuthandwa so the moment ufumanisa ukubana that no ha a andifumani luthando lwaneleyo then uhambe uzifaka uzinyhala then ke ngoku uendapha sowungena kwezi ngxaki because you want to satisfy loo mntu uthile then ya.
(It is being rebellious and not being able to take advices and then one ends up leaving home then some end up staying with their loved ones and all that stuff. Then, in that situation she gets hurt and having no other place to go. She just throws herself to the man because most of the time we girls like to be loved. When you do not get enough love from that man, you go and force yourself to another one because you have left your home and through that, you find yourself in this problem of HIV because you want to satisfy everyone that you meet.)

(M5) I think religion is playing a huge role in reducing ilantuka I rate ye HIV and AIDS in the sense that, my experience has been always that abantu aba more engaged kwizinto zee religions they tend not to have time for izinto nje ezisecaleni that is isexual intercourse. For instance, if I am going to talk about Christianity it is like vehemently forbidden for umntu ukuba athandane nomnye umntu because kaloku iqala kwi relationship lento yokuba umntu ayolala nomnye umntu. So if awuthandananga, iichances zezokuba awuzukuya nokuya kwiinto ezidibene ne sexual intercourse. Bane law yabo ethi umntu makalale nomntu xa sele betshatile which kum iyinto endiyibona ngathi mos xa sele nitshatile of course nizohamba nyothesa nazi ukuba nobabini ni HIV negative and therefore nokuba niyalala nisafe yonke loo nto. So ndicinga ukuba it is effective in reducing the rate of HIV.

(I think religion is playing a huge role in reducing the rate of HIV and AIDS in the sense that, my experience has been always that people who engage in religious programmes tend not to have time for other things like sexual intercourse. For instance if I talk about Christianity, it is vehemently forbidden for a person to be in love with another person because it starts in a relationship for a person to sleep with another person. They have a law, which says sexual intercourse is only allowed when married with your partner, which to me seems ok because before marriage, you will have to go for an HIV test and therefore even if you have sexual intercourse you are safe and all that. So I think religion is effective in reducing the rate of HIV.)
4.3.3 Grade 12 learners’ attitudes towards the vulnerability of contracting HIV

4.3.3.1 Theme 3: Some controversies regarding what constitutes risky situations

Sometimes adolescents were not sure as to what constitute risky situations for them and they even contradicted themselves. Consequently, participants engaged in a debate on a number of issues. Some of the issues are presented as follows.

(a) Condom promotion and use

Grade 12 learners have a negative attitude towards condom promotion and condom use. Participants’ concerns are centred on uncertainty about the safety of condoms, their ignorance about its proper use, and the way in which condoms are advertised. On the other hand they view condoms as unsafe since they have invisible pores on them and prefer not to use them when engaging in sexual activities. The following is what they had to say about condom use:

(G3) Sikhuselekile phofu because u government iicondoms uzikhupha free nasezi clinics. Noxa zi free abazisebenzisi (they all agreed) noba bayazisebenzisa bambahla abazisebenzisayo.

(We are safe because the government supplies us with free condoms at clinics, although they are free there are very few who use them. They all agreed to her statement.)

(M5) … kukhutshwa ii condoms but nazo nezicondoms zikhutshwayo zisibeka kwakwi risk yokuba singane AIDS ngoku sowuyisebenzisile. Kukho izinto zokuba izogqabhuka loo condom uyisebenzisa kuhindwe kuthiwe kwayona it has got like pores ezithile ezinokwenza ukuba ubene AIDS. So uvele ubone ukuba le nto lena it is somehow condoning AIDS itself because kaloku omnye umntu uba ebehlele esoyika ukulala nomntu uzokuthi xa ebona ukuba ok kuhona icondom athi at least I am safe. Sendisitsho nokuba ubu absteyna but xa unento ethi if kuhona icondom andizukuyifumana iAIDS then I might as well engage myself kwi sexual intercourse only to find out that uyazifaka.
(...) condoms are freely available but even when using a condom you are exposed to a risk of contracting HIV. There are risks of it breaking out and they say a condom has some tiny pores, which may cause you to contract HIV. So you end up saying this thing is condoning AIDS because one may have been sceptical about sex but when seeing condoms being promoted she/he may say at least I am safe, I will not get AIDS and let me indulge, and by so doing she/he gets infected.)

4.3.4 Grade 12 learners’ perceptions on the effectiveness of the available intervention strategies at school in reducing HIV infections

4.3.4.1 Theme 5: Awareness of various HIV and AIDS programmes offered to Learners

(a) School-based programmes

As with vulnerability to HIV infections, levels of awareness among secondary school learners regarding school intervention programmes are high. Participants were able to state which HIV and AIDS programmes are available to them in their respective schools. Some participants were also able to mention programmes, which are available in other schools and not specifically offered in their own school.

(B4) ...nalapha esikolweni siyatithwa ngalo lonke ixesha nge HIV so ke asinako ukuba sebungozini because siyayazi into yonke.

(... even here at school we are taught all the time about HIV so we cannot be at risk because we know everything.)

(b) Non-school-based programmes

Participants indicated their awareness of programmes that operate around the school and, in addition, which involve learners. Participants mentioned “LoveLife”, an organisation that comes to conduct HIV and AIDS activities in schools. Since LoveLife conducts mobile activities from school to school, it sometimes takes a bit of time before they can return to a school. Nurses from local clinics have also been mentioned where they also do voluntary HIV testing. The following are participants’ experiences with non-school-based programmes:
(G2) LoveLife nabantu baseklinik, amanesi.

(LoveLife and people from the clinic, nurses.)

(M5) Akukho ziprogrammes apha esikolweni ezidibanisa ne AIDS andiyazi ukuba mandithini because kaloku baye beze abantu abazothetha ngazo so I don’t know whether to say izobayi programme yesikolo okanye aiyio programme yesikolo of course people do come now and then mhlawumbi abazothetha ngayo so what I do not know is whether they are being invited by the school okanye bazizele voluntarily.

(There are no AIDS related programmes here at school, I do not know what to say because sometimes people come so I don’t know whether to say they are school based or not. Of course people do come now and then maybe to talk about HIV and AIDS so what I do not know is whether they are being invited by the school or come voluntarily.)

4.3.4.2 Theme 6: Learners’ experiences of HIV and AIDS programmes

(a) Positive experiences

Learner participants reported that they have had positive experiences with the programmes. These experiences ranged from acquisition of knowledge about HIV and AIDS to personal conviction of some behavioural change. The life skills programmes were reported to have had considerable influence on self-awareness, decision-making and behavioural change. The following are what participants had to say about their positive experiences with the programmes:

(B4) Yha ziyasebenza kakhulu kuba kaloku ngoku mna ndiyayazi into yokuba ngoku ukulala ngaphandle kwecondom nepartner yakho ayonto iright leyo ungafumana isifo se HIV and ndiyayazi ukuba ne HIV xa unayo kuyanyazelekwa ukuba uDibane ne counselling aiyionto ekunokude ube ungazistresa ngayo okanye ude uzibulale iyakwazi nokukhuseleka.

(Yea they are very helpful because now I know that having sex without a condom with your partner is not right; you may contract HIV and I
know that if you discover that you have contracted HIV, you must go for counselling and not stress about it to the point of committing suicide.)

(B2) I think nam ziyasebenza because bayasixelela ukuphathwa komntu one HIV singathi asinokuhlala naye and stuff and how to ukuhlala nomntu onayo singakwazi ukuba sosuleleke.

(I also think they help because they tell us about how to treat people living with HIV so that we do not discriminate them and stuff and how to stay with such people without being infected.)

(b) Negative experiences

Although participants reported positive experiences as individuals, they believed that, generally, learners have had negative experiences with the programmes, thus leading to lack of interest. Participants reported that the programmes have not been able to attract most learners; hence there has been little noticeable behavioural change. The following are comments from participants regarding their negative experiences:

(G4) Azibancedi tu because sibethwa yi peer pressure okokuqala iyasibhuqa. Injalo isibhuqa nqo.

(They do not help them at all because first of all, peer pressure is killing us. We are overwhelmed by it.)

(M5) Ee… andiyazi andinokuthi bakhona okanye abekho because they do not come as often as aba bachaziweyo do so we wouldn't necessarily count them under programme yabantu besikolo because bona they come seldom as in like very seldom. We have not seen them this year.

Ee… I do not know I cannot say there are or there are not, because they do not come as often as those mentioned, so we would not necessarily count them under a school-based programme because they rarely come as in like very seldom. We have not seen them this year.)
4.3.5 Grade 12 learners’ perceptions on what needs to be done to reduce their vulnerability to HIV infections

4.3.5.1 Theme 4: Voices of participants regarding what could and should be done to reduce the risk of Grade 12 learners’ vulnerability to HIV infections

Participants made their voices heard on what they consider should be done to reduce the risk of contracting HIV and AIDS. They addressed their concerns, first to themselves and fellow learners, and thereafter to the school management and government. Words of advice to fellow adolescents centred around abstinence, religiousness, participation in HIV and AIDS clubs and the need to encourage each other in the wake of the HIV and AIDS adversity. The following are the voices of participants on these issues:

(a) To fellow learners

(F5)...into ixhomekeke emntwini abanye abantu tend to think uba iHIV is sort of a disease ethile but balibale uba ayohlukanga kwezinye izinto ezifana like ne cancer because like nazo azinyangeki in a way. So we have to make people aware that nonayo akwazi ukuziaksephtha that ngoku mna ndinayo so I think ilapho nje.

(This all depends on an individual; other people tend to think that to live with HIV is sort of a disease or something and forget that it is not different from other diseases like cancer because they are also incurable in a way. So we have to make people aware so that even the infected will be able to accept themselves.)

(G1) Kukuthi xa umntu ethandana nepartner yakhe nisaqala ukudibana before baheve isex then badishkase ukuba mahambe baqalw bayokwenza itest so that bathi beqala ukuheva isex babe bezazi izteythas zabo ukuba ba negative or ba positive na so that bangaheva isex xa sebezinonile izteythas zabo ukuba zinjani.

(When meeting a partner for the first time before they have sex there should be a discussion on HIV testing so that when they start having
sex they would already know their status whether they are negative or positive.)

(b) To Parents

(F2) Ndicinga ukuba mna abazali kumele bathethe nabantwana ngokwabelana ngesonso without protection nobungozi abangathi bazifake kubo xa besabelana ngesondo ngaphandle kokuzikhusela.

(I think parents should discuss the dangers their children might find themselves in when having unprotected sex.)

(c) To school management and government

(G5) Kuyakufuneka kaloku zinqunyanyiswe ezi zinto kuphelwa kusabelwana ngamasondo like iinto ezifana nee match kufokhaswe kwizinto ezidibene nee SCO.

(Things like matches need to be scraped off from extra-curricular activities and focus on things like the Students Christian Organisation because learners end up having sex when they go out.)

(F6) Ndicinga ukuba kwii rural areas I don’t think ukuba banayo I information eninzi nge HIV and AIDS so ukureyza I awareness pha kubantu bakwi rural areas could help uba bazikhusele and giving them ii condoms and everything ukwenzela ukuba bakwazi nabo ukuba bangosuleleki I think it would help.

(I think in rural areas people do not have enough information about HIV and AIDS, so to raise the awareness among them could help in terms of protection and giving them free condoms so that they do not contract HIV. I think it would help.)

(G3) Oogqirha ingaske bazame amayeza man kuba abantu abazisebenzisi ezi condoms ezi zikhutshwayo.
(I wish doctors could find out a cure for HIV because people do not use these freely available condoms.)

(G3) Okanye urhulumene ngakuzanywa icebo kukhutshwe abantu bahambe behlola abantu kwizindlu ngezindlu, umntu ongaphantsi kwe 18 years oheve isex abanjwe.

(Or the government can make a plan by having officers who go from home to home checking those who have had sex while below the age of 18 and if found they should be arrested.)

(d) About the ABC strategy

(M5) Mm… ndizothi nangona inzima ke lena ingeyo solution e easy but ke ndizoyibiza nevertheless aam! Iabstinence okokuqala is the best thing ever just to abstain okwangoku. Eyesibini like faithfulness and loyalty in a relationship ibaluleke kakhulu. Masithetheni silulutsha masithetheni sizilearners uba ha a makhe sihambe ngoku siyontho uyabo before siyenze yonke le nto siyontho so that xa siyenza lento siyenze kakhile siyazi uba sise. Okwesithathu I plead this one, I plead that ndicela urhulumente azame iicordoms ezingcono kunezi azinikeza abantu, because ezi zona ziyalotzeka inani ndicela nje iicordoms ezingconwanyana because you cannot run away from the fact that abantu sebebadalanyana uyababona abantakwethu aba noko iminyaka seyihambile hahahaa… (laughing).

(Mmm… I would say even though this is difficult and not an easy solution, nevertheless abstinence is the best thing ever at the moment. Secondly, faithfulness and loyalty in a relationship is very important. Let us talk as youth, let us talk as learners that we should test for HIV so that we engage in sex knowing that we are safe. Thirdly, I plead with the government to issue better condoms than the ones available because you cannot run away from the fact that people are a bit old as you can my brothers here at least they are of age hahahaa…(laughing).
### 4.3.5.2 Theme 7: Participants’ voices of what could and should be done about the programmes

A number of issues were raised by participants, regarding how the programmes could be improved. Participants also expressed the need for more external visitors to schools especially from HIV and AIDS organisations for encouragement, and commended our involvement as encouraging. Participants thought that our coming was part of the regular effort to help with the HIV and AIDS activities and that we would continue coming to schools. The following represent some of their voices:

**(B4) Ndicinga ukuba mna u government makaintavine ngoluhlobo lokuba azame ukukhuthaza amanesi ukuba nayo mawaphume ngaphandle ngamaxesha athile avizithe ezikolweni nasemaphandleni akhe ahambe eyicacisa le nto le yokuba iHIV inobungozi and ikhuselwa njani yha.**

(I think the government should intervene by encouraging nurses to go to communities at specific times to visit schools and in rural areas so that they spread the message that HIV is risky and explain how it can be prevented, yea.)

### 4.4 The Discussion of Findings

The findings of this study imply that the onus is first on the individual learner’s willingness to effect behavioural change because if they see the need for behavioural change, they will be safe. This study has established that attitudes, lack of skills in impulse control, decision-making and self-efficacy, and low self-esteem, seem to be important internal factors in learners’ continued engagement in risky behaviour. Based on these the researcher agrees with Bandura (1982) that, the reasons that adolescents do not change their risky sexual behaviour, even with the full knowledge of the consequences of HIV and AIDS, is because they lack self-efficacy to manage situations effectively.

The HSRC (2014) report shows the trend in condom use at last sex among respondents aged 15 years and older over the past four surveys both nationally and
provincially. The figure shows that condom use at last sex increased significantly both at national level and in all provinces (p<0.001) from 2002 until 2008 and then decreased in 2012. The decreases in 2012 are significant nationally and for eight provinces, Western Cape (p<0.001), Eastern Cape (p<0.001), Free State (p=0.008), KwaZulu–Natal (p<0.001), North West (p<0.001), Gauteng (p<0.001), Mpumalanga (p<0.001) and Limpopo (p<0.001). The Northern Cape had a decrease in condom use at last sex, however, this difference was not significant (p=0.111).

Findings of this study have helped the researcher develop a greater understanding of how prone adolescents are to sexual impulses and why, if not controlled, these can make them vulnerable to HIV infection. The findings suggest the need for raising self-esteem and the development of skills in risk and impulse control among learners. It has also become clearer from the findings that adolescent learners had difficulties in relationship building, especially with the opposite sex, and were easily influenced by peer pressure.

These findings have implications for the promotion of self-determination, not only in Grade 12 learners, but in all members of the school community so that they can provide appropriate support to adolescents to make them less vulnerable to HIV-infections. The findings of this study have determined the extent of learners’ understanding of the consequences of HIV and AIDS in shattering their hopes for the future, but it is also evident from the study that learners seemed to have problems in participating in interventions, because they have lost hope in their usefulness.

The findings have also shown that the learners have problems in charting their futures and establishing goals for themselves in life. It is these inadequacies that place them at risk of HIV and AIDS. The current findings have also highlighted that idle bodies, as in the absence of activities, tend to place learners at risk of HIV and AIDS; all they may think about is how to engage themselves in sexual activities.

Prevention programmes should be vigorously implemented with evidenced-based prevention strategies that combine both biomedical and social and behavioural interventions in schools, in order to prevent new infections as well as reduce mortality, and thus increase life expectancy. This is crucial because judging by the levels of knowledge and social and behavioural indicators prevention programmes
do not seem to be focusing on behaviour change communication and social change associated with undesirability of risky behaviours such as having multiple sexual partnerships, early sexual debut, age-disparate relationships and inconsistent condom use.

Furthermore, drawing on behavioural models, the study showed how the learners realised the consequences of engaging in risky sexual behaviour; the need to change behaviour; have knowledge of which specific behaviours need to be changed; acknowledge the need for support from friends or adults in the process of behaviour change, and have knowledge about the benefits of adopting new behaviours such as use of condoms. On the other hand, the Social Cognition Theory which deals with aspects of cognition and emotion has provided useful insights into understanding how adolescents acquire and maintain certain behavioural patterns including risky sexual behaviour. Unfortunately, as has been pointed out, the participants in this study did not seem to have sufficient self-efficacy to adopt new behaviour, and this puts them at risk of HIV and AIDS.

The following sections briefly discuss how the focus group interviews, have contributed to the researcher’s understanding of the learners’ vulnerability to HIV-infections at both individual and interpersonal levels.

4.4.1 At the Individual level

During adolescence sexuality develops among learners, triggering intense sexual feelings towards members of the opposite sex. Unfortunately, as explained (see 4.3.1.1), their problem is to satisfy their sexual needs in socially acceptable ways. This is compounded by the societal link between sex and reproduction, namely that sex is for pleasure, to the exclusion of sex for procreation. These societal expectations coupled with the off-limits placed on discussing sex and sexuality; tend to encourage sexual experimentation among adolescents placing them at risk of HIV and AIDS.

Literature does not specifically deal with this issue of morally acceptable means of satisfying sexual needs for everyone. The reason being that, this depends on cultural principles and religious principles. However, learners tend not to stick to such
principles and hence the message of abstinence, being faithful to one partner and condom use whenever one has sex has to be emphasised.

At the individual level, understanding of adolescent vulnerability to HIV-infection is concerned with individual characteristics that influence behaviour, such as knowledge, attitudes and beliefs. For example, the findings of this study have made the researcher more aware of how the learners’ negligence, negative attitudes, and abnormal beliefs about condom use place them at risk of contracting HIV and AIDS. Based on the findings it seems that sexuality development is a risk factor in adolescents’ vulnerability to HIV, and is indeed determined at the individual biological level.

The following sections will discuss the societal influences on the learners’ sexual behaviour and consequent vulnerability to HIV infections.

4.4.2 The Peers

Although peer influence on adolescents’ risk taking behaviour is not a new phenomenon, this study has increased the researcher’s understanding of masculine domination among adolescents as a serious factor in learners’ vulnerability to HIV. Also it has reinforced previous studies which indicate that pressure from peers to engage in sexual intercourse, either to conform to peer norms, or to please a partner, places adolescent learners at risk of HIV and AIDS.

4.4.3 The Family

While the researcher is in agreement with the view held by Donald, Lazarus, & Lolwana, (2002), that the family is the basic source of security and support, and consequently provides a safe environment for adolescents, the findings of the current study showed that poverty can, at times, drive parents to force their daughters into early marriages or prostitution thereby putting their daughters at risk of contracting HIV. It has also been indicated in the interviews that lack of openness on the part of parents to talk about HIV and AIDS and sexuality issues; places the learners at risk of HIV and AIDS. Perhaps some parents are still in denial about the disease and, like the participants in this study, tended to externalise it.
4.4.4 The School

Contrary to Donald et al. (2002), the findings of this study have indicated, schools do not generally provide learners with safe environments from HIV and AIDS which are crucial for solving social and interpersonal problems. Through this study it is becoming clearer that lack of good role models by teachers (who shave relationships with learners) and facilitators of HIV and AIDS programmes, especially those that visit schools from community-based HIV and AIDS organisations, puts learners at risk of HIV infections. Inter-school meetings have also been found to contribute to the use of drugs and alcohol abuse, which later puts the learners at risk of contracting HIV.

Using Bishop-Sambrook’s (2003) model, the presence of good role models can contribute to risk reduction in learners, through observing how their role models, whether infected or not, are managing or coping with the impact of HIV and AIDS. The researcher agrees with Donald et al., (2002), that role models are vital in transmitting values that shape adolescent learners. The findings that HIV and AIDS programmes are not taken seriously by both learners and teachers are of concern.

4.4.5 The Community

The current findings indicated that many learners are at risk, due to some beliefs and practices held by the community/society. For example, beliefs like having sex with a virgin cures HIV, and practices such as wife inheritance, use of surrogate husband, and initiation rites, place learners at risk of HIV and AIDS. These findings have serious implications for policy at both community and society levels, and although the researcher does not propose their abolition, but tends to be in agreement with the suggestion by Swartz et al. (2004), towards influencing changes in some harmful cultural practices. The study has revealed the position of learners on cultural practices, who have made a strong plea to government and traditional leaders to consider legislation that would regulate or abolish some harmful practices in South Africa.

The focus group interviews have demonstrated that Grade 12 learners are not passive recipients of information or intervention programmes on HIV and AIDS, but
that they too can, and need, to have a voice. This has been demonstrated through valuable suggestions they have made when speaking their minds to fellow learners, parents, community leaders and the government (see 4.3.5.1). The study provided participants with an opportunity to express themselves on an issue that seemed important to them.

4.5 Summary

This chapter has presented, analysed, and discussed the results of the study according to biographical information, self-efficacy scale, and HIV vulnerability scale. A summary of the respondents’ responses to the questionnaire was arranged and presented in a tabular form. On the other hand, the participants’ responses to focus group discussions have been presented verbatim from Xhosa into English, analysed according to the research themes, and briefly discussed to get an overview of the study.

The next chapter provides a summary of findings, conclusion and makes recommendations based on the results of this study.
CHAPTER 5
SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter focuses on the summary of the findings, demonstrating how they address the research questions. The conclusions are also drawn from the findings of the study. Limitations of the study as well as final recommendations are provided and then suggestions for further research are outlined.

5.1 Implications of theory for policy and practice

Other researchers applied the theory of planned behaviour in order to accommodate situations of low individual control. Such studies added perceived behavioural control to the original theory of reasoned action. Bryan, Ruiz, and O’Neill (2003) tested the utility of the theory of planned behaviour in the prediction of intentions to engage in safe sex behaviour and safe needle use behaviour among incarcerated individuals. A similar high-risk group study was conducted by Wise, Goggin, Gerkovich, Metcalf and Kennedy (2006) on condom use intentions in a diverse group of African-American youth. Results from both studies indicated a positive relationship between theory of planned behaviour variables and condom use intentions.

Consistent with Sheeran and Taylor’s (1999) meta-analysis, Bryan et al (2003) found that the theoretical constructs of the two theories account for a significant proportion of the variance in intention to use condoms. Perceived behavioural control was stronger for non-needle sharing behaviour than for condom use, and to be higher among African-American participants. Wise et al (2006) found that the Theory of Planned Behaviour accounted for a lower variance in condom use intention than Sheeran and Taylor suggested, and that perceived behavioural control for condom use was the lowest among the female sample, a possible indicator of their weaker position in relationships. Greater perceived behavioural control co-varied with positive condom attitudes and subjective norms for the sexually experienced sample. These two studies found support for the Theory of Planned Behaviour in predicting condom use intentions.
In a study with sexually active undergraduate students, Boldero, Moore, and Rosenthal (1992) examined the applicability of Ajzen and Madden's (1986) Theory of Planned Behaviour to condom use intentions and condom use behaviour in specific contexts, namely the type of relationship (steady or casual), consumption of alcohol or drugs, sexual arousal and concern about infection with HIV and other STIs. To assess the stability of intentions, intention was measured twice, the first measurement being performed prior to an independent of a sexual encounter (prior intention) and the second immediately before a specific sexual encounter (intention in action). The results of the Boldero et al (1992) study showed that measures of AIDS beliefs and AIDS evaluation indicated that respondents held positive beliefs towards condom use.

The three significant role players who mostly influenced normative beliefs were health professionals, family, and friends, in that order. The significant players, with whom participants were most motivated to comply, were friends, family, and health professionals respectively. Participants also perceived the benefits of condoms while acknowledging a few disadvantages. The majority of participants met the behavioural conditions of condom use - that is, they intended to use a condom prior to the sexual encounter, had a condom available, communicated with their sexual partners about the need to use a condom, and actually used one. This finding further validates the link between intentions and actual behaviour.

Prior intentions, communication about condom use and condom availability were also significant predictors of condom use. Intention in action, occurring in the third step of a regression analysis, together with sexual arousal, also predicted condom use. The results of this study suggest that the contextual factors of sexual arousal, condom availability, and communication with a partner about using a condom have direct effects on condom use. The study provided limited support for Ajzen and Madden's (1986) Theory of Planned Behaviour, in that there was little proof that condom use was predicted by theoretical constructs in the absence of contextual factors. The African research reviewed, confirms that the Theory of Planned behaviour – perhaps social-cognitive models in general – can be applied to sexual behaviour research in African contexts, and that data can be collected in indigenous
languages, as Giles, Liddell and Bydawell (2005) and Jemmott III, Heeran, Ngwane, Hewitt, Jemmott, Shell, and O’Leary (2007) did.

5.1.1 Application of the Social Cognitive Theory on the current study

The model suggests exposing young people to social pressures while teaching them to examine and develop skills to deal with these pressures. The model often relies on role models such as teenagers slightly older than programme participants to present factual information, identify pressure, role-play responses to pressure and teach assertiveness skills. Life skills programmes offered by LoveLife for instance offer such peer education in an informal but enjoyable manner.

5.1.2 Implications of the Social Cognitive Theory on the current study

According to Bandura (1994), an individual’s belief in his/her personal efficacy to exercise control over and regulate his/her own sexual behaviour, plays a crucial role in whether or not the idea of changing risky behaviour will be considered. In other words, if an individual does not have control over his/her own behaviour, there is little motivation to try to change that behaviour. Within the framework of self-efficacy, there are four interactive components of self-directed change for self-protective behaviours: information, personal determinants, behaviour, and environment (Bandura 1994).

Though it may seem obvious, in order to increase self-protective behaviours, individuals need to have knowledge of what those behaviours actually are. By increasing the public’s awareness and knowledge of health risks associated with not practicing preventive behaviours, the Grade 12 learners may be prompted to examine their own behaviour. Once the idea of vulnerability to HIV infections has been incorporated at the personal level, the focus is on development of self-regulative skills to translate concern or fear into self-protective behaviour. Consequently, intervention programmes in schools should increase or reinforce adolescents’ self-efficacy by making sure that they possess the required communication, negotiation, and problem solving skills.
For an individual to become efficacious at any skill, it must be practiced and guided with corrective feedback (Bandura 1992). Any HIV and AIDS intervention programmes, therefore, must enlist and create social supports, which include the larger environment. Central to this theory is the idea that translating health knowledge into self-protective action against HIV infection requires social and self-regulatory skills and a sense of personal power or self-efficacy to exercise control over sexual situations.

Finally, the Grade 12 learners must have a support group, which approves of and encourages the desired behaviour change. Although the ability to persevere and succeed in the face of difficult and challenging circumstances is an indication of high self-efficacy, initially the behaviour changes must be reinforced and encouraged to increase the probability of maintenance of the behaviours (Bandura 1994).

5.2 Summary of findings based on the objectives of the study
5.2.1 Grade 12 learners' knowledge on HIV and AIDS

The findings from the empirical study validate the information acquired from literature review in that, learners understand themselves as being vulnerable to HIV infections in a number of contexts as members of the society. There is also relatively high awareness among them of how they can contract or avoid contracting HIV, as shown by their ability to pinpoint contexts that might put them at risk of contracting HIV, such as having unprotected sex with an infected person, and practices that might help them avoid contracting the virus, such as abstinence.

5.2.2 Grade 12 learners' perceptions of their vulnerability to HIV infections

The study observed that while Grade 12 learners consider their sexuality development a normal phenomenon; they also perceive it as putting them at risk of contracting HIV. Learners perceive themselves as deficient in exercising control over their sexual desires, arising from their sexuality development. A number of school-related aspects, which predispose learners to the dangers of contracting HIV, such as, inter-schools meetings, peer pressure and sexual harassment, have been
highlighted in this study. Grade 12 learners think that their risky sexual behaviour is often because of pressure from peers to conform, or just imitation.

Also the findings that homes provide unsafe spaces for adolescents, and that they lack good role models have implications as to where and how learners are raised, sometimes putting them at risk of contracting HIV especially girls who repeatedly mentioned poverty as a motivating factor for engaging in risky sexual behaviour. This ought to be weighed against the consequences of contracting HIV, which this study has demonstrated and are well known by Grade 12 learners.

5.2.3 Grade 12 learners’ attitudes towards the vulnerability of contracting HIV

Grade 12 learners have demonstrated that they are quite aware of the consequences of contracting HIV, such as withdrawal from school, being discriminated against in society, long illnesses and suffering and eventual death. They are also aware of the various environments that can put them at risk and are unsafe. Unfortunately, this awareness of their vulnerability to HIV seems to be concealed in misconceptions about the disease and also overshadowed by their attitude of “othering” the disease.

5.2.4 Grade 12 learners’ perceptions on the effectiveness of the available intervention strategies at school in reducing HIV infections

Similar to Pattman (2006), this study found that the teaching of HIV and AIDS or Sexuality Education or Life Skills is not satisfactory. Findings of learners’ mixed responses to the HIV and AIDS programmes offered in schools have their own implications for the delivery of the programmes. For example, learners indicated negative experiences in the form of poor delivery of the programmes by teachers, such as teachers’ failure to relate to real life situations, and lack of openness in discussing issues of sexuality and HIV and AIDS. The findings point to the need for a review of the practice of interventions at school level, to make them more informative, practical, and realistic.
5.2.5 Grade 12 learners’ perceptions on what needs to be done to reduce their vulnerability to HIV infections

It is important for Grade 12 learners to adopt a new language of optimism and of the affirmation of the possibility of change and of the centrality of compassion and concern, as they engage with the AIDS pandemic. These findings also have implications for government to change the mind-set of the society when talking about HIV and AIDS. In particular, programs ought to address the attitude of othering or distancing themselves from the disease by enabling adolescent learners to accept that the pandemic is amongst them.

Learners believed that involvement in extra-curricular activities would help them to develop self-esteem and the ability to resist gangs, drugs, and other anti-social behaviour. Based on these findings, the researcher therefore subscribes to the concept of Grassroots Soccer (GRS), tried in Zimbabwe by an NGO, (Griffiths 2005), where life skills based interventions that use national and international soccer stars as role models has had tremendous success in behavioural change. Griffiths further contends that, because of this success, the concept has already been extended to countries like Zambia, Botswana, and South Africa, where FIFA has embraced it under the theme Football for Hope.

5.3 Conclusions based on the objectives of the study

5.3.1 Grade 12 learners’ knowledge on HIV and AIDS

As mentioned in Chapter 4, Grade 12 learners are quite aware of the intervention programmes available in their schools. Unfortunately, this awareness does not fully translate into behavioural change. These findings have implications for Grade 12 leaners’ vulnerability to HIV infections, as they continue to put themselves at risk of HIV and AIDS. The findings also have implications for the types of programmes offered to learners in schools, namely whether or not they appeal to adolescents.

5.3.2 Grade 12 learners’ perceptions of their vulnerability to HIV infections

Relative to what constitute safe and unsafe environment, the findings of this study have shown that Grade 12 learners consider the location of their schools as posing a risk to them. Participants singled out girls as being particularly at risk of sexual harassment by men and fellow boy learners in and outside school premises. This
observation has implications on the choice of site for new schools, suggesting that before establishing a school, it is necessary to take into consideration the physical location of the school, including the distance from homes.

5.3.3 Grade 12 learners’ attitudes towards the vulnerability of contracting HIV

It has also been established that locating homes close to bars or rest houses poses risks to learners. This has implications for municipal authorities to consider when planning residential and business areas, so that residential areas are not close to bars or rest houses, as these put Grade 12 learners at risk of contracting HIV. The notion of masculine hegemony associated with peer pressure by boys, this study found, has serious implications for adolescent vulnerability to HIV infections as they may be inclined to engage in unprotected sex with their partners or engage with multiple sexual partners to fulfil peer expectations.

5.3.4 Grade 12 learners’ perceptions on the effectiveness of the available intervention strategies at school in reducing HIV infections

Perhaps lack of learner involvement in the design and implementation of the programmes could be one of the reasons why there is low participation by learners in intervention programmes in schools, as noted in this study. This study has established that Grade 12 learners have mixed views regarding a variety of issues in school and debates have ensued about relationships between boys and girls in schools, which some learners view as risk factors.

5.3.5 Grade 12 learners’ perceptions on what needs to be done to reduce their vulnerability to HIV infections

The issue of relationships in schools has implications for intervention programmes where issues such as abstinence, sexuality, gender equity and gender equality could be discussed. The fact that parents are involved in encouraging daughters to engage in transactional sex, calls for serious questions about the moral responsibility of parents towards their children.

This study found that various cultural and religious practices in South Africa predispose learners to risk of HIV infection. These findings have implications for the way society looks at cultural practices in the context of HIV and AIDS. It is therefore incumbent on traditional leaders who are the custodians of culture and also religious
leaders, to seriously review all the harmful practices, but any change will require the support of government and other stakeholders.

While this study has not established a positive link between the media and HIV and AIDS, and while the media has been associated with risk behaviour, there is an observation that the media has been instrumental in slowing down the pandemic. Bearing in mind that the media seems to be the main source of information for learners, it has the potential for behavioural change and its influence requires a review in South Africa.

5.4 Recommendations based on the objectives of the study

5.4.1 Grade 12 learners’ knowledge on HIV and AIDS

To help students to take appropriate decisions when confronted with risky circumstances it is important that schools adopt a rather intellectual approach to guiding learners by adopting a combination of Health Belief Models that are available. It is important that learners know the ‘threats’ they face, the ‘benefits’ of avoiding taking negative steps and develop ‘self-efficacy’ in implementing appropriate behaviour change (lifestyle change) as well as handle negotiations for safe sex which are necessary to remain safe. The secondary school system should be able to set up templates that can provide ‘cues to action’ to constantly remind students what to do in certain circumstances of risk.

Moreover, as alluded in Chapter 2, the concept of the 3 Rs must always be stressed namely; one’s rights, one’s responsibilities and one’s rewards associated with boy-girl relationships (cited in Steyn, Mayburgh & Poggenpoel 2005). Such debates can demonstrate the level of understanding among adolescents of what constitutes a risky or safe context, and should be encouraged so that in the process of discussions and interaction they acquire decision-making skills, and skills in self-control.

To address the problem of low levels of HIV status knowledge, South Africa took a novel approach in launching an aggressive national campaign in April 2010 to encourage 15 million sexually active individuals to test for HIV over 12 months. At the end of the campaign, in June 2011, 14.8 million counselling sessions and 13
million tests for HIV and 8 million tuberculosis tests had been completed (Karim 2013). Campaigns like this should be encouraged and not be a once of thing.

Making use of people living with AIDS seems to support the role of cues in the health belief model, which it is believed could trigger preventive action in adolescents (Kelly 2001). Such initiatives may also correct the many myths about HIV and AIDS among learners and increase their awareness of the realities of the pandemic. In this regard, the researcher disagrees with Schenker and Nyirenda (2006), who maintain that such an approach might arouse fear in learners. On the contrary, it will help them see the reality of the disease; this study established that adolescent learners are quite aware of the disastrous consequences of contracting HIV and so fear is not unknown. Such interaction might be used to reinforce their knowledge.

5.4.2 Grade 12 learners’ perceptions of their vulnerability to HIV infections

The findings that girls are forced to engage in sexual activities just to please a boyfriend, have implications for the girls’ capacity to negotiate safe sex and this places them at risk of HIV and AIDS. While inter-school meetings are considered healthy for social development, they are considered a risk factor, as learners tend to use such opportunities to fulfil their sexual desires, engaging in unplanned and unprotected sex. These have implications for school management and government, to make schools safe places for learners, especially girls. In particular, school management should review their practices with regard to inter-school meetings, either for educational purposes or for sports, since these have been reported to provide potential risk to learners who engage in risky sexual activities. Although sexual harassment by teachers was not prominent in the study, the fact that it was mentioned is indicative enough of its existence. A strong condemnation of the practice by authorities should be followed by action against teachers who perpetrate this practice on girl learners.

5.4.3 Grade 12 learners’ attitudes towards the vulnerability of contracting HIV

Observations in this study have implications for the way sexuality education is taught. Sexuality education ought to include skills in impulse control. Parents should also be encouraged to talk openly about sexuality issues with their children. The
recommendation further verifies the findings by Steyn *et al* (2005) in South Africa, where participants requested to see someone in an advanced stage of AIDS, to be exposed to the harsh realities of the disease. Similarly, Prata, Morris, Mazive, Vahidnia, & Stehr (2006) found that knowing somebody living with HIV was predictive of protective sexual behaviour. These sentiments, however, contradict the views by Schenker and Nyirenda (2006), who believe that HIV and AIDS education cannot be taught effectively if fear and uncertainty surround the disease as this may inhibit learners’ sexual development because they may become accustomed to equate sex with disease and death.

5.4.4 Grade 12 learners’ perceptions on the effectiveness of the available intervention strategies at school in reducing HIV infections

From the findings of this study, effective delivery of intervention programmes should involve active participation by learners. Programmes should be able to appeal to adolescents, and must include play, music, drama, poems, and external guest speakers. To make HIV and AIDS programmes more realistic and practical, arrangements could be made for adolescent learners to visit hospices where AIDS patients are treated. As participants have indicated, this might assist them to internalise their responsibility in terms of the prevention of HIV transmission. Participants expressed the need for facilitators to focus on their lives, to be actively involved in the programmes, to engage in sporting activities, and to have guest speakers so that they can learn from them. The suggestion of bringing in People Living with HIV and AIDS seems to concur with that of Parker (2005), who argues that presenting programmes that are associated with personally knowing people who live with HIV may greatly contribute to HIV and AIDS risk reduction among learners.

5.4.5 Grade 12 learners’ perceptions on what needs to be done to reduce their vulnerability to HIV infections

Participants view abstinence and adherence to religious and moral codes as being the unquestionable way to reduce adolescents’ vulnerability to HIV infections, and condemn the promotion of condom use. In view of the contradictions demonstrated by adolescents where they acknowledge the difficulty of abstinence until marriage but at the same time show negative attitude towards condom use thereby aggravating the spread of HIV infections among the youth especially in schools.
There is need for a strong advocacy on the use of condoms as preventive measures against unwanted pregnancies and STIs including HIV.

Participants also call upon parents to talk openly about sexuality, HIV and AIDS issues with their children and call upon government to provide more, and effectively implement, HIV and AIDS programmes in schools. Religion seems to play a crucial role in learners’ understanding of their vulnerability to HIV; this has implications for the coordination between religious institutions and civil society organisations and government. Learners’ voices require a listening ear from the stakeholders concerned as that is the guaranteed way of succeeding with any interventions that involve them because they feel they are part of the plan.

Mwenyemasi and Kapakasa (2008), report of another initiative aimed at delivering HIV and AIDS messages through the use of hip-hop music which seems popular with teenagers. They report of a tour organised by Alliance 2015 under the theme ‘Virus Free Generation’ that was organised in 2008 and involved Malawi, Tanzania, Namibia and South Africa, as a successful project in spreading HIV and AIDS messages through hip-hop.

Poverty comes out strong from this study and could have implications for inter-generational sex, sugar daddy, concurrent multiple sexual relationship and ‘under cover prostitution’. The victims of poverty are mostly girls. Schools should set up a programme to identify such learners and put a special programme in place to offer support. NGOs could be involved in seeking help for such learners.

5.5 Limitations of the study

The sample analysed in the study was small, and its findings may not readily be generalizable, but according to Guba’s (1981) model cited in Krefting (1991), transferability is possible.

The researcher might have brought his own biases into the study which could influence the findings. This cannot be ruled out completely because as a human being, one has his way of interpreting phenomena drawing on his own cultural
orientation. However, the researcher used the triangulation method in order to ensure validity and credibility of the findings. The researcher also tried to bracket his feelings, experiences and opinions.

The researcher had to negotiate time schedules and was limited in terms of when he could carry out his research activities since schools have their own programme of activities.

5.6 Recommendations for further research

This study involved only two schools as a foundation for further research. While it has provided some insights, into Grade 12 learners’ perceptions of their vulnerability to HIV infections, it is suggested that similar studies be conducted in other districts and provinces using the same methodologies.

Since the voice of the teacher is missing in this study, it might be necessary to research teachers in order to solicit their views and experiences with regards to Grade 12 learners’ vulnerability to HIV infections and interventions in schools.

Cultural practices have been highlighted in this study as being responsible for placing learners at risk of HIV and AIDS. It might be useful to conduct studies to establish the extent of this influence on Grade 12 learners’ vulnerability to HIV infections.

In view of learners’ negative views on condom use, it might be useful to further explore their perceptions of condom promotion and use as protective measures against teenage pregnancies and sexually transmitted infections including HIV.

It might be advisable to conduct a study using the existing visual HIV and AIDS media campaign materials to assess the learners’ understanding of the messages contained in the material.
List of sources


Fort Hare Institute of Social and Economic Research. 2007. BCM Youth at Risk Study. East London: The University of Fort Hare.


APPENDICES

APPENDIX A: Ethical Clearance Certificate

Department of Sociology
College of Human Sciences
3 November 2011

Proposed title: Grade 12 learners' perceptions of their vulnerability to HIV-infections: a study in the Eastern Cape

Principal investigator: Nceba Nyembezi (student number 46120610)

Reviewed and processed as: Class approval (see paragraph 10.7 of the UNISA Guidelines for Ethics Review)

Approval status recommended by reviewers: Approved

The Higher Degrees Committee of the Department of Sociology in the College of Human Sciences at the University of South Africa has reviewed the proposal and considers the methodological, technical and ethical aspects of the proposal to be appropriate to the tasks proposed. Approval is hereby granted for Mr. Nyembezi to proceed with the study in strict accordance with the approved proposal, the recommendations made by the HDC on the 1st of November 2011 and the ethics policy of the University of South Africa.

In addition, the candidate should heed the following guidelines:

- To only start this research study after obtaining informed consent from the interviewees and from the management of the selected schools
- To carry out the research according to good research practice and in an ethical manner
- To maintain the confidentiality of all data collected from or about research participants, and maintain security procedures for the protection of privacy
- To notify the committee in writing immediately if any adverse event occurs.

Kind regards

Dr C Thomas
Chair, Department of Sociology
Tel: 27 12 429 6301

University of South Africa
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APPENDIX B: Permission Letter to ECDoE

P.O. Box 908
Butterworth
4960

Office of the Superintendent-General
Eastern Cape Department of Education
Private Bag X 0032
Bhisho
5605

Dear Sir/Madam

RE: REQUEST TO CONDUCT RESEARCH IN ECDoE SCHOOLS

I, Nceba Nyembezi am currently registered for Master of Arts in Social Behaviour Studies in HIV/AIDS with the University of South Africa and have to complete a dissertation as part of the requirements for the programme. The title of my intended study is as follows:

“Grade 12 learners’ Perceptions of their Vulnerability to HIV-infections: A study in the Eastern Cape”

The purpose of the study is to investigate Grade 12 learners' perceptions of their vulnerability to HIV-infections, in order to gain insight and understanding of their experiences around HIV and AIDS at schools in the Eastern Cape. Learners will be asked to complete a short form on their biographical details.

I would like permission to conduct a research during the second term of 2012 at two senior secondary schools in the Eastern Cape. As part of the data collection process, I intend to administer a questionnaire with twenty Grade 12 learners and conduct focus-group interviews with twelve (six boys and six girls) Grade 12 learners in each school. I will also seek permission from the parents of the children who will participate in the study.

There are no immediate benefits for participating in this research study, but the results of the study can assist in strengthening prevention programmes for grade 12 learners in the fight against HIV transmission. I am willing to share the research findings with you should these be requested.

Only the researchers will have access to the unlinked information. The information will remain confidential and there will be no “come-backs” from the answers they give. No participant or school name will be disclosed in the research study.
Their participation is voluntary and will not be forced to take part in this study. I will not put participants in a situation where they might be at risk of harm (physically, emotionally, socially, politically, economically, and psychologically) as a result of their participation. If they agree to participate, they may stop at any time and tell me that they do not want to go on with the interview. The interviews consist of similar questions for all learners and I expect that they will be as open and honest as possible in answering the questions.

Thanking you in advance.

You are welcome to contact the programme convener Mr L. Roets at 012 429 6587 should you need more information.

Yours faithfully

Mr N. Nyembezi

Cell No: 078 197 9498
Fax: 086 605 0254
05 July 2012

Mr N Nyembezi
P.O. Box 908
Butterworth
4960

Dear Mr Nyembezi

PERMISSION TO UNDERTAKE A MASTERS’ THESIS: GRADE 12 LEARNERS’ PERCEPTIONS OF THEIR VULNERABILITY TO HIV-INFECTIONS: A STUDY IN TWO BUTTERWORTH SCHOOLS IN THE EASTERN CAPE

1. Thank you for your application to conduct research.

2. Your application to conduct the above mentioned research in two (2) Secondary Schools under the jurisdiction of Butterworth District in the Eastern Cape Department of Basic Education (ECDBE) is hereby approved on condition that:
   a. there will be no financial implications for the Department;
   b. institutions and respondents must not be identifiable in any way from the results of the investigation;
   c. you present a copy of the written approval letter of the Eastern Cape Department of Basic Education (ECDBE) to the District Directors before any research is undertaken at any institutions within that particular district;
   d. you will make all the arrangements concerning your research;
e. the research may not be conducted during official contact time, as educators' programmes should not be interrupted;

f. should you wish to extend the period of research after approval has been granted, an application to do this must be directed to the Director: Strategic Planning Policy Research and Secretarial Services;

g. the research may not be conducted during the fourth school term, except in cases where a special well motivated request is received;

h. your research will be limited to those schools or institutions for which approval has been granted, should changes be effected written permission must be obtained from the Director – Strategic Planning Policy Research and Secretariat Services;

i. you present the Department with a copy of your final paper/report/dissertation/thesis free of charge in hard copy and electronic format. This must be accompanied by a separate synopsis (maximum 2 – 3 typed pages) of the most important findings and recommendations if it does not already contain a synopsis. This must also be in an electronic format.

j. you are requested to provide the above to the Director: The Strategic Planning Policy Research and Secretarial Services upon completion of your research.

k. you comply to all the requirements as completed in the Terms and Conditions to conduct Research in the ECDBE document duly completed by you.

l. you comply with your ethical undertaking (commitment form).

m. You submit on a six monthly basis, from the date of permission of the research, concise reports to the Director: Strategic Planning Policy Research and Secretariat Services.

3. The Department reserves a right to withdraw the permission should there not be compliance to the approval letter and contract signed in the Terms and Conditions to conduct Research in the ECDBE.

4. The Department will publish the completed Research on its website.

5. The Department wishes you well in your undertaking. You can contact the Director, Dr. Annetia Heckroodt on 043 702 7428 or mobile number 083 275 0715 and email: annetia.heckroodt@edu.ecprov.gov.za should you need any assistance.

DR AS HECKROODT

DIRECTOR: STRATEGIC PLANNING POLICY RESEARCH AND SECRETARIAT SERVICES
APPENDIX D: Permission Letter to School Principals

P.O. Box 908
Butterworth
4960

The Principal

..........................................
..........................................
..........................................

Dear Sir/Madam

RE: REQUEST TO CONDUCT RESEARCH IN YOUR SCHOOL

I, Nceba Nyembezi am currently registered for Master of Arts in Social Behavioural Studies in HIV/AIDS with the University of South Africa and have to complete a dissertation as part of the requirements for the programme. The title of my intended study is as follows:

“Grade 12 learners’ Perceptions of their Vulnerability to HIV-infections: A study in the Eastern Cape”

The purpose of the study is to investigate Grade 12 learners’ perceptions of their vulnerability to HIV-infections, in order to gain insight and understanding of their experiences around HIV and AIDS at schools in the Eastern Cape. Learners will be asked to complete a short form on their biographical details.

I would like permission to conduct a research during the second term of 2012 in your school. As part of the data collection process, I intend to administer a questionnaire with twenty Grade 12 learners and conduct focus-group interviews with twelve (six boys and six girls) Grade 12 learners in your school. I will also seek permission from the parents of the children who will participate in the study.

There are no immediate benefits for participating in this research study, but the results of the study can assist in strengthening prevention programmes for Grade 12 learners in the fight against HIV transmission. I am willing to share the research findings with you should these be requested.

Only the researchers will have access to the unlinked information. The information will remain confidential and there will be no “come-backs” from the answers they give. No participant or school name will be disclosed in the research study.
Their participation is voluntary and will not be forced to take part in this study. I will not put participants in a situation where they might be at risk of harm (physically, emotionally, socially, politically, economically, and psychologically) as a result of their participation. If they agree to participate, they may stop at any time and tell me that they do not want to go on with the interview. The interviews consist of similar questions for all learners and I expect that they will be as open and honest as possible in answering the questions.

Thanking you in advance.

You are welcome to contact the programme convener Mr L. Roets at 012 429 6587 should you need more information.

Yours faithfully

Mr N. Nyembezi

Cell No: 078 197 9498
Fax: 086 605 0254
APPENDIX E

CONSENT FORM FOR SCHOOL GOVERNING BODY REPRESENTATIVES

Study Title: “Grade 12 learners’ Perceptions of their Vulnerability to HIV - infections: A study in the Eastern Cape”

The researcher: Nceba Nyembezi

Purpose of Research

You are requested to allow your children to participate in the above mentioned study because they are Grade 12 learners who might have knowledge on different types of risk behaviour that learners engage in towards HIV transmission. The purpose of the study is to investigate Grade 12 learners’ perceptions of their vulnerability to HIV-infections, in order to gain insight and understanding of their experiences around HIV and AIDS at schools in the Eastern Cape.

As part of the data collection process, I intend to administer a questionnaire with twenty Grade 12 learners and conduct focus-group interviews with twelve (six boys and six girls) Grade 12 learners at the school. The purpose of this consent form is to give you the information about the study; in order to allow you to make an informed decision on allowing your children to participate. Should you be willing, I will appreciate it if you can sign the assent form.

Research Process

Your children will be asked to complete a short form on their biographical details. Some questions may be of a personal and/or sensitive nature. They may choose not to answer these questions. I will also be asking some questions that they may not have thought about before and which also involve thinking about their involvement in certain situations on how they would feel about each statement. When it comes to answering these questions, there are no right and wrong answers.

Benefits

There are no immediate benefits for participating in this research study, but the results of the study can assist in strengthening support for Grade 12 learners in the fight against HIV transmission. I am willing to share the research findings with you should these be requested.

Anonymity and Confidentiality

I will not be recording participants’ names anywhere on the biographical form and no one will be able to link them to the answers they give. Only the researchers will have access to the unlinked information. The information will remain confidential and there will be no “come-backs” from the answers they give. No participant or school name will be disclosed in the research study.
Voluntary Participation

Please understand that their participation is voluntary and they are not being forced to take part in this study. I will not put participants in a situation where they might be at risk of harm (physically, emotionally, socially, politically, economically, and psychologically) as a result of their participation. The choice of whether to participate or not, is theirs alone. However, we would really appreciate it if they do share their thoughts with us. If they choose not to take part in answering these questions, they will not be affected in any way whatsoever. If they agree to participate, they may stop at any time and tell me that they do not want to go on with the interview. If they do this there will also be no penalties and they will NOT be prejudiced in ANY way.

Once I have completed my study I will inform you of what the results are and discuss my findings and proposals around the research and what this means for grade 12 learners in this province.

If you have questions about this research study do not hesitate to contact Nceba Nyembezi at 0781979498.

CONSENT

Your signature below indicates that the aims of this research have been explained to you, and that your questions have been answered and that you allow your children to take part in this study.

Parents’ name .................................................................

................................................................. Date: .................................

Signature of parent

Parents’ name .................................................................

................................................................. Date: .................................

Signature of parent
APPENDIX F: QUESTIONNAIRE

Self-Efficacy Scale

Gender: ....................
Age: .......................  
Home Language: .........................
Residential Area: ........................

Please use the following scale to respond to the statements:

SA: Strongly Agree/ Ndiyavuma kakhulu
A: Agree/Ndiyavuma
N: Neither agree nor disagree/Andivumi kwaye Ndizingaphiki
D: Disagree/Andivumi
SD: Strongly Disagree/Andivumi kwaphela

1. I think that when two 17-year old learners are considering having sex, it would be wise for them to discuss safer sex.
Ndicinga ukuba xa abantwana abana 17 eminyaka becinga ukwabelana ngesondo bubulumko ukuba baxoxe ngokwabelana khuselekileyo.

2. I shall (when I am in/ready for such a relationship) discuss safer sex with my partner before we have sexual intercourse.
Xa ndithandana okanye ndilungele oko ndiyakubonisana neqabane lam ngendlela ekhuselekileyo phambi kokuba sabelane ngesondo.

3. My friends think it is a good idea to practice safer sex.
Abahlolo bam bayibona iyimbono entle into yokwabelana ngesondo khuselekileyo.

4. I think it’s a good idea to get an HIV test.
Ndicinga ukuba yimbono entle ukuvavanyelwa intsholongwane kagawulayo.

5. I think that when two 17-year old learners are considering having sex, they should discuss HIV-testing.
Ndicinga ukuba xa abafundi ababini abaneminyaka elishumi elinesixhenxe befuna ukwabelana ngesondo kumele ukuba baxoxe ngokuzivavanyela intsolongwane kagawulayo.

6. I shall (when I am in/ready for such a relationship) consider discussing HIV-testing with a sexual partner.
Ndinya (xa ndi/ndilungele ukuthandana) kuwuxoxa umba wokuvavanyelwa intsholongwane kagawulayo nalowo ndabelana naye ngesondo.

7. Condoms help prevent the spread of HIV.
Ii Condoms zinceda ukukhusela ukunwenwa kwentsholongwane kagawulayo.
8. My family thinks it is a good idea to practice safer sex.

Ekhaya bacinga ukuba yimbono entle ukuzikhusela xa ndisabelana ngesondo.

9. I plan to get an HIV test in the future.

Ndiceba ukwenza uvavanyo lwe ntsholongwane kagawulayo kwixesha elizayo.

HIV Vulnerability Scale

Please use the following scale to respond to the statements:

SA: Strongly Agree/ Ndiyavuma kakhulu
A: Agree/ Ndiyavuma
N: Neither agree nor disagree/ Andivumi kwaye Ndingaphiki
D: Disagree/ Andivumi
SD: Strongly Disagree/ Andivumi kwaphela

10. I feel that the chances are good that I can contract HIV.

Ndibona ukuba manintsi amathuba okuba ndingosuleleka yintsholongwane kagawulayo.

11. I am afraid that I might contract HIV.

Ndiyoyika ukuba ndingosuleleka yintsholongwana kagawulayo.

12. I believe that I can be exposed to HIV infection if my sex partner is heterosexual.

Ndikholelwa ekubeni ndingosuleleka yintsholongwane kagawulayo ukuba iqabane endabelana nalo ngesondo alikho gay.

13. I believe that I can get HIV even if I am only having sex with one partner.

Ndikholelwa ekubeni ndingayifumana intsholongwane kagawulayo nokuba ndabelana ngesondo neqabane elinye kuphela.

14. AIDS causes death.

Ugawulayo (AIDS) uyabulala.

15. I would rather have any other terminal illness than AIDS.

Kungcono ndibenesinye isifo esibulalayo ngaphandle kukagawulayo.

16. I would rather die from a violent death (e.g., gunshot, car accident, etc) than from AIDS.

Ndikhetha ukufa ngenxa yokudutyulwa okanye ndigilwe yimoto kunokuba ndibulawe ngugawulayo.

17. AIDS is probably the worst disease a person can get.

Ugawulayo sesona sifo sibi umntu anokusifumana.

18. I believe that the chances of contracting HIV can be significantly
reduced by using a condom.

Ndinenkolo yokuba amathuba okosuleleka yintsholongwane kagawulayo ambalwa xa kusetyenziswa icondom.

_______ 19. I think it is worth the effort to have condoms readily available.

Ndicinga ukuba liphulo elihle ukuba icondom zifumaneke lula.

_______ 20. I feel that the chances of contracting HIV can be reduced by having sex with only one partner.

Ndibona ngathi amathuba okosuleleka yintsholongwane kagawulayo angacuthwa ngokwabelana ngesondo neqabane elinye.

_______ 21. If a condom is not available, it would be worth the effort to refrain from sexual activity to obtain a condom.

Ukuba icondom ayikho iyakubayinto ebalulekileyo ukuba kungabelwana ngesondo de ibe ikhona icondom.

_______ 22. It is embarrassing (to me) to buy condoms.

Lihlazo kum ukuthenga icondom.

_______ 23. I would offer first-aid to an AIDS patient because I would feel guilty of not offering to help.

Ndingalunika uncedo lokuqala kwisigulane sikagawulayo kuba ndingaziva kakubi xa ndingasincedi.
APPENDIX G: Interview Schedule (Translated into Xhosa)

Introduction (Approximately 5 minutes)

- The researcher greets the participants and introduces himself and reads the purpose of the study, benefits of the study, voluntary participation, anonymity and confidentiality to the whole group.
- Introduction of participants: self-introduction.
- Questions about sports, about school life: subjects, career aspirations (To ease the tension)

First Question:

(Tell me how it is being a Grade 12 learner in the era of HIV and AIDS)

Probing questions depending upon the responses to the core question:
1. There is growing problem in secondary schools of learners engaging in risky sexual activities, why do you think they do so?
   
   Kukho ingxaki ekhulayo ezikolweni apho abantwana besikolo bezibandakanya kwezokwabelana ngesondo, ucinga ukuba yintoni unobangela?

2. Which behaviours that you see in boys and girls are risky behaviours?

   Yeyiphi indlela yokuziphatha eniyibona ibeka amantombazana namakhwenkwe engozini yokufumana intsholongwane kagawulayo?

3. Do you perceive today’s learners as vulnerable to HIV infections?

   Ingaba nibabona abafundi banamhlanje besengozini yokufumana intsholongwane kagawulayo?

4. How do the religious values influence the learners’ vulnerability to HIV infections?

   Ezenkolo zibuchaphazela kanjani ubungozi babafundi bokufumana le ntsholongwane?

5. Which scenarios do you think expose Grade 12 learners to HIV infections outside the school?

   Zeziphi iimeko enicinga ukuba zibeka abafundi emngciphekweni wokosuleleka yintsholongwane kagawulayo ngaphaya ngaphandle kwamasango esikolo?

6. Which other situations put the youth at risk of contracting HIV?

   Zeziphi ezinye iimeko ezibeka ulutsha emngciphekweni wokosuleleka yintsholongwane kagawulayo?

7. In your opinion, is the environment at home safe? Probe how?

   Ngokwembono zenu ingaba imeko yokuhlala ekhaya ikhuselekle malunga nale ntsholongwane? Kanjani?

8. What do you think can be done to avoid contracting HIV?

   Yintoni enicinga ukuba ingenziwa ukukhusela ukosuleleka yintsholongwane kagawulayo?
Second Question:
(Tell me about HIV and AIDS programmes in your school)

Probing questions depending upon responses to the core question:

1. How do you think these programmes have been able to change the learners’ lifestyle/behaviour positively?
   *Nicinga ukuba ezi nkqubo ziyitshintshe njani indlela yokuziphatha kwabafundi ngezesondo?*

2. In your view, what programmes seem to be working and why?
   *Ngokwembono yenu, zeziphi iinkqubo ezibonakala zisebenza kwaye ngoba?*

3. Which ones are not working and why?
   *Zeziphi ezingasebenziyo kwaye ngoba?*

4. Which ones are most popular among learners and why?
   *Zeziphi eziqhelekileyo kuni batundi kwaye ngoba?*

5. Which ones are not popular with learners and why?
   *Zeziphi ezingaqhelekanga kubafundi kwaye ngoba?*

6. In your view, how can these programmes be improved to meet the needs of learners in changing their sexual behaviour?
   *Ngokubona kwenu, zingaphuculwa njani ezi nkqubo ukuhlangabezana neemfuno zabafundi ekutshintsheni isimo sabo sokuziphatha ngokwesondo?*

**Concluding questions** (to complement responses to research question one)

1. What is your idea of a good time here at school?
   *Nicinga ukuba yeyiphi indlela yokuzonwabisa apha esikolweni?*

2. Which situations or places in the school or around the school can place you at risk of contracting HIV?
   *Zeziphi iimeko okanye iindawo apha esikolweni ezinokunibeka emngciphekweni wokosuleleka yintsholongwane kagawulayo?*

3. In your own view, what should schools do to prevent the spread of HIV?
   *Ngokweyenu imbono, yintoni emele ukwenziwa sisikolo ukuthintela ukunaba kwale ntsholongwane?*

4. Apart from the school, who else can help learners to avoid contracting HIV? How?
   *Ngaphandle kwesikolo, ngoobani abanye abanokubaluncedo kubafundi ukuba bangosuleleki yile ntsholongwane kagawulayo?*

5. Is there anything else you would like to add concerning the interview?
   *Ingaba ikhona enye into eninokuthanda ukuyonceza ngale ngxoxo?*

Thank the participants for their time and contribution to the study and highlight my willingness to share the research findings with them and a follow up interview with them should there be any missing information. Ask the next group to come in.