HIV/AIDS KNOWLEDGE AND SEXUAL BEHAVIOUR AMONG SCHOOL LEARNERS IN HARARE , ZIMBABWE

by

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DECLARATION

I declare that HIV/AIDS KNOWLEDGE AND SEXUAL BEHAVIOUR AMONG SCHOOL LEARNERS IN HARARE , ZIMBABWE is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete reference and that this work has not been submitted before for any other degree at any other institution.

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Abstract

This study describes the HIV/AIDS knowledge of Form 1 secondary school learners in Harare. Structured interviews were conducted with 75 learners from four schools representing a low density, a high density, a rural and a private school.

Most learners had obtained their HIVAIDS knowledge from schools and a few did so from their parents. None of the learners had reportedly yet engaged in sexual activities and all had heard about HIV, but not all knew what HIV was, and even fewer could define AIDS. Generally the learners' HIV/AIDS knowledge levels were high but some misconceptions persisted.

Future programmes should emphasise that there is no cure for HIV/AIDS, and that condoms should be used at every sexual encounter. Radio, television and school programmes should emphasise that every person can become infected with HIV/AIDS, if preventive measures are disregarded.

KEY TERMS:

HIV/AIDS knowledge, HIV/AIDS prevention, secondary school learners, Zimbabwe

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List of Abbreviations

A number of abbreviations appear throughout the dissertation. In order to assist the readers the following list of abbreviations used is provided.

AIDS -Acquired Immune Deficiency Syndrome

ARV - Antiretroviral

HIV -Human Immuno Deficiency Virus

HIV-ve - HIV negative

HIV+ - HIV positive

MOESC -Ministry of Education Sports and Culture (of Zimbabwe)

MOHCW -Ministry of Health and Child Welfare (of Zimbabwe)

MYDGEC -Ministry of Youth Development, Gender and Employment Creation (of Zimbabwe)

PPTCT - Prevention of Parent to Child Transmission

SSA -Sub Saharan Africa

UN -United Nations

UNAIDS -Joint United Nations Programme on HIV/AIDS

UNICEF -United Nations International Children`s Emergency Fund.

Unisa University of South Africa

VCT - Voluntary Counselling and Testing

WHO -World Health Organization

CHAPTER 1

INTRODUCTION AND BACKGROUND INFORMATION

1.1 INTRODUCTION

Acquired Immuno Deficiency Syndrome (AIDS) is an infectious disease that is caused by the human Immuno deficiency virus (HIV). The virus affects and destroys the immune system and people become more prone to opportunistic infections (Lindsay 2001:4). AIDS was first diagnosed in Zimbabwe in 1985 (MOHCW 1999:1). At that time, only a few people were affected. However, now AIDS has moved from being an individual problem to being everyone's problem because it has affected the lives of every family in Zimbabwe.

HIV/AIDS is a major public health concern worldwide. Sub Saharan Africa (SSA) is the worst affected area with 64% of all people with HIV living in Sub Saharan Africa (UNAIDS 2006:15) and half of the new cases of HIV being among young people aged 15-24 years (UNAIDS 2004:93). Nearly half of the global population are younger than 25 years of age (UNAIDS 2004:93) and nearly half of the population in Zimbabwe (43%) comprises young people aged 15 years or younger, according to the 2003 United Nations report.

HIV sero-prevalence rates among young people aged 15 to 19 years was 12% for women and 2% for men in Zimbabwe (MOHCW 2003:14). HIV prevalence for young women attending antenatal clinics ranges from 28% among women aged 15 years to 33% among women aged 21 years in Harare, Zimbabwe (MOHCW 2000:26). Data on HIV/AIDS in Zimbabwe show that the age group of 6 to 15 years is least affected (MOHCW 2004a:14). The hope of slowing down the spread of HIV among young sexually active persons remains a challenge. The future of the AIDS epidemic will be shaped by the sexual behaviours of this younger age group since it is the least affected,

hence the need to target HIV prevention strategies at this group while they are still likely to be HIV negative.

In response to the HIV/AIDS epidemic, the Zimbabwean government introduced HIV/AIDS education among learners in schools in 1993 as one of the HIV/AIDS prevention strategies. HIV/AIDS education in schools is an important prevention strategy because HIV prevention efforts targeted at young people, before they become sexually active and/or HIV positive, may slow down the spread of the epidemic in Zimbabwe. This study focuses on HIV/AIDS knowledge and high risk sexual behaviour among school learners in Harare, Zimbabwe.

Zimbabwe is a landlocked country in Southern Africa. It borders Zambia to the north, Botswana in the south west, Mozambique in the east, South Africa in the south and Namibia in the west (see figure 1.1). Harare is the largest and capital city of Zimbabwe.

Fig 1.1 Map of Zimbabwe, neighbouring countries and study site.
(http//www.mapsofworld.com accessed 23 August 2007)

1.2 BACKGROUND TO THE STUDY

The education system in Zimbabwe is divided into primary, secondary and tertiary education. Primary school is from grade 1 to grade 7 and secondary school is from form 1 to form 6 and tertiary education institutions are the colleges and universities. There

are low-density schools, high-density schools, private schools, and rural schools. In Harare there are 209 primary schools and 85 secondary schools (MOESC 2005:2).

The Ministry of Education in Zimbabwe introduced HIV/AIDS education in all primary schools from grade 4 to grade 7 and in secondary schools from form one up to form 6. The curriculum for HIV/AIDS education and life skills in schools in Zimbabwe was developed in 1993 and was revised in 2003. Training workshops on how to implement the programme were conducted for education officers and headmasters at national and at regional levels. Both primary and secondary school teachers were trained (Musumi 1993:1). A total of 8-10 teachers from each school in Harare were trained initially and refresher courses have been conducted on an ongoing basis.

The purpose of the HIV/AIDS education and life skills programme in schools is to provide knowledge about HIV/AIDS to learners, to promote healthy lifestyles, positive values and attitudes and responsible behaviour among learners (MOESC 2003:5). This is in line with the Zimbabwe National HIV/AIDS policy which states that children should have access to knowledge and life skills that are needed to avoid HIV infection (MOHCW 1999:22).

The curricula for primary and secondary school learners differ in content levels of the information but basically they include (MOESC 2003:5-7)

- Human growth and development.
- Information on HIV/AIDS
  - What it is
  - How it is acquired
  - How it is transmitted and prevented.
- Life skills that promote positive behaviour change.
- The impact of HIV/AIDS on individuals, families, the nation.
- Promoting behaviour that prevents and reduces HIV infection and transmission among learners.

Through this HIV/AIDS education and life skills programme it is hoped that learners in Zimbabwe will be able to identify ways by which HIV can be acquired, transmitted and prevented. They will acquire knowledge and life skills to protect themselves from acquiring HIV/AIDS, recognise abuse, make informed choices, discuss issues about HIV/AIDS openly, and use life skills that combat substance and drug abuse, deal effectively with challenges and demands of everyday life and uphold moral values based on culture and religion to prevent the spread of HIV and AIDS (MOESC 2003:5-7).

In Zimbabwe, every teacher, teaching grades 4-7, should allocate one 30-minute lesson per class to HIV/ AIDS education and life skills every week. For form 1-4, the lesson lasts for 40 minutes and for form 5-6, the HIV/AIDS education and life skills programme is taught as part of the general paper (MOESC 2003:7) on mastery of the English language and general knowledge in preparation for university entry examinations.

According to the UNAIDS report on the global AIDS epidemic (2006:62**)**, 50% of persons living with HIV were infected during adolescence and young adulthood. The Zimbabwe Young Adult Survey (MOHCW 2001-2002:1) found that many youths engaged in behaviours that put them at risk of HIV infection and 71% of youths aged between 15 and 29 years had sexual intercourse before the age of 20. The age of sexual debut, the degree of sexual activity and number of partners are factors that increase the risk of HIV among youths (Buseh, Glass, McElmurry, Mkhabela & Sukati 2001:526). Sexual debut in Tanzania was as early as 10 years according to Population Reference Bureau 2000 as cited by Ikamba and Ouedraogo (2003:2) which is lower than the findings of a previous study that was conducted in Tanzania, where the age of sexual debut was reportedly 15.5 years for boys and 15.8 years for girls (Maswanya, Moji, Horiguchi, Nagata, Aoyagi, Honda, & Takemoto1999:185). In Zimbabwe there was a delay in sexual debut for girls according to the Minister of Health's report (The Herald Thursday 7th September 2006 (see Annexure E). Two studies in Zimbabwe showed that male adolescents were sexually active by the age of 15 and therefore at risk of HIV infection (Boohene, Tsodzai, Hardee-Cleveland, Weir & Janowitz 1999: 266).

These authors reported knowledge about HIV in their study to be 70% but the HIV knowledge among adults in Zimbabwe is 98% for women and 99% for men (ZDHS 2005-

2006:20). No information on HIV knowledge among young people who are below the age of 15 years in Zimbabwe could be traced and thus there appears to be a need to come up with messages targeted at Zimbabwe's young people so as to influence their sexual risk behaviours to reduce their chances of becoming infected with HIV.

Although the HIV prevalence rate among the age group 15–49 in Zimbabwe has declined from 20.15% (2001) to 18.1% (2006) (UNAIDS 2006:16) a significant proportion of the decline in the prevalence rate could be attributed to high mortality rates (UNAIDS 2006:17). In Harare, the capital city of Zimbabwe, among the age group 15-24, HIV prevalence reportedly remained at 20% in 2005 (MOHCW 2005:27), hence the need to provide targeted HIV information, enabling young people to make informed choices.

If HIV prevention information is targeted at young age groups who adopt preventive sexual behaviours, there is a likelihood of lowering HIV and AIDS rates up to adulthood. Such behaviours include delaying their sexual debuts, avoiding sexual relations between the young women and older men, who are more likely to have had multiple sexual partners (and thus more likely to be HIV positive) than younger men. Having multiple sexual partners and alcohol and drug abuse should be avoided. Young men should not use the services of prostitutes (MOHCW 2004a:16-17).

It is against this background that the researcher proposes a study to assess the knowledge and high risk sexual behaviour of secondary school learners in order to suggest a solid basis for targeted HIV prevention strategies.

1.3 STATEMENT OF THE PROBLEM

Knowledge and high risk sexual behaviour among youths in Zimbabwe need to be assessed in order to come up with targeted health education programmes and development programmes that will enhance preventive behaviour adoption by youths. HIV infection among the age group 5 to 14 years is reportedly low in Zimbabwe with 120 000 children living with HIV compared to 1.8 million adults during 2003 (Lindsay 2001:1) Since the prevalence rate is low among this age group, HIV prevention strategies targeted at this age group may provide an opportunity to reduce the HIV+ve incidence rates among the

future generation(s). The Zimbabwean government recognises the importance of this "window of hope" and has called for HIV prevention strategies that are specifically targeted at this young age group (MOHCW 2004b:14).

Consequently there is a need to study youths' knowledge and high risk sexual behaviours and to come up with strategies to enable young people to make responsible decisions concerning HIV/AIDS before they reach adulthood. According to the Zimbabwe Young Adult Health Survey (MOHCW 2001-2002:31), many youths engage in behaviours that put them at high risk of HIV infection like alcohol and drug abuse, sex with older men who might be infected with HIV. Hence, there is a need to assess their knowledge and sexual behaviours which might suggest strategies for reducing high-risk sexual behaviours among Zimbabwe's secondary school learners.

Although efforts have been made to increase awareness of HIV/AIDS, risky sexual behaviours continue to be documented in studies. Mataure, McFarland, Fritz, Kim, Woelk, Ray and Rutherford (2002:217) studied alcohol use and high risk behaviour among adolescents and young adults in Harare, Zimbabwe. These authors reported that alcohol use among secondary school learners was high with rates of 63% for females and 70% for males and that they engaged in high risk behaviours while intoxicated. Young girls were having sex with older men in exchange for money while young boys were having sex with casual sex workers. Fritz, Woelk, Basset, McFarland, Routh, Tobaiwa and Stall (2002:227) found a strong association between alcohol use and sexual risk behaviours in Harare, Zimbabwe. A baseline survey on experiences of youth in urban Zimbabwe showed that youths engaged in high risk behaviours like early sexual experience, prostitution, drug and alcohol abuse (Phiri 2000:4-9).

The question is whether this is due to a lack of HIV knowledge and/or strategies to adopt in order to reduce high-risk sexual behaviours. According to Zimbabwe's Young
Adult Health Survey (MOHCW 2001-2002:70) human behaviour is influenced by different factors which include knowledge, risk perception and attitude towards condoms, persons infected with HIV and gender roles. However, knowledge is reported as an important influential factor on sexual behaviours. A review on social science research on HIV/AIDS

(Freudenthal 2001:12) showed that many researchers consider education as one of the most important tools in preventing the transmission of HIV.

A joint press release by UNICEF, UNAIDS and WHO (UNICEF 2002:1) stated that a major United Nations (UN) study, (entitled *Young people and HIV/AIDS: Opportunity in crisis*) reported a lack of knowledge about HIV/AIDS among young people which put them at risk of acquiring HIV. The report went on to say that there was a strong linkage between what young people knew and how they acted.

1.4 SIGNIFICANCE OF THE STUDY

This study will provide information about HIV knowledge and high risk sexual behaviour among secondary school learners in Harare, Zimbabwe. This will enable the researcher to assess the impact of Zimbabwe's AIDS awareness campaign and AIDS education drives in the secondary schools.

The findings of the study may be useful in designing health education programmes that are targeted at secondary school learners considering their knowledge, attitudes, beliefs and practices pertaining to HIV/AIDS and sexual behaviours.

1.5 PURPOSE OF THE STUDY

The purpose of the study is to document current information on HIV knowledge and their self-reported sexual behaviours among secondary school learners in Harare, Zimbabwe. This knowledge may be used to re-design more learner-specific HIV/AIDS awareness programmes for secondary school learners in Zimbabwe.

1.6 RESEARCH OBJECTIVES

The objectives of this study are to:

* Describe demographic characteristics of the secondary school learners who participate in this study.

* Assess secondary school learners' HIV/AIDS knowledge.
* Identify high risk sexual behaviours practiced by secondary school learners in Harare, Zimbabwe, as reported by themselves in response to questionnaire items.
* Recommend ways in which Zimbabwe's HIV/AIDS campaign directed at secondary school learners, could become more effective.

1.7 RESEARCH METHODOLOGY

The research methodology will be discussed briefly in this chapter, including information about the research design, population, sample and sampling technique, data collection, validity and reliability, and data analysis.

1.7.1 Research Design

A non-experimental design that is exploratory and descriptive in nature using the quantitative approach will be used. According to Brink (1999:108), a non-experimental study is carried out in a natural setting and the phenomena are observed as they occur. Data can be collected without making changes or introducing treatments. This design has been chosen because it will allow the researcher to collect data in a natural setting.

Exploratory studies address issues that have not been previously studied in order to identify new knowledge, new understandings or new meanings. The aim is to understand the phenomenon of interest (Polit & Hungler 1999:19).

Descriptive designs provide a description of variables in order to answer the research question (Brink 1999:109). Descriptive design is also a way of discovering new meaning and describing what exists, determining the frequency with which something occurs. Descriptive design is usually used where there is little information about a phenomenon (Burns & Grove 1997:26).

The exploratory descriptive design has been chosen because it will generate new information about knowledge and high risk sexual behaviours of secondary school learners

in Harare that could influence their chances of becoming HIV positive or to remain HIV negative.

1.7.2 Population

The study population includes girls and boys in school who have completed seven years of primary education and are in their first year in secondary school. They will be drawn from urban and rural secondary schools which include one high density school, one low density school, one rural school and one religious (private) school. The schools were purposefully selected to represent the different types of schools that are prevalent in Zimbabwe.

1.7.3 Sample and sampling technique

Sampling involves the selection of a group of people, events, behaviours or elements with which to conduct the study (Burns & Grove 1997:341).

A non-probability or convenient sample will be used because it involves participation of persons who happen to be “in the right place at the right time” (Burns & Grove 1997:350).

Ten girls and boys from each of the four secondary schools that have been randomly selected will take part in the study. The total sample size will comprise 40 girls and 40 boys from the form one learners, implying that 20 learners will participate from each of the four participating secondary schools, bringing the sample’s total to 80 respondents. The schools were grouped into four groups representing the different types of schools, namely high density schools, low density schools, rural and religious schools. The participating secondary schools were randomly selected from each of the four groups of schools using a sampling frame. A sampling frame is a listing of all the members of a population that meet the sampling criteria (Burns & Grove 1997:346).

The researcher will talk to the headmasters of the respective schools about the study and request permission to talk to the form one students in their classroom at a time that is convenient to them. The researcher will explain the study to the learners with emphasis on

voluntarism, confidentiality and honesty. The first 10 male and the first 10 female learners who will be available on the day that the researcher will be at a specific school, who meet the study entry criteria and who volunteer to enter the study at each school will be scheduled for a face to face structured interview with the researcher. Consent will be obtained from parents/guardians before the eligible under age learners can be interviewed. The interviews will be conducted over a period of two days in each of the participating four schools.

1.7.4 Data collection instrument

Data will be collected using a structured interview schedule with both open and closed-ended questions. The method has been chosen because it is a quick way of obtaining data and it is less expensive in terms of time and money (Brink 1999:153).

The questionnaire will be designed to include the following aspects: demographics; HIV knowledge; HIV prevention methods; sources of HIV knowledge and sexual behaviours.

1.7.5 Validity and Reliability

According to Brink (1999:167), validity is the ability of an instrument to measure or to test what it is supposed to measure or test while reliability is the ability of an instrument to obtain consistent results when repeated under the same conditions or similar situations even though the subjects differ or the environments differ.

To enhance validity, the instrument will be developed based on questions that have been used in literature, reviewed in chapter 2 of this dissertation, that were assessing HIV knowledge and sexual behaviour. The instrument will also be reviewed by experienced researchers and a statistician.

Validity and reliability issues will be discussed in more detail in chapter 3 of this dissertation.

1.7.6 Method of data analysis

Data will be analysed using descriptive statistics. Descriptive statistics convert and condense data into organised visual presentations, such as graphs and tables, that are meaningful to the readers of the research report (Brink 1999:179). Data will be coded and analysed using the Epi Info 2004 version 3.2.2 statistical software. A statistician will assist with data analysis (see annexure D).

1.8 ETHICAL CONSIDERATIONS

The protection of research participants has become a high priority among members of the scientific and health care communities (Polit & Hungler 1999:29). As such, it is crucial that their rights be protected. In this research, ethical issues will be taken into consideration. The ethical principles that will be considered are beneficence, respect for human dignity and justice.

1.8.1 Principle of beneficence

This principle encompasses the maxim of above all to do no harm (Polit & Hungler 1999:31). The principle includes multiple dimensions which are freedom from harm, freedom from exploitation, benefits of research and risk/benefit ratio. These dimensions will be considered in this study by ensuring that participants are informed about the study, the benefits and risks. Permission of the parents or legal guardian will be obtained before the study is conducted.

1.8.2 Principle of respect for human dignity

This principle ensures that the right to self determination and full disclosure are respected (Polit & Hungler 1999:33). This will be ensured in the study by providing all the information about the study so that participants can decide whether to participate or not without incurring any penalties or prejudicial treatment. No person will be forced to participate.

1.8.3 Principle of justice

This principle includes fair treatment and the right to privacy (Polit & Hungler 1999:35). This right will be fulfilled in the study by ensuring that no identifying information will be collected from participants and confidentiality will be ensured throughout the research process.

1.9 LIMITATIONS OF THE STUDY

The study will be conducted in four different schools in Harare, Zimbabwe, which include one urban high-density school, one urban low-density school, one rural and one mission or religious school. The sample will be small and the results cannot be generalised to all learners in Zimbabwe. Further limitations of this study include that only learners in form 1 (the first year at secondary school) will be included in the study and that only structured interview schedules will be used to collect data.

1.10 DEFINITION OF KEY TERMS USED IN THE REPORT

The following terms are used repeatedly throughout the dissertation. The terms are defined as intended by the researcher so that readers and the researcher can approach this report using similar terms of references.

Acquired Immuno deficiency syndrome (AIDS) is an infectious disease caused by the human Immuno deficiency virus (HIV). The virus affects and destroys the immune system and people become more prone to opportunistic infections and other conditions of ill health (Lindsay 2001:4).

Human Immuno Deficiency virus (HIV) is the virus that causes AIDS. There are two types of HIV, Type 1 and Type 2. Type 1 is the most common and Type 2 is rare (Lindsay 2001:1).

Human Immuno Deficiency virus (HIV) knowledge implies that the person realises that HIV/AIDS is spread from person to person, mostly through heterosexual intercourse, that

there is no cure for HIV/AIDS, and that it can be prevented by using a condom effectively every single time that one has sexual intercourse.

Secondary School learners (form 1) are learners who will have completed seven years of primary education and are in their first year in a secondary school in Harare, Zimbabwe.
Sexual behaviour refers to behaviours leading up to and including sexual intercourse.

Youth includes the terms ‘adolescent’ and ‘teenager’, referring to young people who are undergoing physical, mental and cultural transition from childhood to adulthood. According to the WHO (2006:1) adolescents are people aged 10-19 years and young people 10-24 years. In Zimbabwe youths are those in the age group of 10-30 years. (MYDGEC 2000:12).

For the purpose of this study, young people will be used to cover people aged 10-30 years as defined by the Zimbabwe National Youth policy and will be used interchangeably with youth.

1.11 ORGANISATION OF THE RESEARCH REPORT

The dissertation comprises five chapters and has been outlined as follows:
Chapter 1 presents the introduction, background to the study, the research problem, the aims of the study, objectives, definitions, ethical considerations, limitations and organisation of the report.

Chapter 2 discusses the literature relevant to HIV knowledge and sexual behaviour globally, in Africa and in Zimbabwe.

Chapter 3 outlines the research methodology used in the study.

Chapter 4 presents the data analysis and discussion.

Chapter 5 provides conclusions, limitations and recommendations based on the research results.

A bibliography listing all references used in the text is included in alphabetical order according to the surname of the first author. Annexures containing letters requesting and granting permission to conduct the study (annexures A and B respectively), the research instrument (annexure C) as well as newspaper reports (annexure E) and a letter of assistance with data analysis from a statistician (annexure D) are included.

1.14 CONCLUSION

In this chapter, the background information of conducting this research has been highlighted. The research problem, population, sample and sampling procedure, ethical considerations and limitations of the study were discussed.

Chapter two will review literature relevant to HIV/AIDS knowledge and sexual behaviour among young people globally, in Africa and in Zimbabwe.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Literature review about HIV/AIDS knowledge and high risk sexual behaviour among young people was carried out to identify baseline data on what was known about the topic. Literature review is a systematic process of identifying, scrutinising and summarising written information about a specific research problem (Polit & Hungler 1999:645).

2.2 PURPOSE OF THE LITERATURE REVIEW

The purpose of the literature review is to establish what is known regarding the topic of interest. “The work of a researcher should be built on the works of others” (Burns & Grove 1997:93).

A literature review minimises the chance of duplication and increases the probability of coming up with new information. In this study, literature on HIV/AIDS knowledge and sexual behaviour among youths globally, and in Zimbabwe was reviewed. The literature review showed that a lot of research has been done on HIV knowledge and sexual behaviour among young people in other countries but there was no information on HIV/AIDS knowledge and sexual behaviour among young people in Zimbabwe who are below the age of 15 years. Literature review will discuss what is generally known about HIV/AIDS which is the basic information about HIV/AIDS and sexual behaviour among young people.

2.3 DEFINING HIV/AIDS

Medical, scientific and public health information about the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) and the ways in which HIV can be transmitted are required by individuals to be able to make informed decisions affecting their own lives and the lives of their children.

2.3.1 What is HIV /AIDS?

The human Immuno deficiency virus is the virus that causes AIDS. It was discovered in the early 1980s by scientists in France and America according to Gallo (2006 as cited in http://en.wikipedia.org/wiki/AIDS). There are two different types of HIV, HIV-1 which is the most common type that is found worldwide, and HIV- 2 which is found mostly in West Africa (Lindsay 2001:1). HIV infection affects the immune system which is the body`s defence system against infection. The immune system produces cells called antibodies which kill or fight off micro-organisms. The HIV infects and eventually destroys special cells in the immune system called lymphocytes. These cells carry CD4 antigens called CD4 and T cells. When the immune system is infected with HIV, the body is unable to fight infections. This special weakness of the immune system is called immunodeficiency (WHO 2000:4).

HIV infection gradually reduces the number of circulating CD4 and T lymphocytes and when they are reduced to a level of lower than 200 of these cells per microliter of blood, cellular immunity is lost and one develops AIDS (Wikipedia 2008). Therefore, AIDS is an infectious disease that occurs as the HIV infection progresses and immunity declines resulting in one being prone to opportunistic infections (WHO 2000:6).

2.3.2 HIV Transmission

HIV can be transmitted through unprotected sexual intercourse with an infected partner or through contact with infected blood, semen, cervical or vaginal fluids. Unprotected sexual intercourse is the most common mode of transmission of HIV worldwide (WHO 2004:5). Over 95% of HIV infections are transmitted sexually (Garnett, Garcia-Calleja, Rehle &

Gregson 2006:1). The presence of sexually transmitted infections especially those causing genital ulcers, increase the risk of HIV transmission because the mucous membrane is exposed to the virus.

HIV can also be transmitted through blood transfusions or transfusion of blood products. Injecting equipment such as needles or skin piercing equipment contaminated with HIV, parent to child transmission which can occur during pregnancy, labour, delivery or as a result of breast feeding are other ways HIV can be transmitted (WHO 2004:5). Scientific evidence has ruled out other modes of transmission like insect bites, water, food, touching and sharing cups, glasses or plates (Lindsay 2001).

2.3.3 Methods of prevention.

A cure for HIV has not been found and the only way to reduce the spread of the virus is through prevention strategies. Prevention is about keeping the HIV negative people negative and behaviour change is the cornerstone of HIV prevention.

2.3.3.1 The ABC of HIV/AIDS prevention.

Many countries have adopted a balanced promotion of all the behaviour changes known as the ABC HIV prevention strategy, which became famous because of its success in Uganda. The HIV prevalence rate in Uganda dropped from 15% in the 1990s to 6.5% by 2004.

‘A’ stands for abstinence, which means a delay in sexual initiation among youths.
‘B’ stands for being faithful to ones’ partner or having a monogamous relationship.
‘C’ stands for consistent and correct condom use especially for casual sexual activities or other high risk behaviours (Linsay 2001).
.
Studies have shown that condom use reduces HIV transmission by 80% over long term though this could be higher if condoms were used correctly and consistently (Cayley 2004:1268).

2.3.3.2 Exposure to contaminated body fluids

Exposure to infected body fluids can be reduced by taking precautions to reduce exposure to contaminated fluids. These precautions which are more applicable to health workers than other people include use of gloves, wearing of gowns and aprons and thorough washing of the skin immediately after being contaminated with bloods or other body fluids. (http://www.avert.org/needlestick.htm).

2.3.3.3 Male Circumcision

Male circumcision is another method of HIV prevention. A randomised control trial showed that circumcision reduces the risk of HIV infection among heterosexual men by up to 66%. It is expected that this prevention strategy will be adopted in many countries that are affected by the epidemic. However, there is fear that circumcised men and young people may have lower perceptions of vulnerability that may result in sexual risk behaviour which might have negative preventive effects (Weiss 2007:66-72).

2.3.3.4 Parent to Child Transmission

In October 2000, the WHO recommended that Voluntary Testing and Counselling (VCT) and provision of Anti Retroviral Drugs (ARV) should be introduced into all Maternal and Child Health programmes as an HIV preventative strategy. The Zimbabwe government showed its commitment to this strategy in its 1999 HIV/AIDS policy in which PPTCT of HIV/AIDS is documented as one of the strategies for HIV prevention (MOHCW 2002b:6)

2.4 The scope of the literature review

The study focuses on HIV/AIDS knowledge and reported high risk sexual behaviour among school learners in Harare, Zimbabwe.

2.5 HIV/AIDS Situation in Zimbabwe and other countries

HIV/AIDS epidemic is one of the most challenging public health issues globally and has affected people economically, socially and healthwise in Zimbabwe and in the entire world. In 2007, an estimated 33.2 million people lived with the disease worldwide and an estimated 2.1 million people, including 330,000 children died of HIV/ AIDS. Of the newly reported HIV/AIDS infections, 50% are among young people and 30% of the million people living with HIV/AIDS are young people (WHO 2004:1). An estimated 4.3% of young women and 1.5% of young men aged between15-24 years in SSA were living with HIV in 2005 and 9-13% of young women had given birth by age 16 (UNAIDS 2006:508). This clearly shows that young people should have targeted HIV/AIDS information before they are sexually active in order to reduce the risk of contracting HIV.

In Zimbabwe, the first AIDS case was diagnosed in 1985 (MOHCW 1999:1). Although the HIV prevalence rates among the age group 15-49 years has declined from 20.15% (2001) to 18.1% (2006) (UNAIDS 2006:16), Zimbabwe is still considered among the high epidemic areas. Sero prevalence among young people aged 15-19 years was 12% in females and 2% in males of the same age group (MOHCW 2003:4). This shows that the prevalence rate is not evenly distributed by age and gender. HIV infection rates are higher in females than males. This trend is also seen in SSA where 75% of all people infected with HIV are females (UNAIDS 2004:93). According to the Zimbabwe HIV/AIDs epidemic report, the age group 6 to 15 years is least affected (MOHCW 2004a:14). Targeting prevention strategies to this age group before they are sexually active may reduce the HIV/AIDS epidemic.

In response to the HIV/AIDs epidemic, the Zimbabwe government introduced HIV/AIDS education among learners in schools in 1993 as one of the HIV/AIDS prevention strategies. The education provides scholars with knowledge about HIV/AIDS, it promotes healthy lifestyles, positive values and attitudes and responsible behaviour among scholars (MOESC 2003:5). It is hoped that providing young people with targeted information about HIV/AIDS before they are sexually active and/or HIV positive may reduce their chances of engaging in risky behaviour and thus slow down the spread of the epidemic in Zimbabwe. The Minister of Health and Child welfare showed his commitment to fighting the HIV/AIDS

epidemic in his speech at an annual research conference in Harare, Zimbabwe, where he encouraged researchers to target fighting HIV/AIDS and come up with information on behaviour change (The Herald Friday 3rd October 2008 (see Annexure E).

2.6 HIV/AIDS knowledge and sexual behaviour among young people in Zimbabwe and other countries

According to UNAIDS (2006:62) 50% of persons living with HIV were infected during adolescence and young adulthood (UNAIDS. This shows that knowledge about HIV/AIDS and life skills are crucial before one gets to adolescence. Unfortunately, the lives of millions of young people are at risk because of lack of information and life skills to delay sex until they are physically and socially mature (http://www.who.int/child-adolescent-health/asrh.htm:1).

A study that was conducted among youths in Tanzania revealed that 97% of boys and 95% of girls knew that AIDS exists, 59% of boys and 43% of girls knew one or more ways of preventing HIV. However, 25% of boys and 43% of girls used condoms during their last sexual encounters (Ikamba & Ouedraogo 2003:3). In another study in Tanzania condom use among sexually active primary school pupils decreased from 19% in 1999 to 14% in 2000. This shows that although there was increased knowledge on HIV/AIDS, risk taking behaviour was present (Reproductive Health Project 2001:1). Sexual debut in Tanzania was as early as 10 years according to the Population Reference Bureau 2000 (as cited by Ikamba & Ouedraogo 2003:2) which is lower than the findings of a previous study that was conducted in Tanzania, where the age of sexual debut was reportedly 15.5 years for boys and 15.8 years for girls (Maswanya et al 1999:185). Young people who have early sexual debuts are at high risk of HIV/AIDS as they often have sex with older men who usually have multiple sexual partners.

In Malawi, a study was conducted to examine young people's awareness, knowledge and attitudes about HIV/AIDS and other sexually transmitted Infections. Knowledge levels were very high with 99% for adolescent men and 98% for adolescent women. The same study, however, showed that young people initiate sex at as early as 10 years and 50% of adolescence initiate sex before the age of 15 and this puts young people at high risk of

acquiring HIV infection (Munthali, Chimbiri & Zulu 2004:25). Malawi has conducted various HIV/AIDS and lifeskills education in primary and secondary schools since 1989 and information and education campaigns to the whole nation with the assumption that people who are knowledgeable about HIV/AIDS and how it is transmitted will protect themselves. However, studies have shown that despite high knowledge levels about HIV/AIDS, people still engage in high risk behaviours (Munthali et al 2004:25,35).

According to a study that was conducted in four SSA countries (Burkina Faso, Ghana, Malawi and Uganda) on adolescents aged 12-14 awareness about HIV was 90% in three countries with the exception of Burkina Faso where 75% of girls and 80% of boys were aware of HIV. While awareness is a rough measure of knowledge, it was found that it does not provide an indication of the depth of knowledge. Evidence from this study showed that in-depth knowledge about HIV was very low with Burkina Faso having only 5% of young adolescent females and 9% of male counterparts demonstrating in-depth knowledge about HIV. Ghana had 20.9% of young adolescent females and 23% of male counterparts who demonstrated in-depth knowledge about HIV transmission and prevention while Malawi had 18.2 % of females and 24% males and Uganda had 20.8% of female young adolescents and16.8% of young adolescent male counterparts who demonstrated in depth knowledge about HIV transmission and prevention. In-depth knowledge was assessed by correctly answering five questions that constitute an indicator of HIV prevention knowledge recommended by WHO for monitoring HIV prevention programmes for young people (Bankole, Biddlecom, Guiella, Singh & Zulu 2007:28).

In the same study, it was also found that contrary to what might be a general belief, very young adolescents in the four countries in SSA were not all sexually naive. Almost one third the 12-14 year old girls and boys in Uganda and Malawi had experienced some form of intimate sexually activity which ranged from sexual intercourse, kissing or fondling. In Burkina Faso and Ghana 1 in every 10 adolescents had been involved in some sort of sexual activity. There was no consistent pattern in terms of progression from kissing to fondling to sexual activity. Few adolescent females reported ever having sexual intercourse, the highest percent being Uganda with 8% compared to 15% for males. Burkina Faso had 2% of the females and 6% of males reporting having had sexual intercourse while in Ghana there were 2% of females and 1% of males and Malawi had 3%

of females and 19% of males reporting having had sexual intercourse. With the exception of Ghana, more males than females reported having had sex. There is evidence of some level of sexual activity among young people in SSA hence the need for targeted HIVAIDS prevention programmes at young people. Some studies have shown that initiating sex at an early stage increases the chances of having more sexual partners. (Bankole et al 2007:37-38).

In South Africa, a survey on junior high school students found that there were gaps in adolescents` knowledge of HIV especially on the mode of transmission and prevention and the students had a high prevalence of behaviours that put them at risk of HIV infection which include early sexual onset, infrequent condom use and multiple sexual partners. In a review of unsafe sexual behaviour among South African youth, it was found that at least 50% of young people became sexually active by age 16 years (Peltzer 2007:1-2).

South Africa`s response to the epidemic is reported to have been inconsistent but major effort has been the implementation of life skills HIV/AIDS education in secondary schools. However, although there was modest increase in knowledge following the education programme, there has been very small success in influencing sexual risky behaviour among youth in KwaZulu-Natal (Magnani, MacIntyre, Karim, Brown, Hutchinson 2004:290).

In America, young people are waiting longer to initiate sex than they did in the past. *It is reported that 13% of females and 15% of males aged 15-19 years in 2002 had sex* before the age of 15 compared with 19% and 21% respectively in 1995 (Abma et al. 2002) as cited in Facts on American Teens` Sexual and Reproductive Health (Guttmacher 2008).

A joint statement by UNICEF, UNAIDS and WHO (UNICEF 2002:1) stated that a major United Nations (UN) study, (entitled Young people and HIV/AIDS: Opportunity in crisis) reported that there was lack of knowledge about HIV/AIDS among young people especially about HIV prevention although awareness about AIDS was high. In countries such as Cameron, Central Africa Republic, Equatorial Guinea, Lesotho and Sierra Leone, more than 80% of young women did not have sufficient knowledge about HIV/AIDS. Out of 99% of girls who had heard of AIDS, only 9% could name three ways of avoiding HIV infection. The same report revealed that in 60 countries, more than 50% of young people aged

between 15 and 24 years had misconceptions about HIV/ AIDS transmission, an indicator that young people were not getting the right information and they also felt that they are not well informed about HIV/AIDS.

According to the UNAIDS report on the global AIDS epidemic (2006:62), 50% of persons living with HIV were infected during adolescence and young adulthood. In response to the HIV/AIDS epidemic the Zimbabwean government introduced HIV/AIDS education among learners in schools in 1993 as one of the HIV/AIDS prevention strategies. Providing them with knowledge about HIV/AIDS and life skills may help them make responsible decisions before they reach adulthood.

According to the Zimbabwe Young Adult Health Survey (MOHCW 2001-2002:70,71), 93% of young women and 97% of young men aged between 15 and 29 years had heard of AIDS and 83% of the same group of women had heard of HIV while 92% of the young men had heard of HIV. Among those who had heard of HIV/AIDS, 94% of young women and 96% of young men spontaneously mentioned sexual relations/contact as a way of transmitting HIV while 4% of young women and 5% of young men mentioned parent to child transmission. Knowledge on HIV prevention was low with 58% of young women mentioning condoms, 52% monogamy and 36% mentioning abstinence. More young men (73%) knew about condoms while 44% of them mentioned abstinence and monogamy.

Among the young women in the Zimbabwe Young Adult Survey (MOHCW 2001-2002:51) who reported ever having sex, 7% reported having first intercourse before the age of 15 years compared to 12 % of the young men.

A study in Zimbabwe showed that male adolescents were sexually active by the age of 15 and therefore at risk of HIV infection (Boohene, et al 1999:266). Surveys done in Zimbabwe suggest a reduction in sexual experience before the age of 15 years among males and females aged 15-19 years (Mahomva, Greby, Dube, Mugurungi, Hargrove, Rosen, Dehne, Gregson, Louis, & Hader 2006:i42). A delay in sexual debut for girls in Zimbabwe was also confirmed by the Minister of Health in a report in The Herald (Zimbabwe) of Thursday 7th September 2006 (see Annexure E).

The Zimbabwe Young Adult Survey (MOHCW 2001-2002:1) found that many youths engaged in behaviours that put them at risk of HIV infection. Risky sexual behaviours continue to be documented in studies. Mataure et al (2002:217) studied alcohol use and high risk behaviour among adolescents and young adults in Harare, Zimbabwe. These authors reported that alcohol use among secondary school learners was high with rates of 63% for females and 70% for males and that they engaged in high risk behaviours while intoxicated. Young girls were having sex with older men in exchange for money while young boys were having sex with casual sex workers. Fritz et al (2002:227) found a strong association between alcohol use and sexual risk behaviours in Harare, Zimbabwe. A baseline survey on experiences of youth in urban Zimbabwe showed that youths engaged in high risk behaviours like early sexual experience, prostitution, drug and alcohol abuse (Phiri 2000:4-9). Consequently there is a need to study youths' knowledge and sexual behaviours and to come up with strategies to enable young people to make responsible decisions concerning HIV/AIDS before they reach adulthood.

2.6.1 HIV/AIDS knowledge and risk perception as factors that influence HIV/AIDS related behaviours.

One question is whether high risk behaviours are due to a lack of HIV knowledge and/or strategies to adopt in order to reduce high-risk sexual behaviours.

According to Zimbabwe's Young Adult Health Survey (MOHCW 2001-2002:70) human behaviour is influenced by different factors which include knowledge, risk perception, and attitudes towards condoms, persons living with HIV and gender roles. However, knowledge of HIV was reported as an important influential factor on sexual behaviours.

A review on social science research on HIV/AIDS (Freudenthal 2001:12) showed that many researchers consider education as one of the most important tools in preventing the transmission of HIV.

In a joint press statement by UNICEF, UNAIDS and WHO emphasised the fact that

youths cannot protect themselves against HIV infection unless they know the facts about HIV/AIDS. The report went on to say that there was a strong linkage between what young people knew and how they acted (UNICEF, UNAIDS & WHO 2002:2).

According to 83 studies that were conducted in developed and developing countries, factors that contribute to behaviour change are knowledge, perceived risks, values and attitudes, perception of peer norms and self efficacy and skills. There was also evidence that the HIV/AIDS education programmes increased knowledge about a wide variety of topics including risky sexual behaviour (Kirby, Laris & Rolleri 2005:1, 3, 21).

In a study conducted in South Africa among young people aged 15-24 years (Pettifor, Rees, Steffenson, Hlongwa-Madikizela, MacPhail, Vermaak & Kleinschmidt 2004:54) it was reported that young people will take precautions to protect themselves if they think that they are potentially at risk of becoming infected. In that study, 36% of young people reported that they believed they were not at all at risk of contracting HIV, 35% reported being at small risk while 12% reported being at moderate risk and 14% at high risk of contracting HIV. The same study revealed that 67% of young people reported having had sexual intercourse.

In another study conducted in Malawi among primary and secondary school pupils, 79% of young people generally perceived themselves to be at risk of getting HIV and 61% of males and 57% of females were reportedly sexually active (Munthali et al 2004:29 & 25)

According to The Zimbabwe Young Adult Survey (MOHCW 2001-2002:72) 21% of females and 13 % of males perceived themselves to be at medium and high risk for HIV infection while 57% females and 73% males reported being at no risk. The same study revealed that 66% females and 55% males reported having had sex. This shows that there might be no increased HIV risk perception among young people who engage in sexual behaviours that could substantially increase their risk of being infected.

2.7 CONCLUSION

The literature review has shown that there is information on HIV/AIDS knowledge and sexual behaviour among youths from the age of 15 years and above, however, the researcher could not find that information among the age group below the age of 15 years and yet that is the age group that should be targeted for HIV prevention strategies that may help in keeping them uninfected. There is a need to assess HIV/AIDS knowledge and sexual behaviour of this group. Understanding the current HIV/AIDS knowledge and sexual behaviour may help in developing targeted HIV/AIDS information and prevention strategies. HIV prevention strategies targeted at this group before they get infected may reduce the spread of HIV infection.

As Carol Bellamy, UNICEF Executive Director. (UNAIDS, UNICEF, WHO 2002:1)
said, “Global success in combating HIV/AIDS must be measured by its impact on our children and young people. Are they getting the information they need to protect themselves from HIV? Are girls being empowered to take charge of their sexuality? Are infants safe from the disease, and are children orphaned by AIDS being raised in loving, supportive environments? These are the hard questions that need to be asking. These are the yardsticks for measuring our leaders. We cannot let another generation be devastated by AIDS.”

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter, the research methodology is discussed in terms of design, methods, population, research instrument, sample and data collection procedures.

3.2 RESEARCH DESIGN

The research design is a plan or blue print of how the researcher intends to collect data. It can also be defined as an outline for conducting a study in a way that will maximise control over factors that could interfere with the validity of the research results (Polit & Hungler 1999:155). The purpose of the study was to document current information on HIV knowledge and self reported sexual behaviours among secondary school learners in Harare, Zimbabwe, who are below the age of 15 years. The study therefore used a non-experimental, quantitative, exploratory and descriptive research design. The researcher chose this design because there is no literature that describes the HIV/AIDS knowledge and sexual behaviour among secondary school learners in Harare, Zimbabwe, who are below the age of 15 years. This design will describe and generate current information about knowledge and high risk sexual behaviour among secondary school learners in Harare, Zimbabwe, who are below the age of 15 years.

3.2.1 Non- experimental

According to Brink (1999:108), a non-experimental study is carried out in a natural setting and the phenomena are observed as they occur. Data can be collected without making

changes or introducing treatments. This design was chosen because it allowed the researcher to collect data in a natural setting and since the study was descriptive, a non-experimental design was appropriate since the intent of descriptive research is not to explain or understand the underlying causes of variables of interest (Polit & Hungler 1999:175).

The non-experimental design was also appropriate because according to Polit and Hungler (1999:177), a number of characteristics associated with individuals are inherent and are not subject to experimental control. In this study, the variables concern human knowledge and high risk sexual behaviours which cannot be collected using experimental research.

3.2.2 Quantitative research

According to Babbie and Mouton (2001:49), a quantitative researcher believes that the best way to measure properties of a phenomenon, the attitudes of individuals towards certain topics is through quantitative research. Numbers are assigned to perceive quantities of things. The approach used in this study involved systematic collection of quantifiable information about knowledge and high risk sexual behaviour of secondary school learners in Harare, Zimbabwe.

3.2.2.1 Characteristics of Quantitative research.

Polit and Hungler (1999:24) described the characteristics of quantitative research with which the study complied as follows:

- Quantitative research focuses on a relatively small number of specific concepts which in this study are HIV knowledge, sexual behaviour and young people.
- Quantitative research starts with preconceived ideas about how concepts are interrelated. In this study there was an indication that young people lack HIV knowledge and/or strategies to adopt in order to reduce high-risk sexual behaviours.
- Quantitative research uses structured procedures and formal instruments. A structured interview schedule was used to collect data from secondary school learners.

- Quantitative research emphasises objectivity in the collection and analysis of data. Objectivity was achieved through the use of a structured interview schedule.

3.2.3 Exploratory Descriptive design

Exploratory studies address issues that have not been previously studied in order to identify new knowledge, new understandings or new meanings and to explore factors related to the topic and the aim is to understand the phenomenon of interest (Polit & Hungler 1999:19). In this study, the researcher explored the literature, HIV knowledge and high risk sexual behaviour of school learners in Harare, Zimbabwe in order to come up with current status of their knowledge and high risk sexual behaviour.

Descriptive designs provide a description of variables in order to answer the research question (Brink 1999:109). Descriptive design is also a way of discovering new meaning and describing what exists, determining the frequency with which something occurs and is usually used where there is little information about a phenomenon (Burns & Grove 2005:26).The design aims at describing phenomena rather than explaining them. This design could be important in laying foundations for future studies (Polit & Hungler 1999:144). Descriptive studies do not focus on the link between variables but their purpose is to observe, describe and document aspects of a situation as it naturally occurs (Burns & Grove 1997:232). The purpose of this study is to document a situation that relates to HIV/AIDS knowledge and high risk sexual behaviour among young school learners as it naturally occurs. This design has been chosen because it will generate current information about knowledge and high risk behaviours of secondary school learners in Harare that could influence their chances of becoming HIV positive or to remain HIV negative.

3.3 RESEARCH METHOD

This section covers the research population, sample, the study population, sampling procedure, setting, and data collection.

3.3.1 Research population

The population is a total group of persons that is of interest to the researcher (Burns & Grove 1997:293) that meets the set of criteria established by the researcher. Polit and Hungler (1999: 710) define population as the totality of all subjects that conform to a set of specifications, comprising of the entire group of persons that is of interest to the researcher and to whom the research results can be generalised.

The research population in this study includes boys and girls in school, who have completed seven years of primary education and are in the first year in secondary school in Zimbabwe. They were drawn from urban and rural secondary schools which include one high density school,one low density school, one rural school and one religious (private) school.

Eligibility criteria are the specifications used by the researcher that designate the specific attributes of the target population to determine which subjects are selected for participation in a study (Polit & Hungler 1999:644).
The eligibility criteria in this study included;

- Male or female first year secondary school learner attending one of the selected schools.
- The participant has to be willing to participate in the study and to give verbal assent.
- Should be at the school on the day the researcher will be conducting interviews.
- The parents should give consent for participation of their child.

3.3.2 The sample and sampling procedure

A sample is a small portion of the population that a researcher is studying in a particular site or setting (Burns & Grove 1997:293). The sample in this study comprised 80 participants. A sample of 80 participants is considered adequate given the time constraints and the economic situation in Zimbabwe at the time when the study was conducted.

Sampling is the process of selecting people, events, behaviours or other elements with which to conduct a study (Burns & Grove 1997:341). In this study, a non-probability sampling approach will be used. Non-probability sampling is a process in which a sample is selected from elements or members of a population through non-random methods (Brink 1999:212). There are different types of non-probability sampling which include convenience sampling, quota sampling, purposive sampling, network sampling and theoretical sampling (Burns & Grove 1997:350). In this study, convenience sampling will be used. Brink (1999:207) describes convenient sampling as a non-probability sampling which involves the selection of the most readily available people or elements.

Non-probability sampling is economical and practical and accessible and requires less time to acquire the sample size (Burns & Grove 1997:351). Non-probability sampling has a disadvantage that every person has not an equal chance of being included in the sample and some segments of the population might be over or under represented and the results might not be generalisable (Polit & Hungler 1999:260).

3.3.2.1 Sampling procedure

The researcher will talk to the headmasters of the respective schools about the study and request permission to talk to the form one students in their classroom at a time that is convenient to them. The researcher will explain the study to the learners with emphasis on voluntarism, confidentiality and honesty. The first 10 male and the first 10 female learners who volunteer to enter the study at each school will be asked to request their parents or guardian to come to the school so that the researcher can obtain consent for the learners to participate in the study. Parents or guardians who are unable to meet the researcher at the school will be visited in their homes if they are willing. The learners will take a copy of the consent form to their parents or guardian for them to read before they come to the school. The participants will be scheduled for a face to face structured interview with the researcher after consent from the parents or guardians have been obtained. The interviews will be conducted over a period of two days in each of the participating four schools.

Since it was impossible to predetermine who would be willing to be interviewed and who would get consent from their parents or guardians, a random sample could not be drawn.

3.3.2.4 Setting

Setting refers to the place where data is collected. The study will be conducted in four schools, which include one high density school, one low density school, one private school and one rural school. The researcher chose to conduct the study in these schools because they represent the different types of schools in Zimbabwe. A sampling frame for each of the group of schools was used to select the four schools. A sampling frame is a listing of all the members of a population that meet the sampling criteria (Burns & Grove 1997:346).

A list of all the high density secondary schools (N= 35), low density secondary schools (N=25), private secondary schools (N=15) and rural secondary schools (N=5) was obtained from the MOESC. The schools were selected using simple random sampling method, involving selecting elements at random from the sampling frame (Burns & Grove 2005:347).The names of the schools were written on pieces of paper in their different groups, placed in a container, mixed well and drawn out one by one from each group.

3.4 DATA COLLECTION

Data will be collected using a structured interview schedule with both open and close-ended questions. The method has been chosen because it is a quick way of obtaining data and it is less expensive in terms of time and money (Brink 1999:153). Although one has the advantage of clarifying questions and probing during a face to face interview one major disadvantage of face to face interview is that the presence of the interviewer may affect the respondent`s perception of the question or the answer given.

3.4.1 Structure of the interview schedule

A structured questionnaire (Annexure C) was designed by the researcher based on the findings from literature review. The interview schedule consisted of the following sections.

Section A: comprised questions relating to biographic data which includes age, sex and religion.

Section B's questions related to the knowledge of HIV/AIDS.

Section C asked questions about sexual behaviours.

3.4.2 Reliability

According to Brink (1999:167), reliability is the ability of an instrument to obtain consistent results when repeated under the same conditions or similar situations even though the subjects or the environments differ. Reliability is a measure that is used to assess the quality of an instrument as it measures the degree of consistency (Polit & Hungler 1999:653).

There are different ways in which reliability of an instrument can be measured and these include stability, internal consistency and equivalence.

3.4.3 Stability

Stability of an instrument is the extent to which the same results are obtained on repeated administrations of the same instrument (Polit & Hungler 1999:368). When a researcher administers the same test to the same individuals on two different occasions and then compares the results obtained, this is called test-retest reliability. Stability of the instrument will be checked by pretesting the interview schedule in two schools and the results of the pre-tests will be compared. No areas required revisions after the pre-test.

3.4.4 Internal consistency

Internal consistency is when all subparts of an instrument measure the same characteristics (Polit & Hungler 1999:371). This is done using what is called split half. This is when items in a research instrument are randomly assigned to two sets and each set should provide a good measure of the phenomena of interest and should classify respondents the same way.

In order to ensure internal consistency, the interview guide was pre-tested before administration to ensure that the instrument measured what it intended to measure. The pre-test will be done with a group of participants from different schools who have the same characteristics as those involved in the study. Pretest participants will not be included in the actual study.

3.4.5 Validity of the research instrument

According to Brink (1999:167), validity is the ability of an instrument to measure or to test what it is supposed to measure. It is the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration (Babbie 2001:142). There are three methods of validating a research instrument, namely criterion-related validity, construct validity and content validity.

3.4.5.1 Criterion-related validity

This method is sometimes called predictive validity. Emphasis is on establishing the relationship between the instrument and some other criterion (Polit & Hungler 1999:376). There should be a reasonably reliable and valid criterion with which the measures obtained from the target instrument can be compared.

3.4.5.2 Construct validity

This is based on the logical relationship among variables (Babbie & Mouton 2001:142). Construct validity is used by researchers concerned with questions like," What is this measuring device really measuring?" The significance of construct validity is its linkage with theory and theoretical conceptualisation and there is an emphasis on logical analysis and the testing of relationships predicted on the basis of theoretical considerations (Polit & Hungler 1999:377).

3.4.5.3 Content validity

This refers to how much a measure covers the range of meanings included within a concept (Babbie & Mouton 2001:144). In order to ensure content validity of the instrument, the instrument was submitted to a statistician and a reproductive health researcher who is experienced in research among adolescents. Two supervisors of this study and the statistician who analysed the data also considered the content of the questions to be appropriate to the topic, therefore to have content validity.

3.5. EXTERNAL VALIDITY

External validity is the degree to which study results can be generalised to other people or settings (Brink 1999:209). One aspect of a study's external validity concerns the adequacy of the sampling design. External validity was ensured in this study by having young people from different schools that represent the types of schools in Zimbabwe.

3.6 ETHICAL CONSIDERATIONS

The protection of the rights of human subjects has become high priority among members of scientific and health care communities (Polit & Hungler 1999:29).
Research ethics observed in this study are in accordance with those stated by Polit and Hungler (1999:153), which are the principle of beneficence, respect of human dignity and justice.

3.6.1 Principle of beneficence

The principle includes multiple dimensions which are freedom from harm, freedom from exploitation, benefits of research and risk/benefit ratio. These dimensions will be considered in this study by ensuring that participants and their parents/guardians are informed about the study, the benefits and risks. Permission of the parents or legal guardian will be obtained before the study is conducted.

3.6.2 Principle of respect for human dignity

This principle ensures that the right to self determination and full disclosure are respected (Polit & Hungler 1999: 33). This will be ensured in the study by providing all the information about the study so that participants can decide whether to participate or not without incurring any penalties or prejudicial treatment. No person will be forced to participate.

3.6.3 Principle of justice

This principle includes fair treatment and the right to privacy (Polit & Hungler 1999: 35). This right will be fulfilled in the study by ensuring that no identifying information will be collected from participants and confidentiality will be ensured throughout the research process. No names of any participating schools will be mentioned.

3.6.4 Steps taken for ethical considerations

The researcher will take the following steps to comply with the ethical requirements of research:

- Permission to conduct the research was requested from the Ministry of Education and a research proposal was attached (annexure A).
- Permission to conduct the research was granted by the Ministry of Education (annexure BI).
- A consent form was signed by the parents or guardians of the learners who were willing to participate in the study.
- Permission obtained from the participating schools are not included in the annexures to protect the anonymity of these schools.
- The learners and their parents/guardians were fully informed about the purpose of the study and that their responses would remain anonymous; participated voluntarily and could discontinue doing so at any point incurring any ill effects. This ensured respondents' rights to voluntarily decide whether or not to participate or to withdraw from the study at any time without the risk of incurring

any penalties (Polit & Hungler 1999:33). As only structured interviews were conducted, the respondents were not subjected to any harmful effects. However, talking about sexual behaviour might have been embarrassing to some learners.

- Confidentiality and anonymity were maintained as no identifying information was be collected from the respondents. The completed structured interview schedules were accessible to the researcher only. The researcher kept all data locked up. Once the research report had been accepted, the researcher would destroy all raw data. The research report will only portray figures and statistics and discussions but no names.
- The right to privacy was also respected by conducting the structured interviews in private rooms.
- The anonymous completed interview schedule was placed in a sealed envelope so that neither the interviewer nor any other person could link the signed consent form from the parents or guardian with any specific completed interview schedule.

3.7 DATA ANALYSIS

Data were analysed using descriptive statistics, converting and condensing data into organised visual presentations, such as graphs and tables (Brink 1999:179). Data were be coded and analysed using the Epi Info 2004 version 3.2.2 statistical software. A statistician assisted with the data analysis and statistical interpretations (see annexure D).

3.8 CONCLUSION

This chapter discussed the research methodology that will be used in this research which includes research design, setting, sampling, data collection and data analysis. Chapter 4 presents the data analysis and discussions of the research results.

CHAPTER 4

ANALYSIS AND DISCUSSION OF RESEARCH RESULTS

4.1 INTRODUCTION

This chapter presents and discusses the results of the study. The purpose of the study was to document current information on HIV knowledge and self-reported sexual behaviours among secondary school learners in Harare, Zimbabwe. This knowledge may be used to re-design more learner-specific HIV/AIDS awareness programmes for secondary school learners in Zimbabwe. The objectives of the study were to:

- Describe demographic characteristics of the secondary school learners who participated in this study.
- Assess secondary school learners' HIV/AIDS knowledge.
- Identify high risk sexual behaviours practised by secondary school learners in Harare, Zimbabwe, as reported by themselves in response to questionnaire items.
- Recommend ways in which Zimbabwe's HIV/AIDS campaign directed at secondary school learners could become more effective.

The researcher planned to recruit a total of 80 learners, 20 from each of the four schools as described in chapter 3 of this dissertation. However, 75 learners took part in the study due to the non-availability of learners in high density schools where most of the teachers were not coming to work because of a dispute over salaries between the Zimbabwe government and teachers. The researcher had also planned to interview an equal number of boys and girls from each school as explained in chapter 3 of the dissertation but more girls than boys were interviewed because of the voluntary nature of the study. Data obtained from the 75 interview schedules were analysed and will be discussed in this chapter. The results will be presented under the following headings, demographic data, HIV/AIDS knowledge and sexual behaviours. All figures will be rounded off to the nearest decimal point.

4.2 DEMOGRAPHIC DATA

This section addresses results pertaining to name and type of school, learners` gender, age, and religion and places where the learners grew up.

4.2.1 Type of school

A total of 75 learners were interviewed from four schools identified as A, representing a low density school (27%; n=20), B, private school (27%; n=20), C, high density school (20%; n=15) and D rural school (27%; n=20) (see table 4.1).

Table 4.1 Number of learners according to the type of school (n=75)

Name & Type of School	Frequency	Percentage
A Low density school	20	26.7
B Private school	20	26.7
C High density school	15	20.0
D Rural school	20	26.7
Total	**75**	**100.1**

4.2.2 Gender

There were more female 52.0% (n= 39) than male 48.0% (n=36) learners in the study. The age distributions for both male and female learners in this study were similar to those reported in the Zimbabwe Demographic and Health Survey Report (ZDHS 2005-6:184). However, there were differences in gender distribution by type of school. There were more males (66.7%; n=10) than females (33.3%; n=5) among the learners from the high density school, and more males (55.0%; n=11) than females (45.0%; n=9) from low density school. However, there were more females (70.0%; n=14) and (55.0%; n=11) than males (30.0%; n=6) and (45.0%; n=9) in both private and rural schools respectively. Overall, female learners constituted 52.0% of the sample whilst male learners constituted the remainder 48.0%, representing both genders. Gender distribution is an important demographic factor that may influence the results because gender affects the sexual behaviours of young

people in Zimbabwe since gender attitudes define socially acceptable sexual behaviours (Zimbabwe YAS 2001-2002:75).

4.2.3 Learners' ages

The participating learners' ages ranged from 12 to 14 years; 69.3% (n= 52) of the respondents were 13 years old, followed by learners aged 14 years (26.7%; n=20) while learners who were 12 years old were in the minority (4.0%; n=3). The age range is consistent with learners who have completed seven years of primary education in Zimbabwe given the fact that they enrolled in grade one at six years of age and had completed at least seven years' schooling when the data were colledted.

4.2.4 Respondents'' religious affiliations

All respondents (100.0%; n=75) reportedly had religious affiliations. The largest number of learners (26.7%; n=20) belonged to the 'other' religious groups that formed as breakaway groups from the conventional religious groups; followed by Pentecostal followers (21.3%; n=16) and a few were Seventh Day Adventists (10.7%; n=8) see table 4.2.

All the learners were Christians. There are other religions besides Christianity in Zimbabwe, like Hinduism and Islam but these were not represented in this study, probably because children belonging to these religious groups did not attend the four types of schools that participated in this study.

Table 4.2 Learners' religious affiliations (n=75)

Religion	No of Learners	Percentage
Other	20	26.7%
Pentecostal	16	21.3%
Methodist	11	14.7%
Roman Catholic	11	14.7%
Anglican	9	12.0%
Seventh Day Adventist	8	10.7%
Total	**75**	**100.1%**

4.2.5 Areas where learners grew up

Learners were asked whether they grew up in a rural area, small town or urban area. Of the learners 68.0% (n=51) grew up in an urban area; 17.3% (n=13) in small towns and 14.7% (n=11) in rural areas. Stratified by gender, more males (19.4%; n=7) than females (10.3%; n=4) grew up in the rural areas and almost an equal number of males and females grew up in urban areas (see table 4.3). Stratified by school, all the learners from high density school grew up in an urban area while none of the low density and private school learners grew up in the rural areas. The area where one grew up may affect behaviour and also sources of HIV/AIDS information.

Table 4.3 Areas where female and male learners grew up (n=75)

Area	Females		Males		TOTAL	
	n	%	n	%	n	%
Rural Area	4	10.3	7	19.4	11	14.7
Small Town	10	25.6	3	8.3	13	17.3
Urban Area	25	64.1	26	72.2	51	68.0
Total	**39**	**100**	**36**	**100**	**75**	**100**

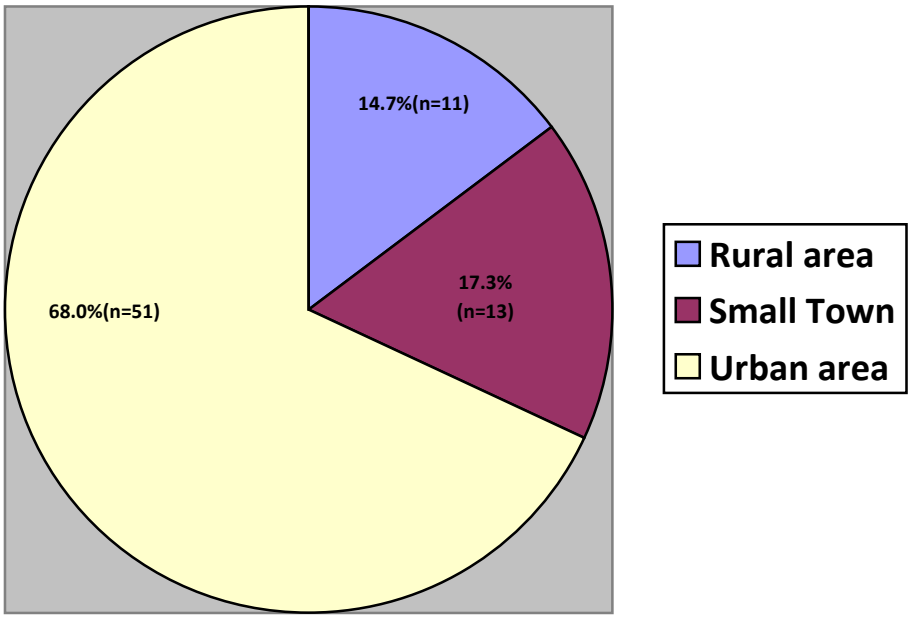

Figure 4.1 Areas where learners grew up (n=75)

The percentages in table 4.3, indicate that 68.0% (n=51) of the learners grew up in urban areas where HIV/AIDS information should have been more readily available than in small towns or rural areas. Thus the assumption would have been that most students should be knowledgeable about HIV/AIDS aspects based on the urban areas where they grew up.

4.3 LEARNERS' HIV/AIDS KNOWLEDGE

This section addresses information pertaining to knowledge about HIV/AIDS, whether the learners had heard about HIV/AIDS, the sources of their knowledge, what HIV/AIDS entails, how it is transmitted, how to avoid HIV infection, and whether a person with HIV can look healthy.

4.3.1 Learners' sources of HIV/AIDS knowledge

Learners were asked whether they had heard about HIV/AIDS and all learners (100%; n=75) had done so. This result was anticipated because the Zimbabwe Ministry of Education incorporated HIV/AIDS education programmes in both primary and secondary schools' curricula. The school (92%; n=69) was the most frequently mentioned source of information about HIV/AIDS (see figure 4.2). These results are higher than those of the Zimbabwe YAS (2001-2002:100) in which 38% of females and 58% of males reported the school as a source of HIV/AIDS information before they reached the age of 15.

The television (60.0%; n=45) and radio (41.3%; n=31) were common sources of information. Zimbabwe broadcasts a variety of HIV/AIDS television programmes ('Mai Chisamba show' focussing on various social issues including HIV/AIDS; 'Studio 263 emphasising the importance of not being cheated by 'sugar daddies'). This is the reason why 60% (n=45) of learners reported the television as their source of information for HIV/AIDS. Radio programmes also target young people in Zimbabwe with HIV/AIDS presentations from doctors allowing people to ask questions on HIV/AIDS telephonically. HIV/AIDS information also came from other sources including parents (13.3%; n=10), newspapers (9.3%; n=7) and community activities (4.0%; n=3). Parents ranked very low as sources of HIV/AIDS information (13.3%; n=10). This might indicate that aspects related to sex (including HIV/AIDS) are not discussed in these learners' homes.

The two most common sources of information on HIV/AIDS according to the ZDHS (2005-2006:105) were pamphlets/posters and radios with over 60% of these respondents having heard about HIV/AIDS from these two sources while in the current study the most common source of HIV/AIDS information was the school. Different groups use different sources of information and appropriated media should be used.

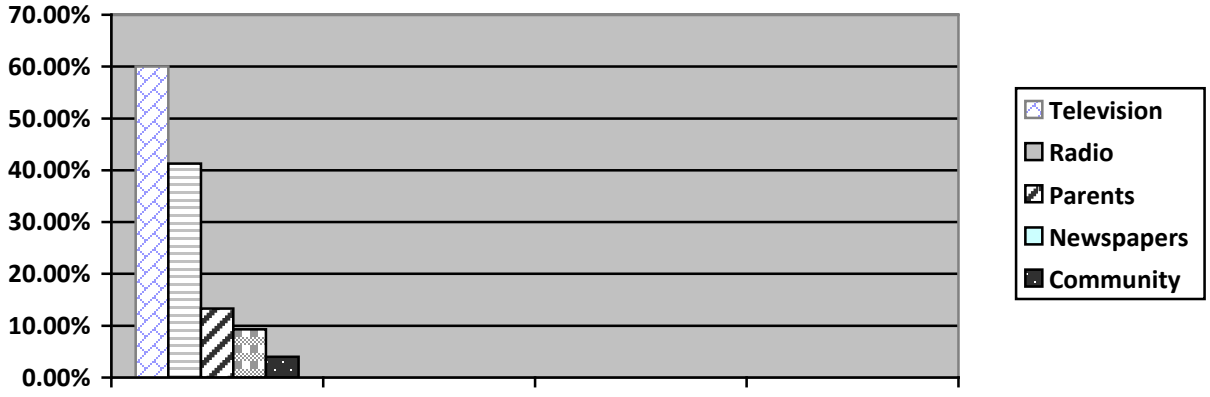

Figure 4.2 Learners' sources of HIV/AIDS information (n=75)

4.3.2 Learners' HIV/AIDS knowledge levels

When asked what HIV is, 94.7% (n=71) of the learners answered correctly, although 100% (n=75) had heard about HIV (see section 4.3.1). This matches the ZDHS (2005-6:184) report stating that in the population aged 15-49, the knowledge levels were 98% among women and 99% among men. According to the ZDHS (2005-6:184) report, youths aged 15-24 generally have lower levels of HIV/AIDS knowledge than those in older age groups, and never-married respondents are less likely to know about HIV/AIDS prevention than married persons or those who have already initiated sexual intercourse. The ZDHS (2005-6:184) report also indicates that urban residents are more knowledgeable about HIV/AIDS prevention than rural residents.

In the current study, all learners (100%; n=75) knew what HIV was, but when asked what AIDS was, only 89.3% (n=67) of the learners gave correct answers, implying that 10.6% (n=8) of the learners did not know what AIDS was, The learners' levels of HIV and AIDS knowledge was compared among schools, as portrayed in table 4.4.

Table 4.4 Learners' knowledge about HIV and AIDS (n=75)

Type of School	HIV knowledge		AIDS knowledge	
	n	%	n	%
High density	15	100	13	86.7
Rural	19	95	19	95.0
Private	19	95.0	17	85.0
Low density	18	90.0	18	90.0
Total	71	94.6	67	89.3

Information in Table 4.4 indicates that learners from the high density school knew what HIV was (100%; n=15). When asked what AIDS is 86.7% (n=13) gave correct responses. (95%; n=19) of learners from the rural school and private school knew what HIV is. However, when asked what AIDS is, (95%; n=19) of the rural school learners and 85% (n=17) of the private school learners gave correct answers (see figure 4.3). The study showed that learners knew what HIV is but their knowledge level about what AIDS is, was lower. Some of the learners indicated that they did not know what AIDS was (9%; n=7). There is need to emphasise the difference between HIV and AIDS in all educational programmes for young people.

Learners from the private schools (85%; n=17 correct responses), high density (86%; n= 13 correct responses) and low density (88%; n= 18 correct responses) trailed behind the rural school (95%; n= 19 correct responses) concerning their levels of AIDS knowledge.

Stratified by gender, as shown in table 4.5, female learners (97.4%; n=38) were more knowledgeable about what HIV is than their male counterparts (94.4%; n=34). However the knowledge level of female learners on what AIDS is was lower (82%; n=32) compared to that of the male learners (97.2%; n=35).

Table 4.5 Learners' HIV and AIDS knowledge levels

Correct answers	Females		Males	
	n	%	n	%
HIV	38	97.4	34	94.4
AIDS	32	82.0	35	97.2

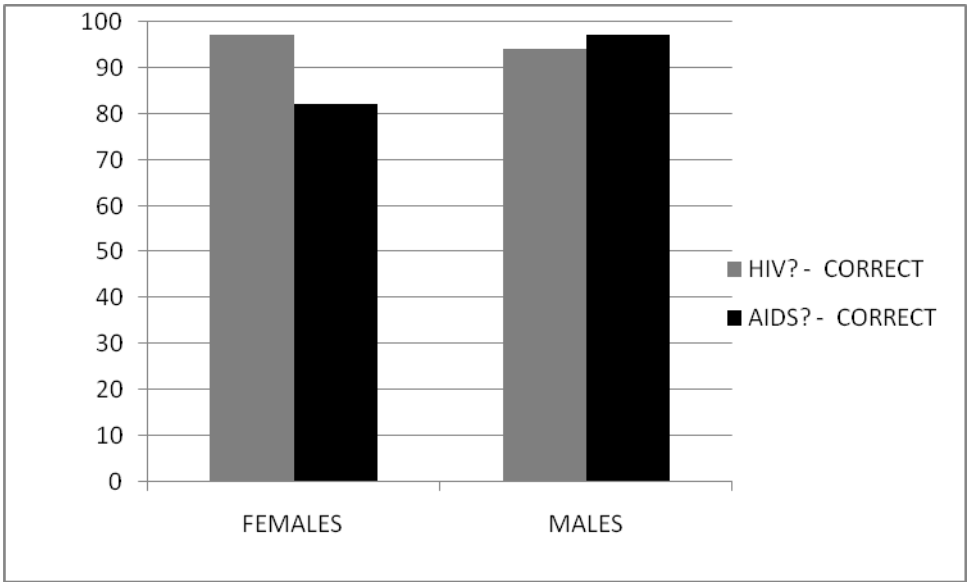

Figure 4.3 HIV and AIDS knowledge rate among learners(n=75)

4.3.3 HIV transmission

When learners were asked in an open ended question how HIV is transmitted, 96.0% (n=72) mentioned unprotected sex; 82.7% (n=62) sharp objects; 25.3% (n=19) parent to child transmission (PTCT), 13.3% (n=10) body fluids while 9.3% (n=7) mentioned other ways including accidents, being scratched by an infected person's nails, and looking after someone who is HIV positive. Unprotected sex is the most common cause of HIV transmission worldwide (WHO 2004:5) and it is encouraging to know that almost all learners knew about this mode of transmission.

Stratified by type of school, all the respondents in the high density school mentioned unprotected sex as a way of preventing HIV transmission compared to 95%(n=19) from each of the other three schools. Knowledge of parent to child transmission was very low in the private school with 15%(n=3), followed by 20%(n=4) in the rural school, 33.3% (n=5) in the high density school and 35% (n= 7) in the low density school. (Learners could provide more than one answer to this question therefore the total does not add up to 75).

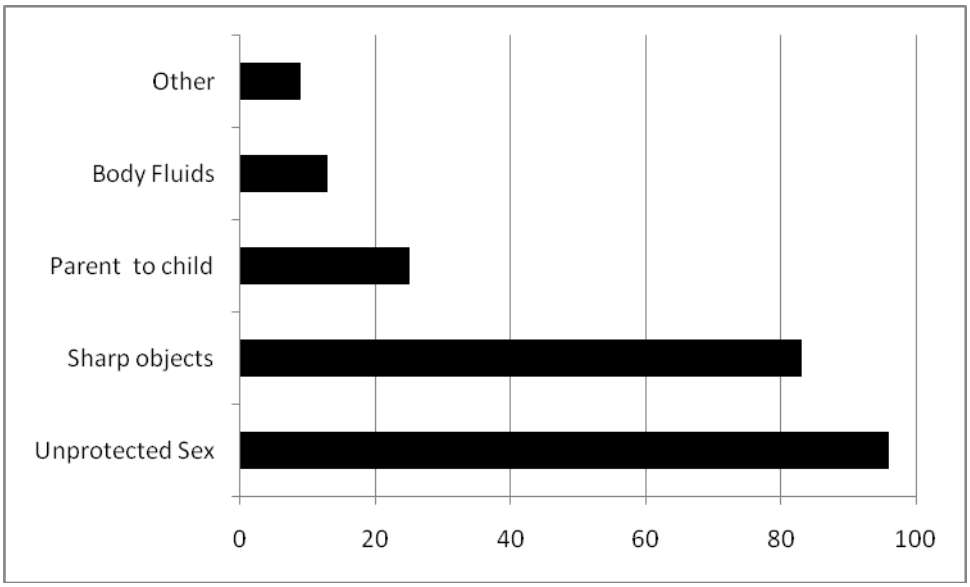

Figure 4.4 Respondents' views on ways in which HIV is transmitted (n=75)

Learners' knowledge on HIV/AIDS transmission was generally high, in response to yes/no questions, as shown in table 4.6.

All the learners (100%; n=75) knew that having sex with an infected partner could cause HIV infection; 94.7% (n=71) were correct about a person NOT getting infected through mosquito bites, nor from eating from the same plates as infected persons (94.7%; n=71), nor using the same toilets as infected persons (97.3.%; n=73), nor through coughing (97.3%; n=73). Knowledge about getting infected through parent to child transmission was high (94.7%; n=71) and about getting infected through needle prick injuries (96.0%; n=72).

Lower correct percentages were reported concerning French kissing (73.3%; n=55) and blood transfusions (74.7%;n=56). Of the learners 52.0% (n=39) did not know that a person could get infected with HIV through tattooing. (The interviewers reported that they had to explain what French kissing and tattooing implied because most learners were unfamiliar with these terms).

Table 4.6 HIV transmission response to yes/no questions (n=75)

Yes/no questions	**Correct response**		**Incorrect response**		**TOTAL**	
	n	%	n	%	N	%
Sex with an infected partner	75	100	0	0.0	75	100
Using same plates as infected persons	74	98.7	1	1.3	75	100
Cough	73	97.3	2	2.7	75	100
Using same toilets as infected persons	73	97.3	2	2.7	75	100
Needle prick injuries	72	96.0	3	4.0	75	100
Mosquito bites	71	94.7	4	5.3	75	100
Parent to child transmission	71	94.7	4	5.3	75	100
Blood transfusion	56	74.7	19	25.3	75	100
French kissing	55	73.3	20	26.7	75	100
Tattooing	36	48.0	39	52.0	75	100

4.3.4 Appearance of HIV positive persons

Of the learners, 96.0% (n=72) knew that a person who is HIV positive can look healthy. The results are higher than the findings of the Zimbabwe YAS (2001-2:71) in which 73% of young women and 77% of young men knew that a person with HIV infection could look healthy.

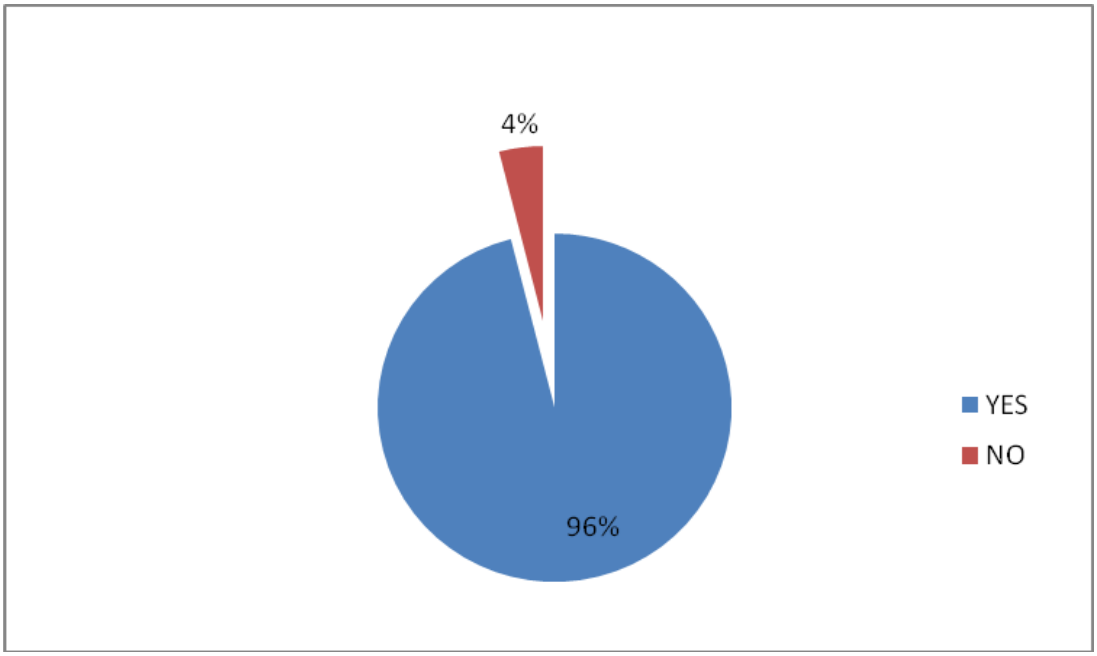

Figure 4.5 Respondents who knew that an HIV positive person can look healthy (n=75)

4.3.5 Knowledge of three behaviours to remain HIV negative

Learners were requested to mention three behaviours that would ensure that they remained HIV negative. These responses included abstinence (66.7%; n=50), being faithful (21.3%; n=16), using condoms (66.7%; n=50) and 'other' (85.3%; n=64). In comparison with the prevention methods emphasised worldwide which are abstinence, being faithful and using condoms (ABC), as many as (85.3%; n=64) respondents mentioned other ways of preventing HIV, including avoiding sharing sharp objects, getting HIV tested before marriage and avoiding peer pressure as ways of ensuring that one remains HIV negative.

Of the learners, 28.0% (n=21) spontaneously mentioned three different ways of avoiding HIV infection, 56.0% (n=42) mentioned two ways and 14.7% (n=11) only mentioned one way and one learner failed to mention any method of preventing HIV infection.

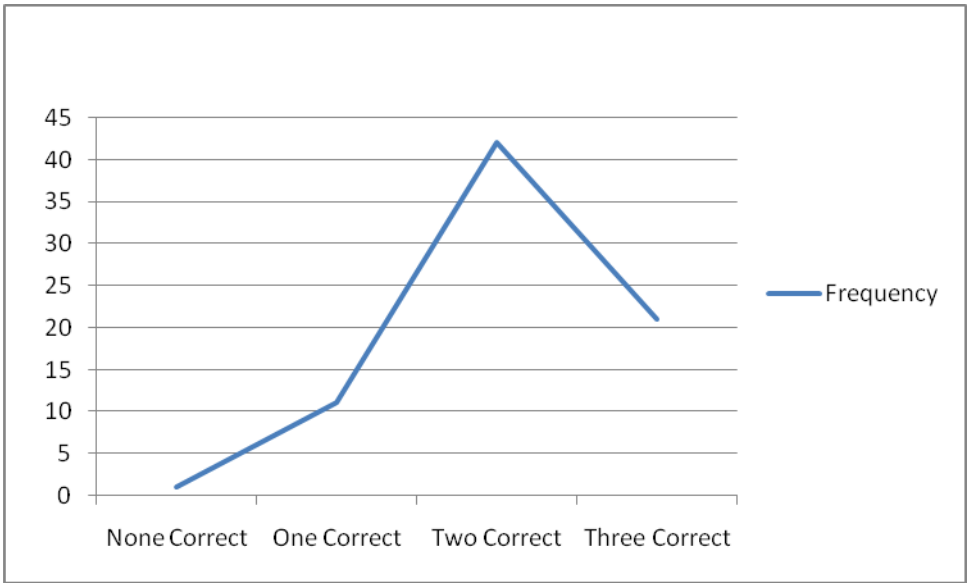

Figure 4.6 Number of correct answers for preventing HIV infection (n=75)

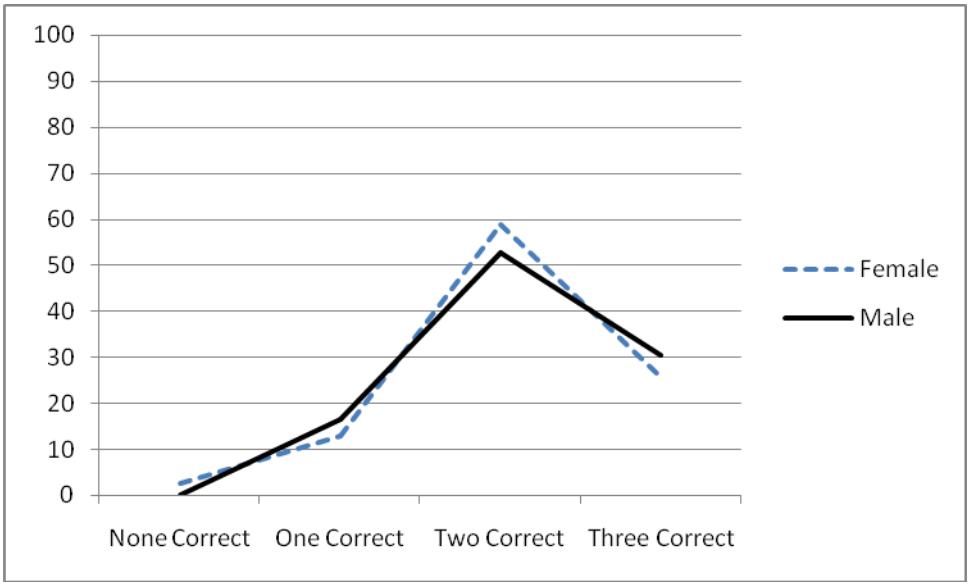

Figure 4.7 Number of HIV preventive strategies mentioned by females (n=39) and males (n=36)

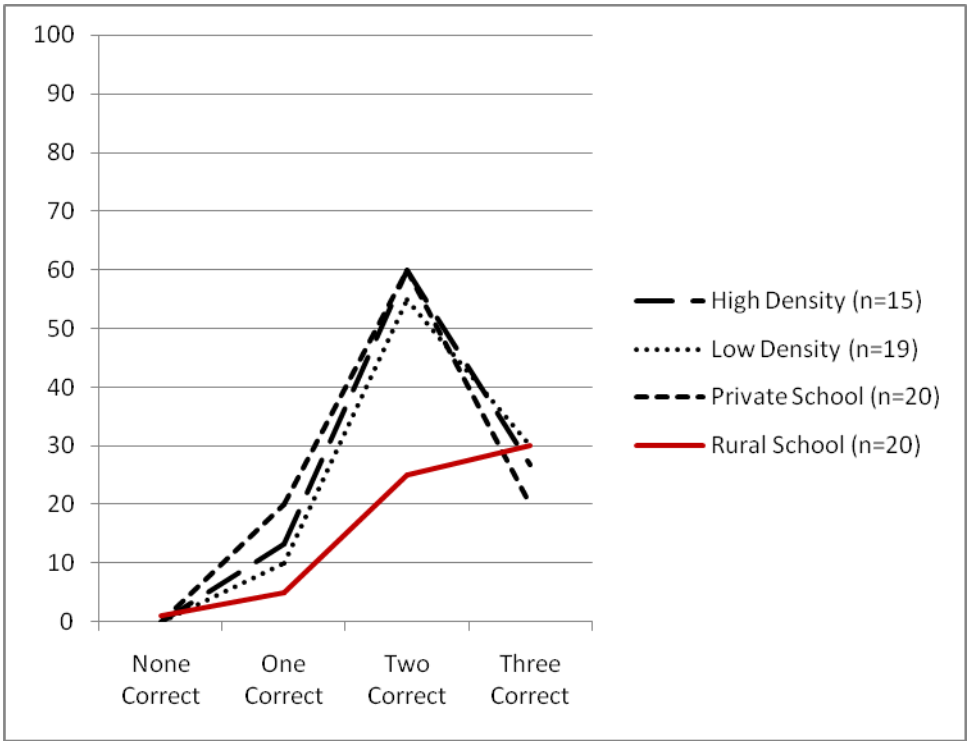

Figure 4.8 Number of preventive strategies mentioned by learners from different schools

As indicated in figure 4.8, learners from the rural school mentioned fewer HIV/AIDS preventive strategies than learners from the other three types of schools.

4.3.6 Learners' reported sexual behaviours

Learners' reported sexual behaviours included their responses to whether or not they involved in kissing, fondling and sex. Other questions asked whether the learners perceived themselves to be at risk of becoming HIV positive, they had actually been tested for HIV, they wanted to be tested for HIV, how many people they knew who were HIV positive and HIV negative respectively, whether there was any treatment for AIDS sufferers and whether sleeping with a virgin cured AIDS.

4.3.6.1 Kissing, fondling and sexual intercourse

Of the learners 94.7% (n=71) reported that they had never been involved in kissing while 5.3% (n=4) reported having done so. One was a female from a low density school and three male learners were from a private school. All the learners (100%; n=75) reported that they had never been involved in fondling nor in sex. Data obtained in Zimbabwe showed that the age group 6-15 years is least affected by HIV/AIDS (MOHCW 2004a:4) The findings of this study do not compare with the results of a study that was done in SSA on young people, in which almost one third of the 12-14 year old girls and boys in Uganda and Malawi had experienced some form of intimate sexual activity. In Burkina Faso and Ghana 1:10 adolescents had been involved in some form of sexual activity (Bankole, Biddlecom, Guella, Singh & Zulu 2007:1, 11-12).

The structured interview schedule's questions pertaining to sexually active learners were omitted as no learner had reportedly been sexually active. These questions included age at first intercourse, use of condoms and number of sexual partners.

4.3.6.2 HIV risk perception

The majority of learners (80.0%; n=60) did not feel at risk of HIV infection, while only 18.7% (n=14) felt that they were at risk while 1.3% (n=1) did not know whether he/she was at risk or not. According to the Zimbabwe YAS (2001-2:72), if individuals do not perceive themselves to be at risk of getting HIV infection, they are unlikely to adopt behaviours that are needed to avoid being infected.

Of the learners 54.7% (n=41) reported that they were not at risk because they had never had sex before, 8.0% (n=6) reported that they did not share needles or razor blades, 2.7% (n=2) reported that they could be at risk if they dated someone who was HIV infected, 2.7% (n=2) believed that they were at no risk because there was no one in their family who was HIV infected, 1.3% (n=1) reported they were at risk because they could get infected through injuries in an accident or during sexual abuse respectively, while 1.3% (n=1) were

not at risk because their parents were HIV negative, and 1.3% (n=1) reportedly felt not at risk because they knew how to prevent getting HIV.

Learners in the high density schools expressed a higher risk of perceived HIV infection (33.3%; n=5) as compared to the other three types of schools. Urban youths might be more exposed to literature, films, arts and media impacts that might influence their sexual behaviours and thus also their perceived susceptibility to HIV infection.

Table 4.7 Respondents' perceived susceptibility to HIV infection according to type of school (n=75)

Type of school	**No**		**Yes**		**Don't know**	
	n	%	n	%	n	%
High density	10	66.7	5	33.3	0	0
Low density	17	85	2	10	1	5
Private	17	85	3	15	0	0
Rural	16	80	4	20	0	0

4.3.6.3 Voluntary counselling and testing (VCT)

Of the learners, 93.3% (n=70) reported that they had never been tested for HIV while 6.7% (n=5) had been tested. However, 70.7% (n=53) reported that they wanted to be tested for HIV but 29.3% (n=22) did not want to be tested. Out of the 70 learners who had not been tested, 31.4% (n=22) reported that they did not want to be tested for HIV and 68.6% (n=48) were willing to be tested. All the learners who had been tested previously (n=5), wanted to be tested again for HIV.

4.3.6.4 Number of people known to be HIV negative and HIV positive

Of the learners, 62.7% (n=47) reported that they did not know anyone who had tested HIV negative, 6.7% (n=5) knew one person, 14.7% (n=11) knew two people, 2.7% (n=2) knew

three and four people respectively, 4.0% (n=3) knew five people while only 1.3% (n=1) knew six or more people.

Although 62.7% (n=47) of the learners did not know of anyone who had tested HIV negative, 54.7% (n=41) also did not know anyone who had tested HIV positive, but 16.0% (n=12) knew one person, 10.8% (n=8) knew two people, 6.7% (n=5) knew three people, 2.7% (n=2) knew four people, 4.0% (n=3) knew five people and 1.3% (n=1) knew seven or more people who had tested HIVpositive.

4.3.6.5 AIDS cure

Of the learners, 86.7% (n=65) knew there was no cure for AIDS while only 2.7% (n=2) reported that there was a cure. Most learners (97.3%; n=73) believed that sleeping with a virgin could NOT cure AIDS while 2.7% (n=2) reported that this behaviour could cure AIDS.

4.3.6.6 Dangers of using the services of prostitutes

All learners (100%; n=75) mentioned that boys who used the services of prostitutes could acquire HIV/AIDS and/or sexually transmitted infections.

4.3.6.7 Dangers of girls having sex with older men

Learners indicated that the risks of having sex with older men included acquiring HIV/AIDS (89.3%; n= 67), getting STIs (5.3%; n=4) and pregnancy (18.7%; n=14). The girls' loss of virginity (1.3%; n=1) and the possibility of murder (2.7%; n=2) were also mentioned.

4.3.6.8 Lifestyle behaviours

Learners indicated that they strongly disagreed, disagreed, were not sure, agreed or strongly agreed with specific statements relating to their lifestyles. The strongly disagreed and disagreed responses were grouped together as disagreed, while the strongly agreed and agreed responses were grouped together as agreed. The learners showed mixed

reactions to French kissing with 58.7% (n=44) disagreeing, 30.7% (n=23) being unsure whilst 10.7% (n=8) agreed. (These mixed reactions might be partly attributable to the learners' potential lack of understanding of the term "French kissing" as the interviewers indicated that they had to explain this term to almost all interviewees who were unfamiliar with it).

Although 29.3% (n=22) of the learners had previously indicated that they did not want to be tested for HIV, in response to this item, 97.3% (n=73) agreed that they wanted to undergo VCT.

Table 4.8 Learners' actual/anticipated reported behaviours (n=75)

Lifestyle behaviour	**Disagree**		**Not sure**		**Agree**	
	%	n	%	N	%	n
I will have unprotected sex (without a condom) with a person whose HIV status is unknown	98.7	74	1.3	1	0	0
I will insist to use a condom every time I have sexual intercourse even if I know my partner well	8.0	6	4.0	3	75.0	66
I will have anal sex with a person who is HIV positive	81.3	61	18.7	14	0	0
I can reuse the same condom twice	97.3	73	1.3	1	1.3	1
I intend having more than one sexual partner	97.3	73	1.3	1	1.3	1
I will share needles for using drugs	97.3	73	2.7	2	0	0
I will French kiss someone who is HIV positive	58.7	44	30.7	23	10.7	8
I will pay or accept payment for sex	98.7	74	0	0	1.3	1
I use alcohol/drugs and might often not be fully in control of my own behaviour	97.3	73	2.6	2	0	0
I am willing to undergo VCT	2.6	2	0	0	97.3	73

Anal sex, unprotected sex with a person whose HIV status is unknown, condom reuse, multiple sexual partners, sharing needles, french kissing, being paid for sex and drug abuse were lifestyles that were not accepted by school learners (see table 4.8) Of concern were the indications that some learners were uncertain about French kissing someone who is HIV+, having anal sex with a person who is HIV postive, and using a condom at every

sexual encounter. (However, it is possible that the learners might have been unfamiliar with the term “anal sex”).

4.4 SUMMARY

In this chapter, information on demographic characteristics of Form 1 secondary school learners, their HIV/AIDS knowledge and sexual behaviours have been highlighted. The learners were drawn from a rural school, low density school, high density school and private school and they were between the ages of 12 and 14 years. There were slightly more female (n=39) than male (n=36) learners. The learner’s levels of HIV/AIDS knowledge were generally acceptable although some lacked of information on AIDS. The prime source for HIV/AIDS information was the school and the radio and television. Parents ranked low in providing HIV/AIDS information to their children. All the learners reported that they were not sexually active although some had been involved in kissing. They were all aware of the dangers of being involved in risky behaviours like having sex with prostitutes or older men. More than half of the learners reported that they were willing to be tested for HIV and would not be involved in risky sexual behaviours.

The conclusions will be presented chapter 5, as well as the limitations and recommendations of the study.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The main purpose of the study was to document secondary school learners' information about HIV/AIDS and their self reported sexual behaviours in Harare, Zimbabwe. Two research questions were addressed namely: What are the levels of knowledge about HIV/AIDS among of secondary school learners aged 12-14 years? What sexual behaviours are reported by these learners? The conclusions based on the research findings discussed in chapter 4 of this dissertation will be used to address the objectives which were formulated. Each objective will be listed and a conclusion related to the objective will be provided.

5.2 OBJECTIVES

5.2.1 Describe the demographic characteristics of the secondary school learners who participated in the study

A total of 75 first year secondary school learners were interviewed, aged 12-14 years. There were more females (52.0%; n=39) than males (48.0%; n=36). All the learners belonged to Christian religious groups and most grew up in urban areas. The group's characteristics were comparable with the report of the ZDHS (2005-6). The demographic characteristics of the learners were comparable across the four schools.

5.2.2 Describe HIV/AIDS knowledge among learners in Zimbabwe

The HIV/AIDS knowledge levels of the learners were generally high. All the school learners had heard about HIV/AIDS and the school was the most frequently mentioned source of information (92%; n=69). The television (60%; n=45) and the radio (41% ; n=31) were also common sources of information. Parents (13.3%; n=10), newspapers (9.3%; n=7) and community activities (4%; n=3) were also mentioned.

Knowledge levels about what HIV were very high (94.7%; n=71) but these were lower when they were asked what AIDS is (89.3%;n=67). Knowledge about HIV transmission was high (94.7%; n=71). However, when asked to mention three ways of preventing HIV infection, only 26.6% (n=20) reported three such strategies while 56% (n=42) reported two. There were misconceptions about modes of transmission of HIV by being scratched by the nails of a person who is HIV positive and by caring for HIV/AIDS patients. Almost all learners knew that a person who is HIV positive could look healthy (96%; n=72).

5.2.3 Identify sexual behaviours as reported by learners

High risk behaviours did not appear to be prevalent in this group of learners. All the learners reported that they were not sexually active and the majority were not involved in any sexual activities like fondling (100%) and kissing (94.7%). Only a few (5.3%; n=4) were involved in kissing. The majority of the learners (80%; n=.60) felt that they were not at risk of acquiring HIV because they were reportedly not yet sexually active. The minority who felt that they were at risk of HIV infection were from the high density school where there is high population, poverty, harsh economic conditions which leave young people at increased risks of abuse. Some of the reasons given for high risk perception were accidents and dating someone who might be HIV positive.

All the learners were aware of the dangers of prostitution and of having sex with older men. They all mentioned that there was a high possibility of acquiring HIV infection. Of the learners (86.7%;n=65) mentioned that AIDS has no cure and and most of the learners (97.3%;n=73)believed that sleeping with a virgin does not cure AIDS.

Learners were willing to adopt positive lifestyle behaviours as shown by their their disagreement and agreement to statements pertaining to some lifestyle behaviours. Of note was their disagreement with payment for sex, having unprotected sex, reusing the same condom, having more than one sexual partner, sharing needles for using drugs and use of alcohol/drugs. The learners however showed mixed reactions to French kissing with 58.7% (n=44) disagreeing, 30.7% (n=23) being unsure whilst 10.7% (n=8) agreed. (These mixed reactions might be partly attributable to the learners' potential lack of understanding of the term "French kissing" as the interviewers indicated that they had to explain this term to almost all interviewees who were unfamiliar with it).

Although 29.3% (n=22) of the learners had previously indicated that they did not want to be tested for HIV, in response to the item on willingness to undergo VCT, 97.3% (n=73) agreed that they wanted to undergo VCT.

5.3 LIMITATIONS

Limitations identified during the study included that:

- Research results might be limited to the four schools since the sample was small. However, the sample comprised learners from the rural, high density, low density and private schools representing the four types of schools in Zimbabwe, and the demographic characteristics of the learners were comparable across the four schools, as well as to those reported in the ZHDS (2005-6;158).

- Only 75 learners were interviewed because the interviews were conducted at a time when Zimbabwe was undergoing economic hardships and there was a low turnout of both teachers and learners in schools, due to teachers' strikes for better salaries.

- The study was conducted at a time when there were problems with e-mails and that greatly affected communications with the statistician and the supervisors.

- Only Form 1 secondary school learners participated in this study. Reportedly none of them had been sexually active, making questions about sexual practices irrelevant, and the study incapable of reporting on these issues.

Knowledge levels about HIV/ AIDS of learners was generally high. They showed that they had mastered HIV/AIDS knowledge and knew what behaviours were needed to protect them from becoming HIV positive. These young people are not yet sexually active but may be at the brink of sexual activity. They have the lowest rates of HIV, are at risk of sexual exploitation, but may be easier to influence than the sexually active young people who have already adopted some behaviours hence the need to provide then with programmes that will help ensure that they delay sexual activities and do not acquire HIV.

5.4 RECOMMENDATIONS

- As most learners acquired their HIV/AIDS information from schools, these school-based programmes should be sustained, improved and expanded.

- Based on the fact that the minority of learners acquired their HIV/AIDS information from their parents, school-based parent-empowering HIV/AIDS and sex-related education programmes should be provided to parents, in addition to those existing for learners.

- The school curriculum needs to be revised to emphasise improving learners' HIV/AIDS knowledge and addressing misconceptions (even if only held by a minority of learners) including HIV/AIDS transmission through being scratched by the nails of a person who is HIV positive, the fact that there is no cure for HIV/AIDS the fact that HIV/AIDS can not be cured by having sex with a virgin. The school-based HIV/AIDS programme should also stress that, provided that one takes precautionary measures to protect oneself against contamination with the HIV positive person's body fluids, one is unlikely to become HIV infected by caring for such a person.

- The school curriculum should also emphasise the difference between HIV and AIDS.

- The finding that 80% (n=60) of the learners did not feel themselves to be at risk of contracting HIV/AIDS should be addressed by HIV/AIDS programmes, emphasising that every person can be at risk.

- Radios should be made available to learners, especially those in rural areas, to provide them with HIV/AIDS information.

- Television programmes, targeting young people with HIV/AIDS information, should be sustained and expanded.

- Comparative surveys should be conducted in a number of SSA countries. If country-specific differences in learners' knowledge levels are detected, then the HIV/AIDS education programmes should be compared for compiling best practice guidelines for the most effective HIV/AIDS education school-based programmes.

- Future studies should involve learners from Forms 1-5 to identify the average ages at which learners commence sexual activities.

As all Form 1 secondary school learners, who were interviewed during this study, were reportedly not yet sexually active, this study demonstrates the importance of targeting this age group with HIV/AIDS information before they become sexually active so that they can remain HIV negative. If the learners' responses revealed their sexual practices of sustained abstinence, this finding offers some hope of addressing the HIV/AIDS epidemic in Zimbabwe by focussing health education and empowerment drives at this age group.

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ANNEXURE A

Requesting permission to conduct the study

ANNEXURE B

Permission granted to conduct the study

ANNEXURE C

Structured interview schedules

ANNEXURE D

Statistician’s letter

ANNEXURE E

Newspaper report

ANNEXURE F

Clearance certificate from the Department of Health Studies, University of South Africa

Annexure A

21 Bexley Circle
Southerton
Harare

05 July 2007

Ministry of Education Sports and Culture
P.O. Box CY Causeway
Zimbabwe

Dear Sir/ Madam

RE- REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN SCHOOLS IN HARARE

By way of this letter, I do hereby request for permission to conduct research in four secondary schools in Harare in partial fulfillment of my studies in MA Cur with the University of South Africa.

The research Title is ' HIV Knowledge and Sexual Behaviour of Secondary School Learners in Harare Zimbabwe' The results of the study will help in coming up with targeted health education programmes that will enhance preventive behaviour adoption by adolescents in Zimbabwe.

Thank you for your consideration

Sincerely

M MLINGO

Annexure B

all communications should be addressed to
"The Secretary for Education Sport and Culture"
Telephone: 734051/59 and 734071
Telegraphic address : "EDUCATION"
Fax: 734075

ZIMBABWE

Ministry of Education, Sport and Culture
P.O Box CY 121
Causeway
Zimbabwe

MRS M. MLINGO
21 BEXLEY CIRCLE
SOUTHERTON
HARARE

RE: PERMISSION TO CARRY OUT RESEARCH

Reference is made to your application to carry out research in the Ministry of Education, Sport and Culture institutions on:

HIV KNOWLEDGE AND SEXUAL BEHAVIOUR OF SECONDARY SCHOOL LEARNERS IN HARARE ZIMBABWE

Permission is hereby granted. However, you are required to liaise with the Provincial Education Director responsible for the schools from which you want to research.

You are also required to provide the Ministry of Education, Sport and Culture with the final copy of your research since it is instrumental to the development of Education in Zimbabwe.

MINISTRY OF EDUCATION
HARARE
pp Z.M.Khuliga 2007
ZIMBABWE

FOR: SECRETARY FOR EDUCATION, SPORT AND CULTURE

Annexure C

Date of interview _____

Interviewer no:----------

1	2	3

INTERVIEW SCHEDULE

HIV knowledge and sexual behaviour among secondary school learners in Harare, Zimbabwe.

Participation is voluntary.
All information herewith provided will be treated confidentially.
It is not necessary to indicate your name in this questionnaire.

SECTION A: Demographical and Biographical information

1. Name of School you are attending

A	
B	
C	
D	

2. Type of school

2.1 High-density school	
2.2 Low density school	
2.3 Private School	
2.4 Rural School	

3. What is your gender?

Gender	**ANSWER**
3.1 Male	
3.2 Female	

4. What is your age in completed years? ----------

5 What is your religion?

5.1 Seventh Day Adventist	
5.2 Methodist	
5.3 Roman Catholic	
5.4 Anglican	
5.5 Pentecostal	
5.6 Traditional	
5.7 Other (Specify)	

6 Where did you grow up?

6.1 Urban area	
6.2 Small town	
6.3 Rural area	

Section B HIV/AIDS knowledge

7. Have you ever heard of HIV/AIDS? **Yes**
No → skip to Q 15

8. Where did you hear about HIV/ AIDS? (More than one option may be ticked)

8.1 Church	
8.2 School	
8.3 Friends	
8.4 Health workers	
8.5 Radio	
8.6 Television	
8.7 Other (specify)	

9. What is HIV?

_____

10. What is AIDS?

_____

11. How is HIV transmitted?

_____
_____
_____

12 Can HIV be transmitted through:

	Yes	No
12.1. Sex with an infected partner?		
12.2 Mosquito bite?		
12.3 Eating from the same plate with an infected person?		
12.4 Mother to child?		
12.5 French Kissing?		
12.6 Using the same toilet as an infected person?		
12.7 Needle prick or injection?		
12.8 Blood transfusion?		
12.9 Cough?		
12.10 Tattooing		

13 Can a person with HIV look healthy?

13.1 Yes	
13.2 No	

14 List three behaviours that can ensure a person remains HIV negative.

14.1----------

14.2----------

14.3----------

Section C Sexual Behaviour

15 Have you ever been involved in

	Yes	No
15.1 Kissing		
15.2 Fondling		
15.3 Sex		

If 15.3 is “no”, go to question 23.
16.1 At what age did you **first** have sexual intercourse? _____

16.2 Did you use a condom the first time you had sex?

16.1 Yes	
16.2 No	

16.3 If yes, why, if no, why not.

---

17 How many sexual partners have you had in your lifetime? ----------
(Please write down the actual number given by the respondents)

18 Have you ever used a condom?

18.1 Yes	
18.2 No	

19. List three advantages of using condoms.

19.1----------

19.2----------

19.3----------

20. List three places where you can obtain condoms from.

20.1----------

20.2----------

20.3----------

21. Have you ever encountered problems in getting condoms?

21.1 Yes	

21.2 No	

Please explain.----------
---

22. Indicate if the following is "true" or "false" relating to the use of condoms:

	True	False
22.1 The use of male condoms shows that the man is prepared to take responsibility in the relationship.		
22.2 It is not necessary to use a condom when you know your sexual partner well.		
22.3 Male condoms do occasionally break, in which case the penis and the condom should be removed immediately.		
22.4 There is an expiry date on the condom package that should be checked before usage.		
22.5 The condom should be pulled tightly against the tip of the penis.		
22.6 You can use lubrications such as Vaseline, cooking oil and baby oil with a condom.		
22.7 It is not necessary to remove the condom immediately after ejaculation.		

23. Do you feel that you are at risk of having HIV?

23.1 Yes	
23.2 No	

Please explain.----------
---

24. Have you ever been tested for HIV?

24.1 Yes	
24.2 No	

If yes Go to Q 26

25. Would you like to get tested for HIV?

25.1 Yes	
25.2 No	

26. How many people do you know who have been tested and found to be HIV-ve? ….

27. How many people do you know who have been tested and found to be HIV+ve? …

28. Is there a treatment (pills) that can cure AIDS sufferers?

28.1 Yes	
28.2 No	

29 Having sex with a virgin can cure AIDS.

29.1 Yes	
29.2 No	

30. What are the dangers to boys/men who use the services of prostitutes/sex workers?

---

31. What are the dangers to girls who have sex with older men?

For question 32, please use the following scale:

1 = strongly disagree 2=disagree 3=not sure 4=agree 5 = strongly agree

32. The following behaviour is part of my lifestyle:

	1	2	3	4	5
32.1 I have unprotected intercourse with a person whose HIV status is unknown. 32.2 I insist to use a condom everytime I have sexual intercourse, even if I know my partner well. 32.3 I have anal sex with a person who is HIV positive.					
32.4 I re-use the same condom twice. 32.5 I have more than one sexual partner. 33.6 I share needles for using drugs. 34.7 I French-kiss someone who is HIV positive. 35.8 I pay/or am paid for sex. 36.9 I abuse alcohol / drugs and is often not in control of my own behaviour. 37.10 I am willing to undergo VCT					

Thank you for participating.

Annexure D

Statistical Center for
HIV/AIDS Research & Prevention
SCHARP

November 29, 2007

Margaret Mlingo
UZ-UCSF Collaborative Research Programme
15 Phillips Avenue
Belgravia, Harare, Zimbabwe
margaret@uz-ucsf.co.zw

Dear Maggie,

I will be happy to provide statistical assistance for the research efforts involved with your dissertation about the assessment of HIV knowledge and sexual behavior among secondary school learners in Harare, Zimbabwe.

Sincerely,

Cliff Kelly
Statistical Research Associate

FRED **HUTCHINSON**
CANCER RESEARCH **CENTER**
A LIFE OF SCIENCE

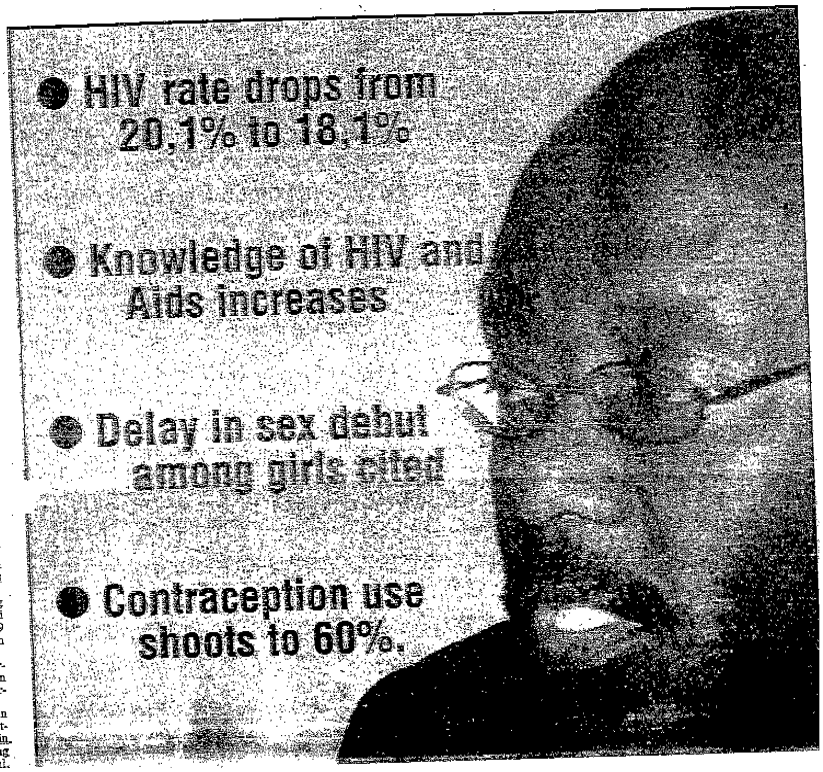
1100 Fairview Ave N LE-400 PO Box 19024 Seattle, WA 98109-1024 (206) 667-7000 (206) 667-4812 Fax

Annexure E

The Herald

Harare, Zimbabwe, Thursday 7 September 2006

HIV rate falls



UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee
(HSREC)
College of Human Sciences

CLEARANCE CERTIFICATE

Date of meeting: **20 October 2008** Project No: **3155-319-2**

Project Title**:** **HIV Knowledge and sexual behaviour among youth in Zimbabwe**

Researcher**:** **Ms M Mlingo**

Supervisor/Promoter**:** **Prof VJ Ehlers**

Joint Supervisor/Joint Promoter**:** **Dr JH Roos**

Department: **Health Studies**

Degree: **MPH**

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Date: **4 November 2008**

Prof L de Villiers
RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES

Prof SM Mogotlane
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

Student Number: 3155-319-2

DECLARATION

I declare that HIV/AIDS KNOWLEDGE AND SEXUAL BEHAVIOUR AMONG SCHOOL LEARNERS IN HARARE , ZIMBABWE is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete reference and that this work has not been submitted before for any other degree at any other institution.

---------- **----------**

MARGARET MLINGO (MRS) **DATE**

HIV/AIDS KNOWLEDGE AND SEXUAL BEHAVIOUR AMONG SECONDARY SCHOOL LEARNERS IN HARARE , ZIMBABWE

STUDENT NUMBER: **31553192**

STUDENT: **Margaret Mlingo**

DEGREE: **Master of Cur (Public Health)**

DEPARTMENT: **Health Studies, University of South Africa**

SUPERVISOR: **Prof VJ Ehlers**

JOINT SUPERVISOR: **Dr JH Roos**

ABSTRACT

The study assessed HIV/AIDS knowledge and sexual behaviour among secondary school learners in Harare Zimbabwe. HIV information was high but AIDs information was low. The school was their prime source of information and parents raked low in proving information.There were misconceptions on HIV transmission that need to be addressed. All the school learners reported that they were not sexually active although a some had been involved in kissing.The majority of the learners indicated that they were willing to adopt positive lifestyles, therefore the need to keep this young age group HIV negative is imperative.

ACKNOWLEDGEMENTS

I would like to thank the Almighty God for his guidance and for giving me the strength and wisdom to complete this study.

I would also like to give my appreciation to the following people for their support:

- My family, OP Mlingo, Tawanda and Chido,Beke and Pride, Kudzi and Allan, Imnah and my grand children, Oni, Kuku, Laura and Kupa.
- Prof VJ Ehlers and Dr JH Roos, for their tireless guidance, support and the knowledge and skills they passed on to me and the encouragement to keep on going.I am immensely indebted to both of you.
- The Ministry of Education and all the school learners who were involved in the study.
- Tapera Henry Chinhemhute for his assistance with data entry.
- Cliff Kelly for data analysis.
- My colleagues and friends for their invaluable contributions.

To all those whom I did not mention, please accept my sincere gratitude, appreciation.

Date of interview _____

Interviewer no:----------

1	2	3

INTERVIEW SCHEDULE

HIV knowledge and sexual behaviour among secondary school learners in Harare, Zimbabwe.

Participation is voluntary.
All information herewith provided will be treated confidentially.
It is not necessary to indicate your name in this questionnaire.

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3. What is your gender?

Gender		**ANSWER**
3.1	Male	
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6.3 Rural area	

Section B HIV/AIDS knowledge

7. Have you ever heard of HIV/AIDS? **Yes**
No → skip to Q 15

8. Where did you hear about HIV/ AIDS? (More than one option may be ticked)

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_____

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_____

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12.8 Blood transfusion?		
12.9 Cough?		
12.10 Tattooing		

13 Can a person with HIV look healthy?

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13.2 No	

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14.2----------

14.3----------

Section C Sexual Behaviour

15 Have you ever been involved in

	Yes	No
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15.3 Sex		

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16.3 If yes, why, if no, why not.

---

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Please explain.----------
---

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---

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_____

31. What are the dangers to girls who have sex with older men?

_____

For question 32, please use the following scale:

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32. The following behaviour is part of my lifestyle:

	1	2	3	4	5
32.1 I have unprotected intercourse with a person whose HIV status is unknown. 32.2 I insist to use a condom everytime I have sexual intercourse, even if I know my partner well. 32.3 I have anal sex with a person who is HIV positive.					
32.4 I re-use the same condom twice. 32.5 I have more than one sexual partner. 33.6 I share needles for using drugs. 34.7 I French-kiss someone who is HIV positive. 35.8 I pay/or am paid for sex. 36.9 I abuse alcohol / drugs and is often not in control of my own behaviour. 37.10 I am willing to undergo VCT					

Thank you for participating.