

**AN EDUCATIONAL- PSYCHOLOGICAL INVESTIGATION OF
THE ATTITUDE OF BLACK LEARNERS TO HIV/AIDS**

MOKGADI GLORIA NTHO

STD (Sebokeng College), B.A., B. Ed. (HONNS) (PU for CHE)

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SUPERVISOR: Dr Nzuzo Joseph Lloyd Mazibuko

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SUMMARY

The aims of this research were to investigate the attitudes of Black learners growing up in the townships towards HIV/AIDS; investigate the beliefs of communities in which Black learners grow up about HIV/AIDS; and make suggestions for an educational-psychological programme which schools can use to help Black learners develop healthy and responsible attitudes towards HIV/AIDS.

The literature review revealed that some Black learners believe that HIV/AIDS can be transmitted through various forms of casual contact, such as kissing, sharing a drinking glass, and contact with a toilet seat. Learners who believe that HIV can be transmitted in these forms are much more likely to express discomfort about attending schools with learners who are infected with HIV/AIDS. Such misconceptions have the potential of being contributing factors in discriminating and stigmatizing individuals infected with HIV/AIDS. The literature, also, revealed that the cultural stereotypes about HIV/AIDS among Black learners are also linked to cultural beliefs and convictions, for example, for traditional Africans, illness is not a random event. Rather, every illness is a product of a destiny and has a specific cause. For black Africans, in order to eliminate the illness, it is necessary to identify, uproot, punish, eliminate and neutralise the cause and the agent of the cause of illness. Illness, according to black traditional beliefs, is a result of a disharmony between an ill person and his/her ancestors, deity, spirits, witches and sorcerers; natural causes such as being old; and a breakdown in social relationships between people. This could be the reason for some of the Black learners believing that HIV/AIDS is caused by the wrath of ancestors against people who fail to appease those of their families who have already passed on.

The empirical research investigated the participants' personal beliefs about HIV/AIDS related stereotypes. The findings revealed that the majority of the learners who participated in this study do not know or are not sure of the origins of HIV/AIDS and that they personally have not changed their sexual

behaviours as a result of their knowledge of HIV/AIDS. This could be attributed to the fact that the majority of the respondents revealed that they are not sexually active and they personally had never used condoms.

The empirical research also asked the participants about the beliefs that people in their communities have about HIV/AIDS. Such questions were asked in order to determine the general beliefs about HIV/AIDS that the learners who formed the sample of this research are socialized and enculturated in. The results revealed that the majority of the people in the communities of the learners who participated in this research are unsure of the origin of HIV/AIDS and that condoms, according to their beliefs, cannot protect one from contracting HIV/AIDS.

The analysis and interpretation of both the literature review and empirical research findings have led to this study making some recommendations which have implications for educational and psychological approaches to dealing with attitudes of learners towards HIV/AIDS.

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CHAPTER ONE

INTRODUCTION, STATEMENT OF THE PROBLEM, AIMS, METHODS AND CHAPTER DIVISION OF RESEARCH

1.1 INTRODUCTION AND STATEMENT OF THE PROBLEM

In South Africa, the stereotypes and misconceptions about HIV/AIDS among Black people are linked to cultural beliefs and convictions. For example, for traditional Black people, illness is not a random event. Rather, every illness is a product of a destiny and has a specific cause (Garcia-Morenos & Watts, 2000:255). For Black people, to eliminate the illness, it is necessary to identify, punish, eliminate and neutralise the cause and the agent of the cause of intention. According to Black traditional beliefs, illness can be a result of disharmony between a person and the ancestors, caused by:

- God, spirits, witches and sorcerers;
- natural causes; and
- a breakdown in relationships between people (Mlamuleli, Mabelane, Napo, Sibiya & Valerie, 2000:268).

It is clear from the above-mentioned paragraphs that traditional black African beliefs come from a tradition in which ancestor worship is the norm and for them evil spirits cause misfortunes and disease. There are only three reasons for something bad happening to traditional African people:

- someone has bewitched them and caused the disease and illness to happen;
- the ancestral spirits are angry with them and make them sick; and
- evil spirits are haunting them and making them sick (Kiragu, 2001:4).

A person who grows up with this belief system will not embrace such notions as 'Human immunodeficiency viruses (HIV)' (Mlamuleli, Mabelane, Napo, Sibiya & Valerie, 2000:270). Instead, he tends to believe that he has been bewitched and poisoned. His beliefs are based on a misconception such as that witchcraft medicine was mixed into his food and that is why he has contracted AIDS (Mitchell & Smith, 2001:56). It is the norm for people who live with these beliefs to take revenge for the actions of the person who, they believe, bewitched or poisoned them (Sithole, 2001:1). Sometimes it means eliminating the people who, they are convinced, caused harm to them (Omale, 2000:21; Marcus, 1999:12). Kiragu (2001:6) asserts that as the deadly virus tightens its stranglehold on South Africa, the myth that sex with a virgin cures AIDS becomes the standard belief among primitive and traditional people. This could certainly account for the horrific phenomenon of child rape statistics in South Africa. Justice officials and AIDS workers say that in KwaZulu-Natal alone at least 5 rape cases involving girls under the age eight-years are being dealt with daily in every magistrate's court in the province (Maartens, 1999:1255). The AIDS-suffering people with this myth in their minds believe that raping a child will cleanse them of AIDS and also acts as a preventive measure to avoid contracting the HIV/AIDS virus from older women (Omale, 2000:21). This belief is clearly highlighted in the study of Stadler & Motsepe (1999:56) which reveals that a 23-year-old black respondent told them during their interviews that everybody older than twelve years in the township might already have contracted the virus, so it is better if he goes for the 6 or 8-year-olds who are still virgins. Another 20 year-old boy in the research of Berman and Hein (1999:44) asserted that if he can discover that he is HIV/AIDS positive, he can just go out and spread it to a hundred more other people so that he can die with more other people. Hendrie (2003:3) believes that the increase in child-rape, stereotypes and misconceptions about HIV/AIDS is directly related to the way this pandemic is understood in primitive and traditional communities. Such communities hold the belief that virginity which means the sexual cleanliness and pureness of a baby or child will strip the virus away. Both girls and boys are being raped because of this belief (Fineran & Larry, 1999:627). South Africa has had a case of a two-year-old boy who was discovered near Soweto with his cut off thumbs and there

had been an attempt to gouge out his eyes (Maartens, 1999:1256). Primitive and traditional people believe that *muti* (the 'traditional medicine' used by traditional healers) is considered more powerful if the innocent victim is still alive when the parts are removed (Mirembe, 2001). In South Africa, again, there has been a case of a man who slaughtered his six -year-old child like an animal (at his home at Diepkloof in Soweto). He emasculated him, split open his chest, removed his heart and cooked and ate it. The dead child's genitals were in his pocket when he was arrested (Mitton, 2000:20). According to Stadler and Motsepe (1999:67), thumbs are used as medicine to call up ancestors, while human eyes are gouged out and ground into a paste which users apply to their foreheads in the hope of obtaining a 'third eye vision' enabling them to see the spirit world.

Black learners grow up in communities where the above-mentioned cultural beliefs are practised by some members of the community and it is possible that some of them might be drawn into such beliefs and convictions. This study therefore investigates the attitude of Black learners towards HIV/AIDS from both their personal perspectives and the perspectives of the communities in which they live. An educational perspective is used, because this study is conducted from the educational field where the transmission of certain competencies that are necessary for the learner to acquire in order to cope with the HIV/AIDS pandemic in both schools and communities is regarded as significant. A psychological perspective is used because attitudes are mainly human cognitive dimensions and the HIV/AIDS pandemic can affect the emotional, behavioural and mental activity of learners negatively. The effects of HIV/AIDS on human beings can cause psychosis and emotional turmoil, thus eroding the individual's ability to cope with daily life.

The questions that now come to mind are:

- What are the attitudes of Black learners who grow up in the townships about HIV/AIDS?
- What are the beliefs of communities in which Black learners grow up about HIV/AIDS?

- Which educational-psychological programmes can schools adopt for helping learners to develop healthy and responsible attitudes towards HIV/AIDS?

1.2 AIMS OF THE STUDY

The answers to the above three questions have led this research to the following aims, which are to:

- investigate the attitudes of Black learners growing up in the townships towards HIV/AIDS;
- investigate the beliefs of communities in which Black learners grow up about HIV/AIDS; and
- make suggestions for an educationally and psychologically based programme to help Black learners develop healthy and responsible attitudes towards HIV/AIDS.

1.3 METHODS OF RESEARCH

This study used a literature review and empirical research methods in achieving its aims.

1.3.1 Literature review

Current international and national journals, papers presented at professional meetings, dissertations by graduate students, reports written by school researchers, university researchers and both South African Acts 27 and 84 of 1996 (which provide information on how far research has progressed on HIV/AIDS in schools, the attitude of Black learners towards HIV/AIDS from an educational and psychological perspective, and its effects on teaching and learning) were consulted and serve as primary sources. Books on HIV and AIDS serve as secondary sources.

1.3.2 Empirical Research

In addition to the literature study, data were collected by means of a questionnaire. These data were analysed and interpreted (see chapter 4).

The research was conducted as follows:

The schools which were randomly selected to form the sample of this research were from Zamdela, Heilbron, Lethabo, Orangeville and Deneysville townships. Permission was requested from principals of these schools to conduct research at their schools. The researcher personally visited these schools to administer and collect the questionnaires.

1.3.2.1 Measuring instrument

A self-developed questionnaire was designed by the researcher to measure the attitudes of Black learners towards HIV/AIDS. A self-developed questionnaire was designed because a standardised questionnaire relevant to this study could not be found. Only internationally developed questionnaires were available and were not appropriate for the questions which this research endeavours to answer and for the peculiar cultural and sexual orientations of black learners who grow up in the social environment of unique African beliefs, convictions, values, philosophy of life, life-view, norms about love and sex and knowledge of the origins of HIV/AIDS. The researcher based the items of the questionnaire on the findings of the literature review which is presented in chapters 1 and 2.

1.3.2.2 Target population

All learners of secondary schools in the townships of the Free State Province were initially considered the target population.

1.3.2.3 Accessible population

Since there is a large number of public secondary schools in the Free State Province, which would have taken a long period to cover and would have had serious financial implications for the researcher who did not have any bursary

for conducting this research, it was decided to limit the target population to the public secondary schools in the Northern Free State Province.

1.3.2.4 Sample

A randomly selected sample of 301 learners (n=301) from 15 secondary schools in the Northern Free State area was drawn. These learners were supplied with questionnaires on the attitudes of Black learners towards HIV/AIDS.

1.3.2.5 Statistical techniques

To determine the attitudes of learners towards HIV/AIDS in the Northern Free State area, the data obtained from the target population were analysed, using the SPSS programme in consultation with the Statistical Consultation Services of the North-West University at the Vaal Triangle Campus.

1.4 CHAPTER DIVISION

The research will be divided into the following chapters:

- Chapter 1 provides introduction and the statement of the problem, aims, methods and the chapter division of this research.
- Chapter 2 presents a literature review on HIV/AIDS and educational-psychological approach to HIV/AIDS.
- Chapter 3 discusses the empirical design and research methodology with regard to the questionnaire used in the study and its administration.
- Chapter 4 provides the data obtained from the questionnaires. This data is analysed and interpreted.
- Chapter 5 serves as the conclusion to the study, incorporating significant literature and empirical findings and recommendations

1.5 CONCLUSION

Chapter 1 presented the introduction and statement of the problem, aims, methods and chapter division of this research. Chapter 2 presents a literature review on HIV/AIDS and an educational-psychological approach to HIV/AIDS.

CHAPTER TWO

LITERATURE REVIEW ON EDUCATIONAL-PSYCHOLOGICAL PERSPECTIVES AND THE HIV/AIDS PANDEMIC

2.1 INTRODUCTION

This chapter presents literature review on HIV/AIDS and educational-psychological approach to HIV/AIDS. The educational-psychological approach to HIV/AIDS is presented in the context of educational and psychological theories and practice where HIV/AIDS misconceptions and stereotypes are regarded as addressable by educators on levels of the psychological, educational and social needs of both learners who are not yet infected and affected by HIV/AIDS and those who are already living with HIV/AIDS. The concepts such as HIV/AIDS and educational-psychological perspectives are, also, defined.

2.2 LITERATURE REVIEW ON HIV/AIDS

This section, first, defines concepts such as HIV/AIDS, immune system, immune deficiency, syndrome and attitudes and, second, gives the history of the pandemic.

2.2.1 Definition of concepts

The following concepts which are mainly used in this research are defined below.

2.2.1.1 HIV/AIDS

HIV is an acronym for the Human Immunodeficiency Virus. It is a retro-virus which in the past was called Lymphadenopathy Associated virus (LAV) or simply AIDS virus (Luke & Kathleen, 2002:39). When HIV gets into a human being's body, it slowly breaks down the body's immune system (Anderson & Scharflander, 2002:24; Luke & Kathleen, 2002:39).

HIV is about one sixteen thousandth the size of the head of a pin. Its make-up consists of a double-layered shell or envelop full of proteins, surrounding a 'ribonucleic acid (RNA)' which is a single-stranded genetic molecule (Luke & Kathleen, 2002:39). This explains that HIV is a very small germ or organism which cannot be seen by naked eyes but only through an electron microscope. It only survives and multiplies in body fluids such as sperm, vaginal fluids, blood, and breast milk (Gold and Nash, 2001:45; Heard, 2000:30), which means that human beings can only become infected with HIV through contact with infected body fluids. Once it infects the body, it attacks the body's immune system, that is, the body's natural ability to fight illness and its defense against infection, and reduces the body's resistance to all kinds of illness including flu, diarrhoea, pneumonia, tuberculosis and certain cancers.

When HIV has weakened the person's immune system, the person gets sick more often (Kenyon, 2000:16). In the human blood stream, HIV is attracted to white blood cells, known as T4 helper lymphocytes. These are among the most important cells in the working of the body's immune system because of their effect in causing various different cells to become active in fighting infections, including the cells that produce anti-bodies (Gregson, Nyamukapa, Garnett, Mason, Zhuwau, Carael, Chandiwana & Anderson, 2002:100).

From the foregoing paragraphs it is apparent that HIV causes damage in the following ways:

- It enters T4 helper cells and uses the cells own reproductive material to reproduce itself. Eventually numerous copies of the virus break out of the cells, killing them.
- They then find other T4 cells to invade and the process starts again.
- Next, they cause uninfected T4 helper cells to clamp around infected T4 cells, thus immobilising them.
- Finally, tiger types of cells dependent on T4 helper cells cease to function properly as the T4 cells become depleted. Some cells, other than T4 helper cells, may be directly attacked by the virus or by the damaged

immune system itself (Cole, Suman, Schamm, van Bel, Lunn, Maguire, Collins, & Rau, 2000:10).

This destruction of the immune system, according to Donohew, Zimmerman, Cupp, Novak, Colon & Abell (2000:390), means that infectious organisms can invade the body largely unchallenged, and multiply to cause serious opportunistic diseases and illnesses called the Acquired Immunodeficiency Syndrome (AIDS), which manifest in the form of, among many other diseases:

- weight loss;
- dry cough;
- recurring fever or profuse night sweats;
- profound and unexplained fatigue;
- swollen lymph glands in the armpits, groin, or neck;
- diarrhea that lasts for more than a week;
- white spots or unusual blemishes on the tongue, in the mouth, or in the throat;
- red, brown, pink or purplish blotches on or under the skin or inside the mouth, nose, or eyelids;
- memory loss, depression, and other neurological disorders; and
- tuberculosis, pneumonia, gastro-enteritis, meningitis and cancer.

These opportunistic diseases affect both the physical and psychological health and wellness of learners infected with HIV and AIDS. It is during this process that full-blown AIDS begins.

The 5 stages of the development of the HIV disease in the human body are:

- ***The primary HIV infection***

This happens within a few weeks of HIV infection and it is during this time that individuals' physical health change from being HIV negative to being HIV positive (Nhundu & Shumba, 2001:25). About half of the infected individuals develop a flu-like illness with fever, sore throat, swollen glands, headache, muscle aches and sometimes a rash. This stage of the HIV disease lasts only a week or two, and after this, the individual returns to feeling and looking completely well (Stadler & Motsepe, 1999:90).

- ***The asymptomatic or silent stage***

Pack, Crosby and Lawrence (2001:40) state that, after recovery from the primary HIV illness, individuals infected with HIV continue to be completely well for long periods, often for many years. During this time, the only indication that the individual is infected with HIV is that he/she tests positive on standard HIV tests and may have swollen lymph glands. This means that he/she looks and feels healthy and can easily infect other people through unprotected sex, especially if he/she does not know that he/she is infected.

However, at this stage, HIV is still very active and is continuing to destroy the body's immune system.

- ***The early HIV symptomatic disease***

Several years after infection, some individuals begin to show mild symptoms of the HIV disease. These can include, among other diseases, shingles, swollen lymph glands, occasional fevers, mild skin irritations and rashes, fungal skin and nail infections, mouth ulcers, chest infections and weight loss (Pack, Crosby & Lawrence, 2001:40).

- ***The medium-stage HIV symptomatic disease***

This stage of the HIV disease was once known as 'AIDS-related complex'. This is when individuals with HIV become quite ill without developing the 'AIDS-defining illnesses'. Typical problems include tuberculosis, recurrent oral or vaginal thrush, recurrent herpes, diarrhoea, and blisters on the mouth or

genitals, on-going fever, persistent and more than 10% of the HIV infected human beings develop significant weight loss (Mitchell & Smith, 2001:56).

- ***The late-stage HIV disease Aids***

Harvey, Stuart and Swan (2000:61) and Leach, Fiscian, Kadzamira, Lemani and Machakanja (2003:98) posit that without effective anti-retroviral therapy and treatment, the long-term damage caused to the immune system by HIV results in severe opportunistic infections and illnesses (see the foregoing paragraph for these diseases) and HIV-related damage to other organs such as the brain and lungs. This stage is usually called AIDS.

2.2.1.2 Immune deficiency

This is a condition where the human body's natural defence mechanisms cannot defend themselves against illnesses (Mitchell & Smith, 2001:56).

2.2.1.3 Syndrome

This is a term given to a particular pattern of illnesses which human beings develop as a result of contracting AIDS. The definition of AIDS is based on the secondary complication that develops in a human being infected with HIV. The virus itself, therefore, is not a killer, but it is the complications it produces in a victim body which are often lethal. The virus that causes what is termed 'full-blown AIDS' breaks down a human being's natural immunity against disease. This leaves a person vulnerable to serious illnesses that would not normally threaten someone whose immune system is functioning normally.

The onslaught of these illnesses (secondary complications) is referred to as 'opportunistic'. So, AIDS is defined as the presence of an opportunistic infection or disease in a previously healthy person with no other causes for immune deficiencies (Harvey, Stuart & Swan, 2000:61; Leach, Fiscian, Kadzamira, Lemani & Machakanja, 2003:98)

2.2.1.4 Attitudes

A relatively stable and enduring tendency to behave and react in a certain way towards a person, object, institution or issue (Mitchell, 2000:53).

2.2.1.5 Immune system

The immune system is a flexible and highly specific defense mechanism that kills micro-organisms and the cells they infect, destroys malignant cells and removes the debris. It distinguishes such threats from normal tissue by recognizing antigens, that is, substances that induce the production of antibodies called immunoglobulin when introduced into the body (Morrell, 2001:13; Garber & Feinberg, 2003:136; Evian, 2004:10).

2.2.2 The history of HIV/AIDS

The signs of HIV/AIDS were first seen by doctors in 1981 among ill gay men in the United States of America. These men had developed unusual conditions like a rare chest infection and skin disorders, and special tests showed that their immune systems were damaged (Lee, 1999:56; Bethesda, 2000:12). In 1983 French researchers identified a new virus, now known as HIV, as the cause of AIDS. This type of HIV also became known as 'HIV-1' (Kumar, June & Claudia, 2001:35). In 1985, a second type of HIV was identified in sex workers from Senegal. This virus, called 'HIV-2,' is found mostly in West Africa, and seems to be less easily transmitted and slightly less harmful than HIV-1 (Mitchell, 2000:53).

Scientists have since found out that there are also many different strains or sub-types of HIV. In South Africa, sub-type C is the most common (Heard, 2000:27). Mitchell (2000:12) describes the isolation of a novel retrovirus characterised by an enzyme known as reverse transcriptase which has become known as a second HIV Type II which may cause AIDS.

The following are a few interesting features regarding infection caused by this newly identified retrovirus (Attig, 2000:45; Cyber, 2000:23; Kelly, 2000:25):

- Firstly, HIV infection demonstrates an exceptionally long incubation period (time between initial exposure and appearance of first symptoms, followed by a slow relentless progress leading to death).
- Secondly, although often very high titres of specific anti-bodies are found, they seem fatally incapable of combating the infection (Siecus, 2001:30).
- Thirdly, the degree of immune suppression seen in HIV infection is considerably more intense than that found in any other generalised virus infection.
- Lastly, these viruses are much harder to combat than other viruses because they become part and parcel of the genetic structure of the cells they infect and there is therefore no way of getting rid of them (UNAIDS, 1999:20).

After Aids was discovered among gay men, it was also discovered in drug users in Western Europe, South East Asia, China and India (Johnson & Blackwell, 2000: 58). Although homosexual activity accounted for most sexually transmitted cases in the early years of the epidemic in the United States, heterosexual transmission is rapidly increasing (Hooper, 1999:87). Blood-borne transmission has resulted in infection in three main groups:

- intravenous drug users, who exchange small amount of infected blood when sharing needles;
- people who receive a transfusion of infected blood or blood products like the clotting factor for the treatment of haemophilia in the early years of the epidemic, before stringent testing for HIV was the rule; and
- health-care workers who become infected as a result of accidents involving needles contaminated with infected blood (UNESCO, 2003:10; Kapovn, 2000:10; Rooth, 1999:23).

In South Africa, people initially linked AIDS to gay men, but when a study in 1987 showed a relatively high level of infection among Malawian gold miners, the blame shifted to people who come from other African countries. Later

many people thought AIDS was a White man's disease. Many White people are under the impression that AIDS is a Black person's disease (Meekers, 2000:21). This shows that South Africans have always displayed certain stereotypes and perceptions about the AIDS pandemic. Fishbaugh and Gum (1994:26) feel that because of these stereotypes and perceptions, many years were wasted and HIV began to spread rapidly among all South Africans (Stein, Nan, Tolman, Porsche & Spencer, 2002:38). Between 1990 and 2003, the level of HIV infected pregnant women rose from less than 1% to over 21%.

In the past, politicians in the South African apartheid government sometimes blamed AIDS on terrorists coming from other African countries. As a result, they did very little to educate South Africans about HIV/AIDS (UNICEF, 2003:42; Spain, 1999:4).

The attitude towards HIV/AIDS among Black South Africans is different. Definitions of health, sickness and sexuality have different meanings in the traditional African context, than in the Western world. It has been very difficult to change Black people's attitude because all HIV/AIDS education and prevention programmes have mostly been based on Western principles, without understanding the diverse cultural and belief systems of Africa and incorporating them into such programmes (Kirby, Brenes & Million, 1999:390; Heard, 2000:27; Le Roux, 2001:94).

Topouzis (2000:6) opines that illness among Black people is not a random event. Rather, every illness is a product of destiny and has a specific cause. For Blacks, in order to eliminate the illness, it is necessary to identify, punish, eliminate and neutralise the cause, the intention behind the cause and the agent of the cause of intention. Illness, according to Black cultural beliefs, can be a result of disharmony between a person and the ancestors, caused by God, spirits, witches and sorcerers, natural causes, or a breakdown in relationships between people.

Ancestors are seen to have an integral influence on the lives of Africans. They are believed to protect people against evil. However, ancestors could

purportedly punish people by sending illness and bad luck if people are ignorant of observing traditions that keep the ancestors happy. People can also cause disharmony between themselves and the ancestors if certain social norms and taboos are violated (Forehand, Pelton, Chance & Armistead, 1999:716).

Rugamela (1999a:12) believes that ancestors do not always send illness, but through the withdrawal of their protection, people become susceptible to illness, tragedy and spells cast by witches and sorcerers. Illness caused by ancestors is seldom serious or fatal, and through offerings and sacrifices, a positive relationship is restored between people and their ancestors. There is no available evidence that traditional Africans link AIDS to the anger of the ancestors or to punishment from God. Some Christians do, however, believe that AIDS is God's punishment for immorality and sin (Stein, Riedel & Rotheram-Borus, 1999: 50).

Fisher, Misovish, Kimble and Wenstein (1999:50) state that witches and sorcerers are frequently blamed for illness and misfortune in traditional Black African societies. Because traditional Africans often use the services of witches and sorcerers to send illness and misfortune to their enemies, they in turn, believe that whatever bad luck or illness is incurred, is a product of witches or sorcerers.

Among many rural, poor and uneducated Africans, HIV/AIDS is seen as being caused by witchcraft. Many people ascribe sexually transmitted diseases (STD) to witchcraft. They base this belief on the argument of why does one man become infected and the other remain uninfected when both men have had sexual contact with the same woman (Piwoz & Preble, 2000:8; Gagnon & Godin, 2000:239; Newyork City, 1999:1).

When relationships are in conflict, or threatened, accusations of witchcraft are raised against members of a group or a community. In African societies, death is only accepted as natural when the elderly die. When younger people die, it is viewed as untimely and attributed to punishment or the work of evil spirits or witches. This psychological rationale of blaming witchcraft implies that

Africans are not taking responsibility for their actions and are displaying an external locus of control. This viewpoint prevents people from exercising their personal initiative in preventing a fatal illness such as HIV/AIDS (Flisher, 2000:17; du Plessis, 2000:18).

Carter (2000:30) posits that due to this misconception, many Africans cannot fully appreciate the need for engaging in HIV preventative methods. By blaming witches as the cause of illness, the victim's status suits those who are infected. However, this faulty belief has resulted in many witch-hunts and deaths. By ignoring or undermining traditional witchcraft beliefs, prevention efforts are hindered. Mukumbira (2003:10); Stein, Tolmand, Porsche & Spencer (2002:40) and Russell and Schneider (2000:79) believe that these beliefs should be incorporated into HIV/AIDS prevention programmes at schools. Interventions should recognise the personal or ultimate cause of an illness, which may be witchcraft, but the fact that the immediate cause is a "germ or virus" which is sexually transmitted should be emphasised.

Many traditional Africans believe that witches or sorcerers use sexual intercourse as the entry point for their medicines or spells to infect people with sexually transmitted diseases and HIV. For many years, traditional Africans have worn charms which they believe have preventative and proactive powers (Topouzis, 2000:10). If the use of these "protective" charms prevent misfortune and illness, Lanier, Pack and Di Clemente (1999:183) ask why the introduction of condoms "blessed" by traditional healers cannot be used to increase their use among traditional people.

Traditional Africans believe that some causes of illness can be ascribed to a failure to "purify" themselves adequately through rituals (Kotchick, Shaffer, Forehar & Miller, 2001: 500). Ritual impurities are usually associated with sexual intercourse (especially sex with a taboo person), with activities of the reproductive system or with coming into contact with corpses and death. In order to cleanse oneself of these "impurities", a person has to perform extensive cleansing rituals that involve washing, vomiting and purging (Leonning-Voysey & Wilson, 2001:26).

Kotchick, Shaffer, Forehar & Miller (2001:98) state that although HIV infection is not commonly thought to be a consequence of "ritual impurity," some of the sexual prohibitions may be useful in HIV prevention programmes. For example, the prohibition against sexual intercourse with a woman during menstruation, with a widow before she is cleansed (her husband might have died of AIDS) or with women who have had an abortion or miscarriage should be encouraged because they can prevent HIV infection (Brown, 2002:67; Gupta, 2001:50).

Traditional Africans believe that some diseases such as colds, influenza and diarrhoea in children, STD's and malaria are caused by natural causes such as germs and viruses (Kenyon, 2000:21). Although it is believed that witches may sometimes use germs and sexual intercourse to cause illness, traditional Africans acknowledge that the immediate cause of sexually transmitted diseases is virus-related, that is, it is transmitted through sexual intercourse and can be prevented by behavioural change (Shariff & Neil Verlaque-Napper, 2002:86).

However, the link between STDs, AIDS and sexual behaviour change is often not made in traditional Africa. Many Africans do not understand that they have to alter their sexual behaviour to prevent HIV infection, since the disease affects all organs in the body besides the sexual organs (Coward, 2000:160). The AIDS message should therefore be strongly linked to STD prevention in Africa. The knowledge and assistance of traditional healers should be actively employed in the control and prevention of HIV (Smith, Gertz, Alvarez & Lurie, 2000:685).

Most African patients consult traditional healers for STD treatment since they are believed to be competent in preventing the spread of STD's. Traditional healers advise their patients:

- to abstain from sex while undergoing STD treatment;
- not to have sex with prostitutes; and

- to locate and advise all recent sex partners to be treated (Dorkenoo, 2001:60).

Many Africans believe that children are important legacies, through whom one is remembered and through whom personal immortality can be achieved. Therefore, it is an obligation for everyone to get married and if a man has no children or has daughters only, he needs to find another wife so that sons who would survive him and keep him (with the other living-dead family) may be born, ensuring personal immortality (Lewis, 2000:20). Therefore, for African women the failure to bear children is worse than committing genocide.

Polygamy is also a way of life for most Africans (Cuttmacher, 2001:2; Mirembe, 2001:61). Polygamy is valuable to migrant labour, where men leave their wives in the rural areas to seek work in the cities. If a man has several wives, he could take one at a time to live with him in the city, while the other wife/wives remain behind to take care of the household (Smart, 2000:39).

Parker, Singh & Hatte (2000:90) state that in some societies sexual intercourse between husband and wife is banned while she is pregnant and this abstinence is practiced until after child-birth or even until the child is weaned. In such situations, polygamy prevents husbands from turning to casual sex. Therefore, in areas where polygamy is practiced, AIDS educators cannot effectively preach monogamy. They need to emphasise loyalty and fidelity between a husband and all his wives and discourage sex outside that group (Lyons, 1999:8).

Coombe (2000:34) found that the resistance to condom use in Rwanda has nothing to do with ignorance, but relates to social and cultural dimensions of Rwandan sexuality. They believe that the flow of fluids involved in sexual intercourse and reproduction are indicative of "gifts of self" which Rwandans regard as vital in a relationship. The use of condoms, according to them, blocks this vital flow between partners, and cause infertility and other illnesses. There is also fear that the condom may stay blocked in the vagina and cause "blocked beings." In many parts of Africa, there is a widespread belief that repeated inseminations of semen are needed to form or "ripen" the

growing foetus in the womb. It is also believed that semen contains important vitamins that are necessary for the continued physical and mental health, beauty and future fertility of women (Fleischman, 2003:31; Keller, Gilbert & Labelle, 2001:12; Hyde, 2001:24; Kirigia & Muthuri, 1999:485).

This research intends to investigate whether the above-mentioned misconceptions have not been transmitted as values and norms to children who grow up in communities with such cultural beliefs and convictions. The literature review has revealed that there are learners who believe that HIV/AIDS can be transmitted through forms of casual contact, such as kissing, sharing a drinking glass and contact with a toilet seat (Melvin, 2000:97; Mahwah & Erlbaum, 2000:23). These lingering misconceptions are contributing factors that create prejudice against HIV-positive individuals, since learners who believe that HIV can be transmitted in these ways are much more likely to express discomfort about attending schools with those learners who are infected with HIV/AIDS.

2.3 LITERATURE REVIEW ON EDUCATIONAL-PSYCHOLOGICAL PERSPECTIVE

HIV prevention programmes have largely relied on campaigns to raise public knowledge and awareness about HIV risks and modes of prevention. These prevention strategies presuppose that the informed person will take the appropriate steps to change risky behaviour, and reduce exposure and possible infection (Eng & Guastafson, 1999:19). In South Africa, there is a wide range of prevention programmes currently being implemented, including the distribution of condoms and other protection measures, voluntary counseling and testing, as well as mass media campaigns.

This research uses the educational-psychological perspective in investigating the attitudes of Black learners towards HIV/AIDS. The educational-psychological perspective is used because of its ability to focus on fundamental knowledge that learners have about HIV/AIDS. Such a perspective is premised on the fact that knowledge is the foundation of a healthy behaviour, and without it, behavioural changes will not occur

(Daderman, Wirsén-Meurling, Hallman, 2001:243; Batholet, 2000:8). This perspective regards the learner as a proactive being who has the ability to motivationally, behaviourally and metacognitively develop to an independent and self-regulated learner on the basis of the knowledge that he/she gains in the process of being educated. The educational perspective regards the social context of the learner to be crucial in his/her development, while the psychological perspective regards the cognitive and conative aspects to be crucial in his/her self-regulation of behaviour and development. The educational-psychological perspective means that, in the case of this research, an educational and psychological programme is very important in developing the knowledge of learners about HIV/AIDS. Since learners spend most of their time at schools, schools, therefore, become the most effective sites and wise locations in which to implement a large amount of HIV/AIDS educational and psychological programmes.

From the foregoing description of an educational-psychological perspective, the following deductions about such an approach to research can be made:

- *It emphasises a relationship.* The emphasis here is on the quality of the relationship and help offered to the learner. Characteristics of a good helping relationship are sometimes stated as non-possessive warmth, genuineness and a sensitive understanding of the learner's thoughts and feelings (Dean & Moalusi, 2002:97).
- *It involves a repertoire of skills.* This repertoire of skills both incorporates and also goes beyond those of the basic relationship. Another way of looking at these skills is that they are interventions that are selectively deployed, depending upon the needs and state of readiness of learners. These interventions may focus on feeling, thinking and acting. Furthermore, they may include group work and life skills training. Another intervention is that of consultancy. This may deal with some of the problems "upstream", with the systems causing them rather than "downstream" with individual learners (Davis, Woodward, Goncalres, Meagher & Million, 1999:76).

- *It emphasises self-help.* Helping is a process with the overriding aim of helping learners to help them. Another way of stating this is that all learners, to a greater or lesser degree, have problems in taking effective responsibility for their lives. The notion of personal responsibility is at the heart of the processes of effective helping and self-help (Kadzamira, Chipso, Swainson, Maluwa-Banda&Kamlongera, 2001:199)
- *It emphasises choice.* Cole and Meyer (1999:350) define personal responsibility “as the process of making the choices that maximize the individual’s happiness and fulfillment”. Throughout their lives, people are choosers. They can make good or poor choices. However, they can never escape the “mandate to choose among possibilities”. Helping aims to help learners with conduct disorders, depression and anxiety to become better choosers.
- *It focuses on problems of living.* Helping is primarily focused on the choices required for the developmental tasks, transitions and individual tasks of ordinary people, rather than on the needs of the moderately to severely disturbed minority. Developmental tasks are tasks, which people face at differing stages of their life spans, such as finding a partner, developing and maintaining an intimate relationship and adjusting to declining physical strength. The notion of transitions applies both to progression through the life stages and to acknowledging that changes can be unpredictable and not necessarily in accordance with normative developmental tasks, for instance, being expelled from school, as contrasted with progressing well at school. The notion of individual tasks represents the existential idea of people having to create their lives through their daily choices. This is despite constraints in themselves, from others and from their environments. Though helping skills may be used with vulnerable groups like depressed and anxious learners, helpers are mainly found in non-medical settings (Russell & Schneider, 2000:6; Gifford, Allen & Katie, 2000:10).
- *It is a process.* The word “process” denotes movement, flow and the interaction of at least two people in which each is being influenced by the

behaviour of the other. Both helpers and clients can be in the process of influencing one another (Glynn, Caraël, Auvert, Kahindo, 2001:185). Furthermore, though part of this process transpires within sessions, much of it is likely to take place between sessions and even after the contact has ended. What begins as a process involving two people ideally ends as a self-help process (Anderson & Schwartlander, 2002:23)

Smith, Gertz, Alvarez & Lurie (2000:94) see an educational-psychological perspective as a way of helping learners towards overcoming obstacles to their personal growth, wherever these may be encountered, and towards the optimal development of their personal resources. This perspective takes place when a person occupying a regular or temporary role of educator, offers or agrees explicitly to offer time, attention and respect to another person or persons temporarily in the role of client. Feldman, Eric and Ronald (1999:70) see this perspective as a facilitative process in which the educator, working within the framework of a special helping relationship, uses specific skills to assist learners to help themselves more effectively.

From the foregoing descriptions of an educational-psychological perspective, it is clear that its key terms are:

- a facilitative process;
- special helping relationship;
- specific helping skills;
- assist learners to help themselves;
- offers or agrees;
- explicitly; and
- focuses on problems of living.

These phrases within the descriptions of an educational-psychological perspective provide the nature and range of educational-psychological perspective practice.

An educational-psychological perspective is not viewed simply as a means of providing help in the form of information, advice, or support, but as a complex, interpersonal interaction, which in itself promotes growth and change (Du Plessis, 2000:176). According to this perspective, meaningful change and help take place best when working within the framework of a warm, accepting and empathic relationship. This serves to encourage those seeking help to express themselves more freely and fosters their natural tendency to move towards positive growth and change (Edwards, 1999:30). Specific helping skills, when using this perspective in dealing with learners, include communication techniques and specialized skills which are employed to help change feelings, thoughts or behaviour (Evian, 2000:25).

According to this perspective, the most desirable and permanent help that can be developed in learners is self-help, where the learner accepts responsibility for changing to a more satisfactory way of living, and participates actively in the process (Gold & Nash, 2001:160). It is, therefore, clear that an educational-psychological perspective can only begin when the educator has explicitly agreed to offer his or her services, and when the learner with problems has clearly and explicitly accepted that offer (Fao, 2001:14).

An educational-psychological perspective is, in this research, considered as a process of helping learners to change, not by taking over or providing solutions, but by creating favourable conditions for them to achieve their own insight and to change from within. In this way they gain confidence in their ability to use their own resources and are encouraged to assume self-direction and responsibility for their lives (Trusell, 2000:20; Schneider & Russell, 2000:124). It is seen as a process whose aim is to help learners who are mainly seen during and outside teaching and learning settings to help themselves by making better choices and by becoming better choosers. The helper's repertoire of skills includes those of forming an understanding

relationship as well as interventions focused on helping learners change specific aspects of their feelings, thoughts and actions.

2.4 THE INFLUENCE OF AN EDUCATIONAL-PSYCHOLOGICAL PERSPECTIVE IN CHANGING ATTITUDES AND VALUES

The foregoing paragraphs highlight an educational-psychological perspective as an effective tool in teaching learners to do various things, such as:

1. They recognise what it means to be healthy and what actions they can take to optimise personal health, safety and physical activity, as it:

- describes and discusses similarities and differences in the way people grow;
- expresses ideas and feelings about their body and its development through speaking or artwork;
- helps them identify family and friends from whom they can get help;
- demonstrates simple actions to avoid unhealthy environments, such as safety procedures when they find a needle, safety procedures if they are bleeding or if they find a person who is bleeding;
- helps them identify basic concepts related to growth and development including using correct terminology for body parts as well as sexual organs;
- describes qualities of good friendship and of love; and
- explains different ways people express love and affection.

2. They recognise that there are different aspects to personal health and how these can contribute to their overall health, safety and physical activity, as it:

- describes common and unique characteristics among healthy individuals;
- explains growth from infancy, describing similarities between boys and girls;

- expresses how friendship and love impact to make healthy people feel good about themselves;
 - describes how relationships (such as friendships) that help people feel good about themselves, can be developed;
 - demonstrates what to say or do when someone makes them feel uncomfortable or unsafe; and
 - explains different family structures and how changes in these structures may affect people's health (Donohew, Zimmerman, Cupp, Novak, Colon & Abell, 2000:1079).
3. **They understand that personal health, safety and physical practices enhance the physical, mental, emotional and social aspects of their own and other's health, as they:**
- identify the role love plays in physical, mental, emotional and social health;
 - identify the physical, mental, emotional and social changes that occur during puberty;
 - consider the influence of peers when making decisions about sexual health;
 - describe strategies to protect them from sexually transmissible and blood- borne diseases;
 - develop and implement an action plan for first aid procedures, such as for someone who is bleeding;
 - explain the social and emotional aspects of the different ways in which people express affection;
 - describe the process of birth; and

- describe the process of menstruation and its effect on physical, mental, emotional and social health (Donohew, Zimmerman, Cupp, Novak, Colon & Abell, 2000:1079).

4. They understand how factors influence personal health behaviors and how to appraise their own and others' health, safety and physical activity, as they:

- describe actions to cope with challenges during puberty, such as menstruation, changes in the body shape, moodiness;
- analyse the positive and negative influence of peers when making decisions about sexual health;
- appraise the effect of physical, mental, emotional and social changes that occur during puberty;
- identify the effect of changes experienced during puberty on how they behave and relate to others; and
- explain whether images of relationships presented by the media are realistic, achievable and health-enhancing (Bayer, Ronald & Oppenheimer, 2000:13).

5. They understand the consequences of actions taken to enhance personal and community health, safety and physical activity, and to avoid or reduce the risks associated with lifestyle behaviors, as they:

- identify behaviours that will avoid or reduce the risks of sexually transmissible and blood-borne diseases, such as condom use;
- demonstrate resisting pressures to be sexually active;
- evaluate strategies for avoiding or reducing the risk of sexually transmissible and blood-borne diseases, such as condom use;
- analyse the link between sexual activity and risk of sexually transmissible and blood-borne diseases and pregnancy; and

- critically analyse body messages conveyed by the media and their impact on young people's health (Haddad & Gillespie, 2001:88; Keller, Gilbert & Labelle, 2001:65).

6. They understand the social, cultural, and environmental factors that impact on the health, safety and physical activity of individuals and population groups, as they:

- evaluate the importance of family and friendship networks in supporting mental and emotional health of both males and females;
- examine the social and cultural influences on young people who become sexually active and use condoms;
- evaluate the impact of alcohol on young people's decisions to become sexually active;
- evaluate the relative strengths of different contraceptive methods and suitable sources of information about these methods;
- compare cultural differences about dating and gender roles;
- analyse different levels of power that people have in romantic relationships; and
- identify the impact and likely outcomes of an unplanned pregnancy (Hancock, 2001:276; Anderson & Schwartlander, 2002:73).

7. They understand and evaluate a range of strategies that address social, cultural, and environmental factors to improve their own and others' health, safety and physical activity, as they:

- compare and contrast the incidence of transmissible and blood-borne diseases among males and females and population sub-groups;
- evaluate community health services and sources of information for young people regarding sex health and pregnancy;

- analyse the impact of community –based safer-sex campaigns;
 - plan strategies to encourage positive body image among young people; and
 - develop criteria to evaluate the effectiveness of health programmes that encourage teenagers to discuss issues of sexuality (Campbell, Cleland, Coltumbien & Southwick, 1999:43; Robinson & Sadan, 1999:21).
- 8. They understand the societal, political and legislative responses to factors affecting the health, safety and physical activity of individuals and population groups, as they:**
- critique the effectiveness of health promotion campaigns encouraging safer-sex among young people;
 - investigate the views of different ethnic, cultural or religious groups toward sexuality and analyse the impact of these views on their health; and
 - identify laws related to sexuality and evaluate their impact on young people’s sexual behaviours (Kuhn, Mathews, Fransman, Dikweni, McKenzie & Vashti, 2002:90).
- 9. They demonstrate, with the help of others, an awareness of basic self- management skills for a healthy active lifestyle, as they:**
- recognise the qualities of friends;
 - make decisions based on positive and negative consequences, such as dealing with a person who is bleeding;
 - recognise that more than one option exists when making decisions, such as what to do if they find a needle or syringe;
 - identify individuality and feelings of self-worth;
 - perform basic guided decision-making; and

- understand it often takes several steps to reach a goal (Marais, Muthien, Van Rensburg, Manga, De Wet & Coetzee, 2001:41).

10. They demonstrate basic self-management skills in familiar health and physical activity situations, as they:

- discuss actions that can be taken to resolve conflicts between friends;
- recognise that steps toward a goal must be planned;
- explain basic strategies to cope with stressful situations, such as changes in family situations such as separation, divorce, birth and death;
- explain basic strategies to cope with a bullying situation;
- identify how their strengths and weaknesses affect friendships; and
- demonstrate an understanding of their sexuality (Department of Health, 1999:13; McHaren & Mdunyelwa, 1999:45).

11. They use basic self-management skills to meet personal health and physical activity needs, as they:

- recognise that their decisions about sexual health can have positive and negative consequences;
- clarify their values relating to love and affection;
- recognise the importance of goals in different life contexts, such as in relationships;
- use a decision-making model to make choices related to sexual health issues involving peer influence;
- clarify how their strengths and weaknesses enhance their self-esteem; and

- demonstrate how to cope with positive and negative comments from peers, family and other groups during physical, social and emotional changes that occur at puberty (Cole, Suman, Schamm, van Bel, Lunn, Maguire, Collins & Rau, 2000:64; Piot, 2001:27).

12. They apply self-management skills, showing an awareness of beliefs and values, and predicts the risks and benefits in the achievement of health and physical activity goals, as they:

- describe how their values can affect decisions they make when supporting others going through puberty;
- decide and predict the impact of strategies to cope with growing older and going through puberty;
- prioritise their goals and reflect on their decisions about expressing affection;
- predict and reflect on the consequences of their decisions when faced with peer influence on sexual health issues;
- realise the health risks associated with sexual intercourse, pregnancy, birth and contraception;
- evaluate the health risks associated with sexually transmissible and blood-borne diseases, such as HIV, hepatitis B, hepatitis C; and
- identify ways of developing self-concept and of considering the feelings and beliefs of others in developing relationships (American social health association, 2000:92; Richardson, 2000:67).

13. They apply self-management skills, analyse risks and benefits, and plan for the achievement of personal health and physical activity goals, so as to:

- use a decision-making model to set goals that will reduce the risk of exposure to sexually transmissible and blood-borne diseases;

- analyse how the processes and outcomes of decisions made by other people affect their own planning, such as the need for communication regarding sexual activity;
- justify decisions and implement strategies to inform others about avoiding or reducing risks related to sexual activity;
- analyse the effect of peer values on recognising the role sexuality plays in the lives of all people;
- appraise appropriate and accurate sources of information on sexually transmissible and blood-borne diseases, and conception, pregnancy and birth;
- appraise influences on body-image and the impact on self-esteem, such as by the media; and
- demonstrate in groups and role-play, ways of developing, maintaining and coping with changes in friendships and family relationships (Butt, 2000:85; Malow, Devieux, Jennings, Lucenko & Kalichman, 2001:103).

14. They apply self-management skills in terms of own values and beliefs, to cope effectively with challenging health and physical activity situations to:

- consider and empathise with another person's perspective regarding dating and gender roles;
- examine and cope effectively with the impact of influences on their decision-making and goal-setting regarding sexual activity;
- plan and demonstrate strategies to reduce stress in conflict situations, such as with peers, parents and educators;
- use appropriate skills to manage conflict, differentiating between sexual coercion and consent;

- demonstrate appropriate skills to manage stress related to changes in puberty;
- demonstrate actions they can take to overcome stereotypes and discrimination regarding gender roles and power in relationships;
- set goals regarding the maintenance of a positive body image and consider the impact of life events and influences of other people on these goals and their self-esteem; and
- identify implications and use the decision-making model to consider implications of an unplanned pregnancy (Patient, 2000:33; McCoul, Haslam, 2000:56).

15. They demonstrate self-management skills in challenging situations in which their own and others' values, feelings and health status need to be considered, so as to:

- examine, in a role-play situation, the process they would follow in making decisions in an intimate relationship, such as considering the consequences of sexual behaviour as in pregnancy, sexually transmissible and blood-borne diseases;
- analyse the influence of emotions on decision-making in relationships (such as anger, jealousy, love) and demonstrate strategies to monitor the effects of their emotions;
- plan a health promotion programme for healthy relationships, considering the values of different religious and cultural groups;
- analyse how social, cultural and work factors can influence self-esteem and decisions regarding sexual activity, and plan actions to manage these influences for themselves and others; and
- evaluate the services and programmes offered by community agencies to build self-esteem of groups such as gay or lesbian youth, and people

with HIV/AIDS (Department of Health, 2000:20; Leonning-Voysey, 2000:54).

16. They analyse critically the personal and societal self-management processes that contribute to the health and physical activity levels of individuals and populations to:

- evaluate critically the effectiveness of their decision-making and goal-setting in their own and others' well-being, such as starting, maintaining and ending relationships;
- organise and present their decision-making and goal-setting in light of social and cultural perspectives, such as "What would happen if...";
- analyse government decision-making processes used to promote safer sexual practices in different social and cultural groups;
- evaluate critically how policies and changes in social and cultural identity can affect the self-esteem of populations, such as the acculturation of migrant groups; and
- examine the impact of legislative changes on the self-esteem of groups in society, such as through homosexual law reforms (Scott, 2000:39; Chege & Agha, 1999:76).

17. They demonstrate basic communication and co-operation skills when interacting with familiar people, as they:

- use correct or familiar terminology for body parts, including sexual organs;
- work effectively and play cooperatively in pairs or small groups;
- identify ways they like and do not like to be touched by familiar others;
- deliver clear messages when demonstrating safety procedures, such as finding a needle or syringe, and helping someone who is bleeding;

- demonstrate basic rules of conversation when discussing how to be a good friend;
- identify a circle of family and friends in whom they can confide and share personal problems, and describe whom they can turn to for help; and
- demonstrate an understanding of the differences in relationships and relating (e.g. circles of intimacy concept) (Van den Heever, 2001:88; Carter, 2000:63; Assavanonda & Anjira, 1999:14).

18. They use communication and cooperation skills to share feelings and satisfy basic needs when interacting with other people, as they:

- demonstrate a combination of verbal and non-verbal messages in role-play to address bullying situations; and
- work cooperatively with peers to discover emotional and physical similarities and differences between boys and girls, communicate assertively to resolve conflicts between friends, and describe a bullying situation accurately (Fao, 2001:154; Heard, 2001:69).

19. They demonstrate communication and cooperation skills that contribute to interpersonal and group interactions so as to:

- demonstrate assertive speaking and listening skills when they express the ideas or feelings in a group about changes that occur during pregnancy;
- demonstrate responsibility in first-aid situations involving blood-borne diseases;
- initiate and maintain a conversation when joining a new group;
- show how they can support their family and friends through demonstrating love and affection;
- work cooperatively with others in small groups or teams; and

- use speaking and active listening skills that consider their own and others' feelings about peer influence on sexual health issues (Beckman & Visser, 1999:9; Hooper, 1999:64).

20. They demonstrate communication and cooperation skills that enhance interpersonal and group relationships so as to:

- display sensitivity and tolerance of themselves and others when identifying fears and concerns about experiences related to puberty;
- show initiative and consideration for others in the group in making decisions about supporting others to cope with changes during puberty;
- develop and follow up group discussion procedures by keeping on track and clarifying comments by the speaker;
- demonstrate empathy when interacting with their peer group, such as accepting differences that culture and religion may have on ways of expressing affection; and
- confidently communicate their point of view by making and defending decisions, both independently and as part of the group (Kelly, 2000:46; Center for health policy, 1999:23).

21. They use communication and cooperation skills to participate actively in making and evaluating interpersonal and group decisions to achieve goals to:

- work effectively with others in small groups and teams to achieve consensus about the risks associated with sexually transmissible and blood-borne diseases;
- demonstrate how to communicate with and provide support for a friend coping with family problems;
- display peer-teaching skills with a small group to identify physical, emotional, mental and social changes of puberty;

- perform the task of group leader or manager to identify sexual milestones; and
- demonstrate independence and initiative when completing a goal-oriented group activity (Kaizer's family foundation, 2000:38; Heystek & Louw, 1999:56).

22. They demonstrate the communication and cooperation skills required to cope effectively with conflict and changes in relationships and groups, as they:

- evaluate the impact of media on body-image expressing negative feelings;
- are able to disagree when feeling pressured by others without becoming angry;
- demonstrate skills that would enable them to cope with unhappy relationship situations;
- demonstrate in a role-play situation actions they would take to form, maintain or end a close relationship;
- lead or manage a small group effectively;
- demonstrate negotiation skills when communicating with someone who wishes to participate in unprotected sexual intercourse; and
- demonstrate verbal and non-verbal assertive responses when resisting unwanted sexual behaviour initiated by a close friend (Kenyon, 2000:6; Department of Social Development, 2002:5).

23. They demonstrate leadership and collaboration skills required to enhance interactions in relationships and groups to:

- demonstrate empathy and communication skills to support a friend experiencing relationship problems;

- demonstrate commitment, responsibility and leadership in a school committee;
- demonstrate ways in which empathy and understanding can be restored when communicating with a close friend or family member regarding sexual health decisions;
- lead a group discussion to consider inequities in health care;
- analyse the skills required to be an effective leader and apply these skills; and
- use advocacy to influence others, such as a safer-sex school campaign (Williams, 2000:30; Brundtland, 2000:77; Black, 1999:10)

24. They display the leadership and collaboration skills required to manage conflict and negotiate in challenging relationships and groups so as to:

- liaise with staff, learners and community members to address the relationship and sexual health needs of disadvantaged learners, such as development of school health resources and services;
- lead and facilitate communication between groups to establish priorities for a school sexual health project;
- chair a group including educators, learners, parents, community members and health services to facilitate decisions over learner needs regarding sexual health resources and services; and
- use compromise and arbitration in a leadership role to manage disputes, solve problems and provide a link between groups (Hepburn, 2002:129; Department of State, 1999:65; Du Plessis, 2000:17).

2.5 THE ROLE OF PARTNERSHIPS IN THE EDUCATIONAL-PSYCHOLOGICAL PERSPECTIVE FOR DEALING WITH HIV/AIDS AT SCHOOL

Integrating AIDS education as part of a comprehensive health education programme is important. Success in HIV/AIDS prevention curricula is possible when it is thorough and integrated with other risk-reduction issues, such as drug and alcohol abuse, sexuality and anti-discrimination (Smart, 2000:90). At schools where no clear policy on prevention education exists, even motivated educators often find it very difficult to introduce lessons on HIV/AIDS to their learners. Developing partnerships with others within the school environment (such as other educators, school nurses, counsellors) and setting up teams of 'AIDS Educators' facilitates better exchange of innovative lessons and ensures their sustainability.

A team of people, working together in a coordinated manner, could develop and monitor policies and activities related to HIV/AIDS education within the school thus lending strength and support to the individuals conducting prevention education in the classroom (Bateman, 2002:19). This team could include diverse members of the community such as educators, health providers, social workers and all counsellors. The team should also be actively interested, committed and well-trained in HIV/AIDS prevention at schools (Melvin, 2000:39). School-based HIV/AIDS education should focus on the specific learner population of each school, while maintaining close links with their parents and the community at large. These links allow for the strengthening of protective influences on young people from both the school and the home and also help educators to gain support for introducing and sustaining education for HIV/AIDS prevention at school (Berman & Hein, 1999:6; Atlanta division of STD prevention, 1999:64).

Community-based organisations (non-governmental organisations, hospitals, educators' unions, religious groups, youth groups and sports clubs) could provide support, up-to-date information and practical assistance to school-based initiatives on education for HIV/AIDS prevention (Kleinschmidt, 1999:269).

It is therefore crucial that schools:

- develop a partnership with at least one more person within the school. Teamwork is recommended (Ewing, 1999:24);
- find out about organisations and services involved with HIV/AIDS prevention and care in their community and meet with their representatives in order to learn how they can support the school with information, teaching aids and other resources; and
- suggest a policy paper on education for HIV/AIDS prevention at schools and use the resources and references offered in this booklet to develop a clear statement and work plan to be shared and discussed with colleagues, school supervisors and community leaders (Hanson, 2000:34).

2.6 THE INFLUENCE OF EDUCATIONAL AND PSYCHOLOGICAL STRATEGIES OF TEACHING IN PROVIDING LEARNERS WITH INFORMATION ON HIV/AIDS

Providing school learners with information on HIV/AIDS and its prevention is essential for them to develop meaningful attitudes and learn the necessary skills to help them stay uninfected (Van den Heever, 2001:64). In order that HIV education achieve its goals, teaching methods must evolve from the style in which educators teach their learners from the front of the classroom to more participatory teaching methods wherein learners play an active role in the learning process (Barnet & Schuller, 2002:20; Lewis, 2000:30; United Nations, 1999:45). Education for HIV/AIDS prevention cannot be taught effectively if fear and uncertainty surround the disease. These fears, attitudes, feelings and anxieties may inhibit learning. To curb this problem, interactive educational and psychological strategies can be used to promote learner participation. These strategies have proved effective in facilitating learning in all domains, as well as in encouraging changes toward desirable behaviour at school (William, 2000:30). They also help learners to explore their feelings and gain insight into their own attitudes, values and perceptions. Traditional classroom techniques, like lectures, memorisation and textbook reading should be used

more sparingly, as they tend to restrict participatory learning (Topouzis, 2000:37).

Learners need to be aware of and fully understand the fact that classes on HIV/AIDS prevention are different from all other learning areas in the school curricula. For behavioural change to occur and attitudes to evolve, HIV/AIDS prevention education needs to be singled out as a unique learning area in the school curricula. At the same time, it may serve as a catalyst to more widespread change in teaching styles at different schools (Topouzis, 2001:38; World Bank, 2001:3; Kenyon, 2000:11; Hooper, 1999:87). Participatory, interactive teaching and learning methods are essential to moving from information-based educational programmes to those that are skills-based. The latter were shown to be more successful in helping learners develop the abilities for adaptive and positive behaviour that enables them to deal effectively with the demands and challenges of HIV/AIDS prevention. Participatory methods include small group work and discussions, role-playing, debates, arts and crafts, *etcetera* (Curlee, 2000:21; Davies, Connolly, Sturm, McAdam & Wilkinson, 1999:811).

It is therefore important that educators gain experience and knowledge in using participatory methodologies. Various manuals and other resources such as the Internet can be used to help the educator become acquainted with participatory teaching and learning. They should avoid lecturing their learners on HIV/AIDS, but should have them play an active role in class. They should help their learners become their partners in seeking information, analysing and discussing the pandemic and ways to prevent infection and encourage questions, discussion and the fostering of new ideas (Hospice association of South Africa, 2000:55; Klepp, Masatu, Setel & Lie, 1999:155).

Teaching HIV prevention and anti-discrimination presents several challenges for educators. A primary challenge involves the ability to discuss controversial issues openly with learners in the classroom. Educators who feel comfortable with their sexuality, who adhere to human rights values, and who respect their learners are more successful when discussing important controversial issues relating to HIV/AIDS, such as the disclosure of HIV status, pre-marital sex,

homosexuality and drug use (Kirby, Brenes & Million, 1999:385; Burgess, 2000:64; UNAIDS, 2001:28).

The 'S' factors such as shame, silence and stigma are among the basic reasons behind continued HIV/AIDS fears leading to denial, blame and discrimination, thereby delaying positive action (Van den Heever, 2001:5). Educators must recognise these factors in their community in order to address them in class. Development of an open and honest atmosphere and a caring relationship between educator and learner is vital to AIDS education. However, openly discussing sex, drug use and HIV/AIDS in class does not mean being vulgar or diminishing one's social beliefs and values (French, 2003:25; Van den Heever, 2001:5). Good communication skills allow AIDS educators to examine various behavioural options with their learners and to discuss them in a respectful and frank manner. Recent studies have shown that sex education programmes do not lead to earlier or increased sexual activity among young people. On the contrary, school-based interventions are an effective way to reduce risk behaviours associated with HIV/AIDS and sexually transmitted infections among children and adolescents. Talking openly about HIV/AIDS in class also means helping children and adolescents not to feel left out or out of step with their peers if they are resisting pressure or do not engage in risky behaviour, even if some of their peers do (Public Health Service, 2001:24; Jewkes, Caesar, Fidelia & Jordaan, 2001:735).

Educators should therefore prepare themselves to discuss seven to ten issues that they consider most 'sensitive' openly in the classroom (Lober *et al.*, 1999:322; Human Rights Watch, 2001:30). They should define and explain them, looking into the pros and cons, and also discuss them with colleagues.

In dealing with sexuality and HIV prevention, they may consider several options, such as abstinence from sexual intercourse, delaying sexual 'debut' as long as possible, monogamy with an uninfected partner, non-penetrative sex and condom use (Department of Education, 2000:43; Mensch, Wesley, Lloyd & Erulkar, 1999:12).

In dealing with drug use and HIV prevention, one may wish to consider options, such as abstinence from drug use; non-sharing of intravenous needles, and thorough sterilisation and one-time use of needles (Department of Health, 2000:12; U.S. Center for disease control and prevention, 2001:5).

As a sexually transmitted disease, HIV should be taught in contexts that are gender sensitive and gender appropriate, taking into account the fact that more than 75% of infections worldwide are due to unprotected heterosexual intercourse. Often schools will provide separate sex education classes to boys and girls (World Bank, 2002:11; Colvin, 2000:96; ATLANTA, 1999:1; Haffner & Wagoner, 1999:5). However, this should not be encouraged in HIV/AIDS education (USAID, 2002:3).

Recent studies provide little evidence to support the contention that sexual health and HIV education promote promiscuity. Also, teaching HIV prevention to boys and girls will encourage them to talk about HIV and sexuality among themselves and establish social norms. There are female-managed prevention strategies that need to be mentioned as options for those who are sexually active and unable to conform to the practice of abstinence (Child Health Policy Unity, 2000:30). Women and girls who have been exposed to the virus through rape can be given post-exposure prophylaxis, but this procedure is only available in a few countries to date (USAID, 2002:3; Wingood, 2001:72; UNESCO, 2001:31). When discussing the prevention of HIV, ample time should be devoted to refusal skills that may protect young girls from unwanted sexual relationships. Gender-specific education can help female adolescents address structural and interpersonal inequalities (World Bank, 2001:44).

Using a developmental framework, HIV/AIDS education curricula can be structured around ways in which children of different ages can comprehend the definition, cause, treatment and consequences of infection. Young children (5-7 years) have a limited ability to differentiate between cause and effect, resulting in a lack of concern about causes of AIDS or any illness. However, they have heard about AIDS and know it is a 'bad sickness'. They may also be filled with irrational fears, such as that they assume that HIV

infection is caused in some magical way. For the intermediate age group (8-10 years), HIV/AIDS education could focus on identifying and differentiating causes and non-causes of HIV/AIDS. The emphasis in older children (11 years and above) could be on strategies for HIV/AIDS prevention (Mitchell & Smith, 2001:20; Kusanthan & Suzuki, 2000:3; Flisher, 2000:33; Scott, 2000:12; Kim, Farland, Kellogg & Katz, 1999:1598).

Educators should address the needs of both boys and girls, and promote teaching about HIV/AIDS to gender-mixed groups, talking about the female condom and not focusing solely on condoms for males, relating their teaching to the existing balance of power between boys and girls, and strengthen the girls' refusal and negotiation skills, as well as carefully presenting scenarios with explicit situations to enhance girls' refusal and negotiation skills (Kirby, Brener, Brown, Pererfreund, Hillard & Harrist, 1999:193; Rugamela, 1999b:81).

Educators should take community norms and values into consideration when developing prevention strategies. Working closely with both the target group of young people, as well as with members of the community, during the development, planning, implementation, evaluation and redesigning of HIV/AIDS education curricula can give learners a broader perspective. The intention is to help them assume ownership of the HIV problem and solutions to it. In addition, paying attention to the norms, values and traditions of the target population will allow for wider distribution of the messages (McKenzie & Smeltzer, 2001:21; Lee, 1999:35; Marcus & Xaba, 1999:23). For instance, in more than one African country, the notion that any 15-year-old has the right to have a boyfriend or girlfriend and is free to express his or her sexual urges through intercourse if so wished, is completely non-existent. It is the same for many countries in other continents (Department of health, 2000:12). Other tensions also exist between the social environment and social beliefs in which communities operate. External influences (often modern communication media, such as television, radio and the Internet) by-pass the elders and reach masses of young people (Malow, Devieux, Jennings, Lucenko & Kalichman, 2001:105).

The tasks of 'HIV/AIDS educators' is even more complicated, as they need to bridge the conflicting messages children and adolescents receive. On the one hand, children hear the messages that are culturally routed in community norms and values, and, on the other hand, they hear the message derived from media exposure (McKenzie & Vashti, 2002:45; Le Roux, 2001:114). It is important that learners come to understand the difference between the two and why the gap in meaning exists. It is advisable to combine vernacular with formal terminology to ensure shared understanding of important terms and concepts in HIV prevention, support and counseling (Moya, 2001:10; Dominguez, 2000:42Panos, 2003:5).

Prevention programmes developed locally are often more effective, as they incorporate local traditions, methods of teaching and jargon. If the programmes have been developed elsewhere, local experts should carefully adapt them (Gupta, 2001:3; Strachan, 2000:58).

Educators should set down the knowledge, attitudes, beliefs, values, skills and services in their own community that positively or negatively influence behaviours and conditions most relevant to HIV/AIDS and sexually transmitted infections. They should also provide concrete examples from their own culture when discussing HIV prevention with learners (UNAIDS, 2001:65; Human Rights Watch, 2001:31).

With effective educational and psychological teaching, learners learn to:

- identify and demonstrate attitudes and values that contribute to the prevention of ill-health and take personal responsibility for their health (Heyzer, 2003:11; Niemeyer & Raskin, 2000:60; Edwards, 1999:66);
- value and demonstrate a commitment to the benefits of collaboration. (Children explore friendships, valuing skills to promote health and rewarding relationships with peers, family and the wider community. They demonstrate this by being inclusive and just in their interpersonal relationships in the classroom, peer, friendship and team situations) (Hyde, 2001:20; Jewkes, Rachel, Vendule, Mofora & Jordaan, 2001:4; Maggiore, 2000:99; Richardson, 2000:23);

- value the concept of personal excellence, understanding the need to cope with change to attain their goals and to enjoy a healthy rewarding life (Department of health, 2000:75; Schneider & Russel, 2000:125); and
- acknowledge the value of safety procedures if they find a person who is bleeding (Smart, 2000:15; Department of welfare, 2000).

2.7 CONCLUSION

This chapter presented the literature review on an educational-psychological perspective on the HIV/AIDS pandemic. The next chapter present the empirical design of this research.

CHAPTER THREE

EMPIRICAL DESIGN

3.1 INTRODUCTION

The design of the empirical research of this study is theoretically described in this chapter. The use of a questionnaire is taken as the most appropriate technique in carrying out this research. The empirical research and the questionnaire are further discussed.

3.2 AIMS OF THIS RESEARCH

The aims of this research were to:

- investigate the attitudes of Black learners growing up in the townships towards HIV/AIDS;
- investigate the beliefs of communities in which Black learners grow up about HIV/AIDS; and
- make suggestions for an educationally and psychologically based programme to help Black learners develop healthy and responsible attitudes towards HIV/AIDS.

3.3 RESEARCH METHODS AND CHOICE OF THE MEASURING INSTRUMENT

A self-developed questionnaire was used to collect data which formed the empirical results of this research. This questionnaire was not standardized and validated. An effort was made to get a standardized questionnaire which could help the researcher measure attitudes of Black learners towards HIV/AIDS. Only internationally developed questionnaires could be found and were regarded as unsuitable because of a completely different social context in which Black learners grow up in South Africa. The researcher, then, decided to use the information collected during the literature review process

(see chapters 1 and 2) to develop and design a questionnaire which can be useful for this research (see paragraph (see paragraph 3.8 below for the process which the researcher followed in developing and designing the questionnaire which was used in this research.

3.4 DESCRIPTION OF THE POPULATION

All learners falling under the jurisdiction and control of the Free State Department of Education were considered the study population.

The Free State Department of Education has 340 009 learners in secondary schools. This was confirmed telephonically by a district official. Considering the fact that carrying out the study in the whole Province could cause delay in completing this research and would have expensive financial implications for the researcher who did not have a bursary to conduct this research, it was regarded as practically unfeasible to conduct this research in the whole of the Free State Province. After consultation with the study supervisor, it was decided to limit the study population to the learners in the Northern part of the Free State Province.

3.5 METHOD OF RANDOM SAMPLING

The objective of this research was to reach all Black learners in secondary schools in the Free State Province and find out what their attitudes are concerning the HIV/AIDS pandemic. Samples like unrestricted, stratified, systematic, cluster, quota and multi-phase random sampling were considered for use in this investigation. After careful consideration of the advantages and disadvantages of each of these methods, a quota sample was decided on where a limited number of respondents were officially allowed to fill in the questionnaires in each selected school. The respondents were from the random sample, which consisted of randomly selected secondary schools in the townships of the Northern part of the Free State Province and randomly selected learners.

A total number of 301 learners from fifteen secondary schools participated in the research.

3.6 COVERING LETTER

In a covering letter which appeared on the questionnaire, the purpose of the research was described to the respondents. Written guidelines and personal briefings were provided on the questionnaire in order to ensure, as far as possible, uniform administration and to secure respondents' guarantee of confidentiality. It was also indicated to the respondents that the study is being conducted as a requirement for the dissertation of a M.Ed. degree at the North-West University (Vaal Triangle Faculty) (See addendum A).

It was stressed that the information given by all respondents would be kept confidential.

3.7 PROCEDURE

With the permission of the school principals who agreed not to have access to the completed questionnaires, copies of the questionnaires were personally distributed by the investigator to learners of the participating schools. Learners were given one hour to complete the questionnaire that was collected immediately after a session in the classroom.

3.8 DEVELOPMENT AND DESIGNING OF THE QUESTIONNAIRE AS A MEASURING INSTRUMENT FOR THIS RESEARCH

Although several measuring instruments have been devised to obtain reports on the attitudes of learners towards HIV/AIDS, as far as could be ascertained, only overseas measuring instruments have been designed to determine the attitudes of learners in countries whose socialization, enculturation and even teaching and learning situations are different from that of South Africa. As the result of a unique and peculiar situation in the South African society and schools, especially in Black townships where learners, parents and educators uphold different culturally founded stereotypes of HIV/AIDS, not a single one of these instruments was suitable for use in this investigation. It was then decided to construct a distinctive HIV/AIDS questionnaire that could be used to measure the attitudes of Black learners towards HIV/AIDS within their personal and communities' cultural context.

Based on the information gathered through a literature review in Chapters 1 and 2 on the traditional African cultural beliefs and convictions of Black people towards the HIV/AIDS pandemic, a self-developed questionnaire was designed. The questionnaire comprised 25 questions which investigated the respondents' personal opinions and their communities' beliefs about the cause of HIV/AIDS. Such an investigation was necessary in order to ascertain if the personal opinions about HIV/AIDS the respondents have are not influenced by their communities' beliefs on HIV/AIDS. This research considers communities as one of the organs of the whole social system of the development of children and adolescents which has a great influence in the socialization of learners. The questions were based on:

- what many people in their community believe the cause of HIV/AIDS is;
- what their personal opinions on the origin of HIV/AIDS are;
- what many people in their community believe regarding the origin of HIV/AIDS;
- which pictures come to mind in many people of their community when they think of HIV/AIDS;
- which pictures come to the respondent's mind when he/she thinks of HIV (the agent causing HIV/AIDS);
- what respondents think about traditional healers (sangomas and inyangas) being able to cure HIV/AIDS with their medicines;
- what many people in their community think about traditional healers (sangomas and inyangas) being able to cure HIV/AIDS with their medicines;
- what they think of condom protection against HIV/AIDS;
- what some people in their community think of condom protection against HIV/AIDS;

- what respondents think about men getting rid of HIV/AIDS by having sex with babies or virgins;
- what some people in their community think about men getting rid of HIV/AIDS by having sex with babies or virgins;
- whether respondents think women are powerless and cannot do anything to prevent HIV infections;
- what respondents think about the risk of contracting HIV/AIDS;
- which persons respondents think run the greatest risk of contracting HIV/AIDS;
- whether they have changed their sexual behaviour in any way as a result of their knowledge of HIV/AIDS;
- how many sex partners respondents have had in the previous four weeks;
- how regularly they have been using condoms in the previous four weeks; and
- what the people in their communities say about anti-retroviral medicines (such as Nevirapine).

The first draft of the questionnaire was discussed with the study supervisor and he later suggested certain additional modifications to the questionnaire. The researcher drafted the second version of the questionnaire that retained all the items mentioned above. The second draft of the questionnaire was taken for a pilot study to a number of secondary schools at the Deneysville, Orangeville, Zamdela, Heilbron, and Lethabo township schools. After this, only slight technical modifications needed attention for the final draft. Approval was obtained from the selected schools' principals to have the questionnaires filled in by the learners at their schools.

Table 3.1 Feedback of the selected population group

Number of schools	Number of questionnaires		
	Learners	Total	Percentage
	Number of distributed questionnaires	301	100%
15	Number of returned questionnaires	301	100%

It was possible to have 100% return of questionnaires because the researcher personally visited the schools and administered the questionnaires to all learners who agreed to participate in this research. The researcher collected all the questionnaires after an hour's session.

3.9 STATISTICAL TECHNIQUES

Data was processed using the SPSS programme in consultation with the Statistical Consultation Services of the North-West University (Vaal Triangle Campus) to calculate frequencies and averages of responses. The computer programme performed the TEST procedure of the SPSS System for Windows Release (SPSS -Institute, 2000; Steyn, 1990).

3.10 CONCLUSION

In this chapter, the empirical design of this research was provided. The empirical research method was explained. Chapter 4 presents the analysis and interpretation of data collected during the empirical research.

CHAPTER FOUR

ANALYSIS AND INTERPRETATION OF THE EMPIRICAL RESEARCH RESULTS

4.1 INTRODUCTION

The aims of this research were to:

- investigate the attitudes of Black learners growing up in the townships towards HIV/AIDS;
- investigate the beliefs of communities in which Black learners grow up about HIV/AIDS; and
- make suggestions for an educationally and psychologically based programme to help Black learners develop healthy and responsible attitudes towards HIV/AIDS.

This research investigated the first two aims by means of a questionnaire. The results of the participants' responses to the questionnaire were used to reach the third aim (see chapter 5).

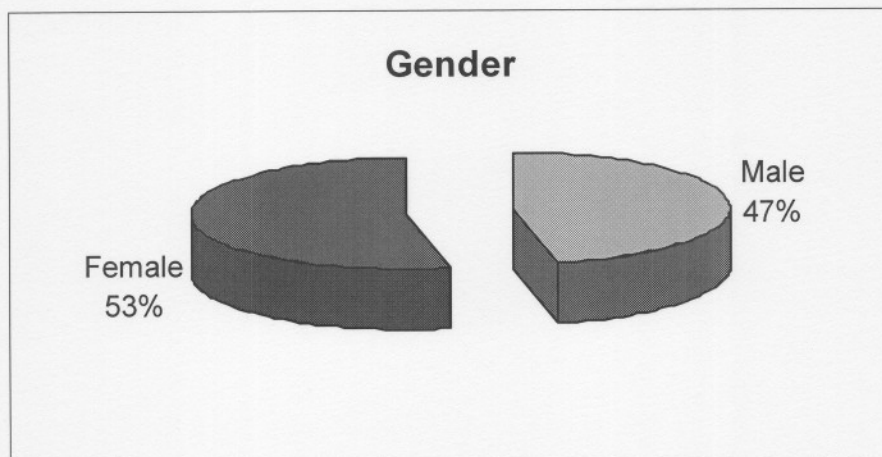
This chapter provides the analysis and interpretation of the empirical research results.

4.2 DATA CONCERNING THE DEMOGRAPHIC INFORMATION OF RESPONDENTS

The first section of the questionnaire asked respondents on demographic questions. The demographic data was collected in order to obtain the personal profile of the respondents. Such information was this study in order to highlight the unique profile of the learners who attend township schools. These data are presented in figures 4.1 to 4.6.

4.2.1 Gender

Figure 4.1: Data on gender



4.2.1.1 Analysis

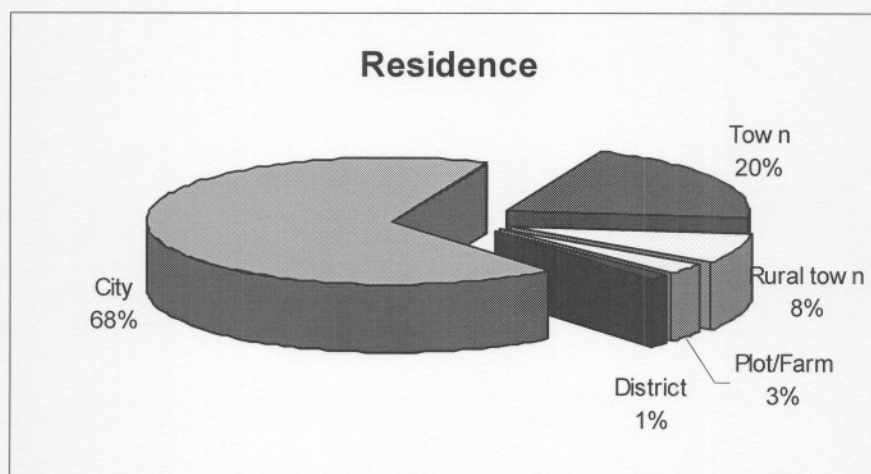
- 53% of the respondents who participated in this study are girls; and
- 47% are boys.

4.2.1.2 Interpretation

The majority of the respondents who participated in this study were girls. This implies that girls are more than boys at the schools that participated in this research.

4.2.2 Residence

Figure 4.2: Residence data



4.2.2.1 Analysis

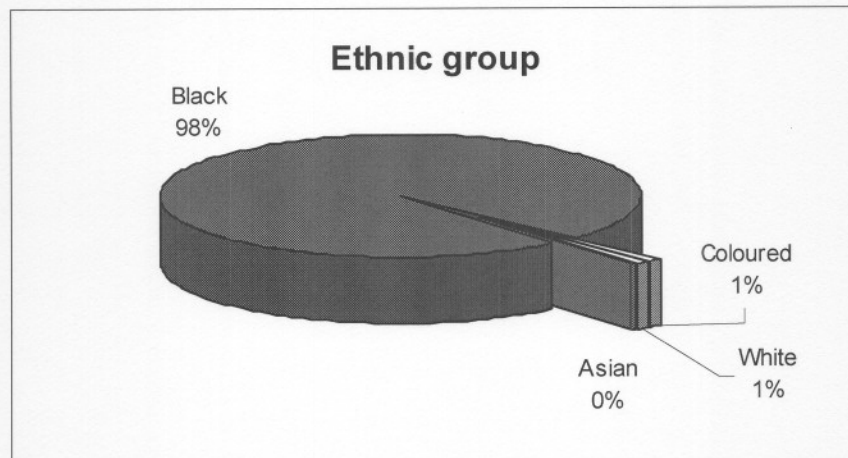
- 68% of the respondents are from the city;
- 20% from town;
- 8% from rural areas;
- 3% from farms; and
- 1% from the district.

4.2.2.2 Interpretation

This table reveals that the majority of the respondents who participated in this study are from cities and this could be attributed to the fact that most of the learners are now leaving farms and moving to town and city schools because their parents get better jobs in highly industrialized cities and towns of Deneysville, Zamdela and Heilbron. There is also the phenomenon of urbanization among Black parents who purchase houses in the cities and towns around the Vaal Triangle area for multicultural and multiracial schools.

4.2.3 Ethnic groups

Figure 4.3: Data on ethnic groups



4.2.4 Ethnic group

4.2.4.1 Analysis

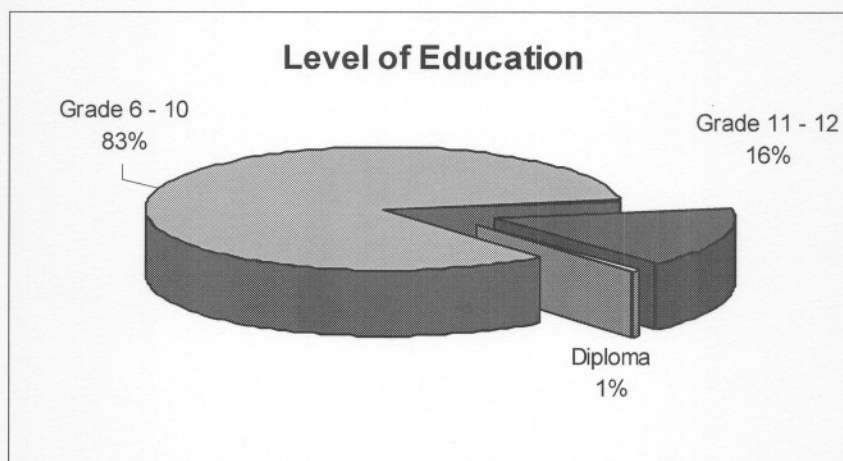
- 98% of the respondents in this study are Black;
- 1% are Coloured; and
- 1% are White. Most of the learners did not understand the meaning of ethnicity and just ticked anywhere.

4.2.4.2 Interpretation

The majority of respondents who participated in this study are Black learners who attend schools in Black townships. Some learners may not have understood the meaning of ethnicity and just ticked anywhere. This is why there is an indication of 1% ethnicity in the results. This is an indication that there is a need for this questionnaire to be translated to the languages of the respondents in future. It was not possible for this research because of the financial implications that such a research exercise would have to the personal funds of the researcher who did not have a bursary to conduct research.

4.2.5 Level of education

Figure 4.4: Data on level of education



4.2.5.1 Analysis

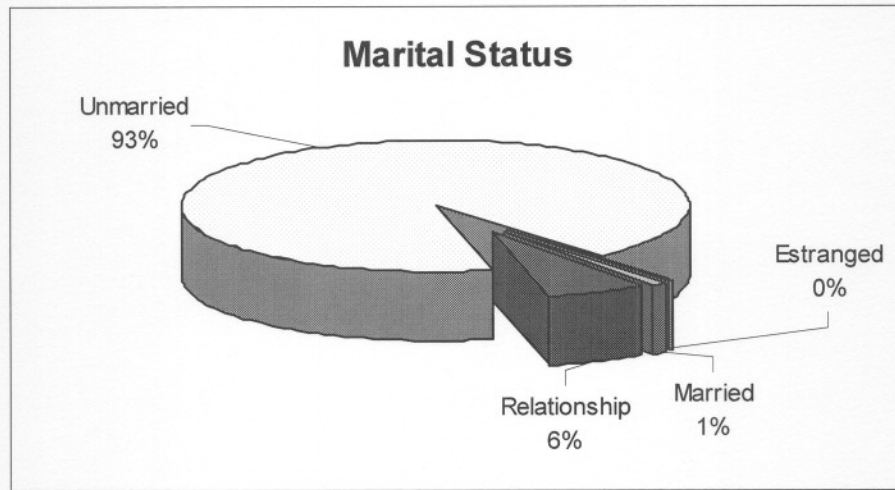
- 86% of the respondents are Grade 6-10 learners;
- 16% are Grade 11-12 learners; and
- 1% are at tertiary level.

4.2.5.2 Interpretation

The majority of respondents in this study are Grades 6 to 10 learners. These learners were targeted by this study because of the assumption that most of the already sexually active learners are in these grades. Some learners may have not understood the meaning of tertiary. Instead of indicating the grades they are in, they ticked tertiary. This shows again the need to have this questionnaire translated into the language of the respondents in future. It was not possible for this research because of the financial implications that such a research exercise would have to the personal funds of the researcher who did not have a bursary to conduct research.

4.2.6 Marital status

Figure 4.5: Data on marital status of the respondents



4.2.6.1 Analysis

- 93% of the respondents are unmarried;
- 6% are in love relationships; and
- 1% of the respondents are married.

4.2.6.2 Interpretation

The majority of the respondents who participated in this study are unmarried as the research concentrated on and targeted adolescent learners at secondary schools, but it should be noted that secondary schools in the townships do have married learners, as revealed in this research.

4.2.7 Personal opinion on the cause of HIV/AIDS

Table 4.1: Personal opinion on the cause of HIV/AIDS

Variable	n	f	%
It is caused by ancestors	296	4	1.35
It is caused by witchery	296	2	0.68
It is caused by poverty	296	23	7.77
It is caused by a virus (germ)	296	247	83.45
It is caused by something unknown	296	20	6.76

4.2.7.1 Analysis

- 83,45% of the respondents indicated that they believe that the cause of HIV/AIDS is a virus;
- 7.77% of the respondents indicated that they believe that HIV/AIDS is caused by poverty;
- 6.76% of the respondents indicated that they believe that HIV/AIDS is caused by something unknown; while
- 1.35% indicated that they believe that ancestors are the cause of HIV/AIDS; and
- 0.68% indicated that they believe that HIV/AIDS is caused by witchcraft.

4.2.7.2 Interpretation

It can be deduced from the findings of this table that the majority of the learners know and are aware that HIV/AIDS is caused by a virus. This shows that the awareness programmes of the government are starting to work on the

minds of learners. However, there is still 16.55% population of learners who are not been educated yet about the cause of HIV/AIDS and they would benefit from the educational psychological programmes at schools which teach about the origin of HIV/AIDS.

4.2.8 Community opinion on the cause of HIV/AIDS

Table 4.2: Community opinion on the cause of HIV/AIDS

Variable	n	f	%
It is caused by ancestors	285	4	1.40
It is caused by witchery	285	17	5.96
It is caused by poverty	285	36	12.63
It is caused by a virus (germ)	285	198	69.47
It is caused by something unknown	285	30	10.53

4.2.8.1 Analysis

- 69.47% of the respondents indicated that people in their communities believe that the cause of HIV/AIDS is the virus (germ);
- 12.63% indicated that people in their communities believe that the cause of HIV/AIDS is poverty;
- 10.53% indicated that people in their communities believe that the cause of HIV/AIDS is something unknown;
- 5.96% indicated that people in their communities believe that the cause of HIV/AIDS is witchcraft; while only
- 1.40% indicated that people in their communities believe that HIV/AIDS is caused by ancestors.

4.2.8.2 Interpretation

It is interesting to note that the majority of the respondents indicated that people in their communities know and are aware of the cause of HIV/AIDS. This could be attributed to the fact that the Department of Health is presently implementing HIV/AIDS awareness programmes in the townships which aim to educate communities about the cause of HIV/AIDS. However, there are still 10.53% people in communities who believe that the cause of HIV/AIDS is something unknown; 5.96% believe that the cause of HIV/AIDS is witchcraft; while 1.40% believe that HIV/AIDS is caused by ancestors. This highlights the need for an educational and psychological programme to reach and educate all people in communities about the real cause of HIV/AIDS, which was clearly highlighted in paragraph 2.2.2 above.

4.2.9 Personal opinion of the respondents on the origin of HIV/AIDS

Table 4.3: Personal opinion of the respondents on the origin of HIV/AIDS

	n	f	%
It originated somewhere in Africa, whence it spread to the rest of the world.	281	47	16.73
It originated in America.	281	20	7.12
It was manufactured by scientists who spread it internationally to kill poor people in Africa and in other countries.	281	80	28.47
It was spread internationally by agents of the previous Apartheid regime.	281	15	5.34
I don't know, or am unsure.	281	119	42.35

4.2.9.1 Analysis

- 42.35% of the respondents revealed that they personally do not know the origins of HIV/AIDS or are not sure;
- 28.47% believe that HIV/AIDS was manufactured by scientists who spread it internationally to kill poor people in Africa and in other countries;
- 16.73% believe that it originated somewhere in Africa, then it spread to the rest of the world;
- 7.12% believe that HIV/AIDS originated in America; while
- 5.34% of the respondents indicated that HIV/AIDS was spread internationally by agents of the previous Apartheid regime.

4.2.9.2 Interpretation

It is worrying to find that the majority of the respondents indicate that they do not know or are not sure of the origin of HIV/AIDS. This highlights the need for schools to infuse the scientific and academic facts on the origin of HIV/AIDS in their curriculum. Ignorance could lead to many people unknowingly involving themselves in irresponsible sex.

4.2.10 Community opinion on the origin of HIV/AIDS

Table 4.4: Community opinion on the origin of HIV/AIDS

	n	f	%
It originated somewhere in Africa, whence it spread to the rest of the world.	269	46	17.10
It originated in America.	269	28	10.41
It was manufactured by scientists who spread it internationally to kill poor people in Africa and in other countries.	269	80	29.74
It was spread internationally by agents of the previous Apartheid regime.	269	27	10.04
I don't know, or am unsure.	269	88	32.71

4.2.10.1 Analysis

- 32.71% of the respondents indicated that people in their communities don't know how HIV/AIDS originated;
- 29.79% of the respondents indicated that people in their communities believe that HIV/AIDS was manufactured by scientists;
- 17.10% indicated that people in their communities believe that HIV/AIDS originated in Africa;
- 10.41% of the respondents revealed that people in their communities believe that HIV/AIDS originated in America; and
- 10.04% of the respondents revealed that people in their communities believe that agents of the previous Apartheid regime spread HIV/AIDS internationally.

4.2.10.2 Interpretation

This is another cause of great concern for this research because of the fact that the community that is ignorant of the origins of HIV/AIDS is likely to fail to socialize and enculturate their children and adolescents according to informed origins and causes of the pandemic. There is definitely a revelation of the need of a psychological and educational programme to educate learners about the origin of HIV/AIDS at schools as highlighted in Chapter 2.

4.2.11 Personal opinion about the agent causing HIV/AIDS

Table 4.5: Personal opinion about the agent causing HIV/AIDS

	n	f	%
It is one large thing, which nestle in one's body (or in blood), making one ill.	293	48	16.38
It is a few smaller things, which occur in certain areas of the body.	293	17	5.80
It is millions of small things (viruses), which are spread throughout the cells of the body.	293	174	59.39
It is an evil spirit or demon, which lives, in the body of the sick person.	293	19	6.48
I don't know, or am unsure.	293	35	11.95

4.2.11.1 Analysis

- 59.39% of the respondents believe that HIV/AIDS is caused by millions of small things (viruses) which are spread throughout the cells of the body;
- 16.38% of the respondents believe that HIV/AIDS is caused by one large thing, which nestle in one's body, making one ill;

- 11.95% of the respondents do not know or are unsure about the agent causing HIV/AIDS;
- 6.48 % of the respondents believe that HIV/AIDS is caused by an evil spirit or demon, which lives in the body of the sick person; and
- 5.80% of the respondents believe that HIV/AIDS is caused by a few smaller things which occur in certain areas of the body.

4.2.11.2 Interpretation

It can be deduced from the findings of this table that the majority of the respondents believe that HIV/AIDS is caused by small things (viruses) which are spread throughout the cells of the body. However, there is still a minority that needs to be educated effectively about the cause of HIV/AIDS. An effective educational and psychological programme can help to educate all learners about the cause of HIV/AIDS.

4.2.12 Community opinion about the agent causing HIV/AIDS

Table 4.6: Community opinion about the agent causing HIV/AIDS

It is one large thing, which nestle in one's body (or in blood), making one ill.	280	43	15.36
It is a few smaller things, which occur in certain areas of the body.	280	26	9.29
It is millions of small things (viruses), which are spread throughout the cells of the body.	280	129	46.07
It is an evil spirit or demon, which lives, in the body of the sick person.	280	42	15.00
I don't know, or am unsure.	280	40	14.29

4.2.12.1 Analysis

- 46.07% of the respondents indicated that people in their communities believe that HIV/AIDS is caused by million of small things (viruses), which are spread throughout the cells of the body;
- 15.36% of the respondents indicated that people in their communities believe that HIV/AIDS is caused by one large thing which nestles in one's body (or in one's blood), making one ill;
- 15.00% of the respondents indicated that people in their communities believe that the agent causing HIV/AIDS is an evil spirit or a demon, which lives in the body of the sick person;
- 14.29% of the respondents indicated that people in their communities do not know or are unsure of the agent causing HIV/AIDS; and
- 9.29% of the respondents indicated that people in their communities believe that a few smaller things, which occur in certain areas of the body, cause HIV/AIDS.

4.2.12.2 Interpretation

The majority of the respondents indicated that the community understands that the agent of HIV/AIDS is millions of small things (viruses) which are spread throughout the cells of the body. This shows that the government awareness programmes on HIV/AIDS are helping to educate communities about the cause of HIV/AIDS.

4.2.13 Personal opinion on whether traditional healers (Sangomas or Inyangas) can cure HIV/AIDS with their medicine

Table 4.7: Personal opinion on whether traditional healers (Sangomas or Inyangas) can cure HIV/AIDS with their medicine

Variables	n	f	%
Definitely yes	291	10	3,44
Yes	291	37	12,71
Unsure	291	56	19,24
No	291	135	46,39
Definitely not	291	53	18,21

4.2.13.1 Analysis

- 46.39% of the respondents think that Sangomas or Inyangas cannot cure HIV/AIDS with their medicine;
- 19.24% of the respondents are unsure whether Sangomas or Inyangas can/cannot cure HIV/AIDS with their medicine;
- 18.21% of the respondents think that Sangomas or Inyangas can definitely not cure HIV/AIDS with their medicine;
- 12.71% of the respondents think that Sangomas or Inyangas can cure HIV/AIDS with their medicine; and
- 3.44% of the respondents think that Sangomas or Inyangas can definitely cure HIV/AIDS with their medicine;

4.2.13.2 Interpretation

The findings in this table indicate that the majority of the respondents do not believe that traditional healers can cure HIV/AIDS. This could be linked to their knowledge that HIV/AIDS is caused by the virus.

4.2.14 Community opinion on whether traditional healers (Sangomas or Inyangas) can cure HIV/AIDS with their medicine

Table 4.8: Community opinion on whether traditional healers (Sangomas or Inyangas) can cure HIV/AIDS with their medicine

Variables	n	f	%
Definitely yes	281	11	3.91
Yes	281	61	21.71
Unsure	281	56	19.93
No	281	112	39.86
Definitely not	281	41	14,59

4.2.14.1 Analysis

- 39.86% of the respondents indicated that people in their communities think that Sangomas or Inyangas cannot cure HIV/AIDS with their medicine;
- 21.71% of the respondents indicated that people in their communities think that Sangomas or Inyangas can cure HIV/AIDS with their medicine;
- 19.93% of the respondents indicated that people in their communities are unsure whether Sangomas or Inyangas can or cannot cure HIV/AIDS with their medicine;

- 14.59% of the respondents indicated that people in their communities think that Sangomas or Inyangas can definitely not cure HIV/AIDS with their medicine; while
- 3.91% of the respondents indicated that people in their communities think that Sangomas or Inyangas can definitely cure HIV/AIDS with their medicine.

4.2.14.2 Interpretation

The majority of the respondents indicated that the people in their community also believe that traditional healers cannot cure HIV/AIDS. This could be linked to their knowledge that HIV/AIDS is caused by the virus.

4.2.15 Personal opinion on whether condoms can protect one against contracting HIV/AIDS

Table 4.9: Personal opinion on whether condoms can protect one against contracting HIV/AIDS

Variables	n	f	%
Definitely yes	290	63	21.72
Yes	290	138	47.59
Unsure	290	38	13.10
No	290	40	13.79
Definitely not	290	11	3.79

4.2.15.1 Analysis

- 47.59% of the respondents indicated that they believe that condoms can protect one against HIV/AIDS;

- 21.72% of the respondents indicated that they believe that condoms can definitely protect one against HIV/AIDS;
- 13.79% of the respondents indicated that they believe that condoms cannot protect one against HIV/AIDS;
- 13.10% of the respondents indicated that they are unsure whether condoms can protect one against HIV/AIDS; and
- 3.79% of the respondents indicated that they believe that condoms can definitely not protect one against HIV/AIDS.

4.2.15.2 Interpretation

It can be deduced from the findings of this table that the majority of the respondents believe that condoms can protect one against HIV/AIDS. This could be attributed to the fact that the government is presently busy with HIV/AIDS awareness programmes, which also promote the use of condoms in sexual relationships outside marriage.

4.2.16 Community opinion on whether condoms can protect one against contracting HIV/AIDS

Table 4.10: Community opinion on whether condoms can protect one against contracting HIV/AIDS

Variables	n	f	%
Definitely yes	284	58	3.91
Yes	284	126	21.71
Unsure	284	51	19.93
No	284	42	39.86
Definitely not	284	7	14.59

4.2.16.1 Analysis

- 39.86% of the respondents indicated that people in their communities believe that condoms cannot protect one from contracting HIV/AIDS;
- 21.71% of the respondents indicated that people in their communities believe that condoms can protect one from contracting HIV/AIDS;
- 19.93% of the respondents indicated that people in their communities are unsure whether condoms can protect one from contracting HIV/AIDS;
- 14.59% of the respondents indicated that people in their communities believe that condoms can definitely not protect one from contracting HIV/AIDS; while
- 3.91% of the respondents indicated that people in their communities believe that condoms can definitely protect one from contracting HIV/AIDS.

4.2.16.2 Interpretation

The findings in this table indicate that the majority of the respondents show that people in their communities believe that condoms can protect one against HIV/AIDS. This could be attributed to government programmes that educate communities about the importance of condomising in sexual relationships outside of marriage.

4.2.17 Personal opinion on whether man can get rid of HIV/AIDS by having sex with a baby/virgin

Table 4.11: Personal opinion on whether man can get rid of HIV/AIDS by having sex with a baby/virgin

Variables	n	f	%
Definitely yes	292	10	3.42
Yes	292	38	13.1
Unsure	292	44	15.07
No	292	127	43.49
Definitely not	292	73	25.00

4.2.17.1 Analysis

- 43.49% of the respondents believe that man cannot get rid of HIV/AIDS by having sex with a baby/virgin;
- 25.00% of the respondents believe that man can definitely not get rid of HIV/AIDS by having sex with a baby/virgin;
- 15.07% of the respondents are unsure whether man can get rid of HIV/AIDS by having sex with a baby/virgin; and
- 3.42% of the respondents believe that man can definitely get rid of HIV/AIDS by having sex with a baby/virgin.

4.2.17.2 Interpretation

The majority of the respondents indicated that they believe that men cannot get rid of HIV/AIDS by having sex with a baby or a virgin. It shows that the belief that men can get rid of HIV/AIDS by having sex with a baby is not entrenched in the minds of all Black people.

4.2.18 Community opinion on whether man can get rid of HIV/AIDS by having sex with a baby/virgin

Table 4.12: Community opinion on whether man can get rid of HIV/AIDS by having sex with a baby/virgin

Variables	n	f	%
Definitely yes	288	15	5.21
Yes	288	57	19.79
Unsure	288	52	18.06
No	288	105	36.46
Definitely not	288	59	20.49

4.2.18.1 Analysis

- 36.46% of the respondents indicated that people in their communities believe that a man cannot get rid of HIV/AIDS by having sex with a baby/virgin;
- 20.49% of the respondents indicated that people in their communities believe that a man can definitely not get rid of HIV/AIDS by having sex with a baby/virgin;
- 19.79% of the respondents indicated that people in their communities believe that a man can get rid of HIV/AIDS by having sex with a baby/virgin;
- 18.06% of the respondents indicated that people in their communities are unsure whether a man can get rid of HIV/AIDS by having sex with a baby/virgin; and

- 5.21% of the respondents indicated that people in their communities believe that a man can definitely get rid of HIV/AIDS by having sex with a baby/virgin.

4.2.18.2 Interpretation

The findings in this table indicate that the people in communities of the respondents do not believe that men can get rid of HIV/AIDS by having sex with a baby or a virgin. It shows that the belief that men can get rid of HIV/AIDS by having sex with a baby is not entrenched in the minds of all Black people.

4.2.19 Data on whether women are powerless to prevent HIV infection

Table 4.13: Data on whether women are powerless to prevent HIV infection

Variables	n	f	%
Definitely yes	292	24	8.22
Yes	292	59	20.21
Unsure	292	48	16.44
No	292	112	38.36
Definitely not	292	49	16.78

4.2.19.1 Analysis

- 38.36% of the respondents indicated that they believe that women are not powerless in preventing HIV/AIDS infections;
- 20.21% of the respondents indicated that they believe that women are powerless in preventing HIV/AIDS infections;

- 16.78% of the respondents indicated that they believe that women are definitely not powerless in preventing HIV/AIDS infections;
- 16.44% of the respondents indicated that they are unsure whether women are powerless in preventing HIV/AIDS infections; while
- 8.22% of the respondents indicated that they believe that women are definitely powerless in preventing HIV/AIDS infections.

4.2.19.2 Interpretation

It can be deduced from the findings of this table that the majority of the respondents believe that women are not powerless in preventing infection.

4.2.20 Data on personal opinion on respondents have run the risk of contracting HIV/AIDS

Table 4.15: Data on personal opinion on respondents have run the risk of contracting HIV/AIDS

Variables	n	f	%
No, because I am not sexually active	289	118	40.83
No, because I am involved in a relationship with one person where both parties are faithful to each other	289	43	14.88
No, because I always use condoms	289	61	21.11
No, I mostly use condoms and have sex with a limited number of people	289	14	4.84
No, if I have not contracted it yet I am hopefully immune to it	289	8	2.77
No, because the ancestors or God will protect me against infection	289	13	4.50
Yes, because my sex mate sleeps around	289	11	3.81

Yes, because sometimes I do not use condoms and have sex with more than one person	289	6	2.08
Yes, because I mostly do not use condoms and have sex with more than one person	289	4	1.38
Yes, because I never use condoms and have sex with more than one person	289	11	3.81

4.2.20.1 Analysis

- 40.83% of the respondents indicated that they do not run the risk of contracting HIV/AIDS because they are not sexually active;
- 21.11% of the respondents indicated that they do not run the risk of contracting HIV/AIDS because they always use condoms;
- 14.88% of the respondents believe that they do not run the risk of contracting HIV/AIDS because they are involved in a relationship with only one person, where both parties are faithful to each other;
- 4.84% of the respondents believe that they do not run the risk of contracting HIV/AIDS because they mostly use condoms and have sex with a limited number of people;
- 4.50% of the respondents believe that they do not run the risk of contracting HIV/AIDS because the ancestors or God will protect them;
- 3.81% of the respondents believe that they run the risk of contracting HIV/AIDS because their sex mates sleep around;
- 3.81% of the respondents believe that they also run the risk of contracting HIV/AIDS because they never use condoms and have sex with more than one person;

- 2.77% of the respondents believe that they do not run the risk of contracting HIV/AIDS because if they have not contracted it yet, they are hopefully immune to it;
- 2.08% of the respondents believe that they run the risk of contracting HIV/AIDS because sometimes they do not use condoms and have sex with more than one person; while
- 1.38% of the respondents believe that they run the risk of contracting HIV/AIDS because they mostly do not use condoms and have sex with more than one person.

4.2.20.2 Interpretation

The majority of the respondents indicated that they are not at risk of contracting HIV/AIDS because they are not sexually active. It is pleasing to learn that the majority of the respondents report that they are not sexually active, which can become a base in educating and psychologizing learners about abstaining from pre-marital sexual intercourse.

4.2.21 Personal opinion on people who run the greatest risk of contracting HIV/AIDS

Table 4.16: Personal opinion on people who run the greatest risk of contracting HIV/AIDS

Variables	n	f	%
People who do not use condoms and have more than one sex mate	283	186	65.72
“Gay”(homosexual) men	283	27	9.54
Women	283	22	7.77
People who are not religious	283	28	9.89
People who have been charmed by a witch	283	20	7.07

4.2.21.1 Analysis

- 65.72% of the respondents think that people who do not use condoms and have more than one sex mate run the risk of contracting HIV/AIDS;
- 9.89% of the respondents think that people who are not religious run the risk of contracting HIV/AIDS;
- 9.54% of the respondents think that people who are “gay”(homosexual) men run the risk of contracting HIV/AIDS;
- 7.77% of the respondents think that women run the risk of contracting HIV/AIDS; and
- 7.07% of the respondents think that people who have been charmed by a witch run the risk of contracting HIV/AIDS.

4.2.21.2 Interpretation

It is interesting to note that the majority of the learners believe that people who do not use condoms and have more than one sex mate run the risk of contracting HIV/AIDS. This shows that people are now aware of the dangers of promiscuity and unprotected sex.

4.2.22 Respondents' change in sexual behaviour as a result of knowledge of HIV/AIDS

Table 4.17: Respondents' change in sexual behaviour as a result of knowledge of HIV/AIDS

Variables	n	f	%
No, I am not sexually active	288	132	45.83
No, because I have always practised safe sex	288	34	11.81
No, I try not to think of HIV/AIDS	288	15	5.21

No, because I believe that one can't do anything to prevent getting infected	288	10	3.47
Yes, I now always use condoms	288	47	16.32
Yes, I have sex with only one reliable sex mate	288	26	9.03
Yes, I now use condoms	288	24	8.33

4.2.22.1 Analysis

- 45.83% of the respondents indicated that they have not changed their sexual behaviour as a result of their knowledge of HIV/AIDS, because they are not sexually active;
- 16.32% of the respondents indicated that they have changed their sexual behaviour as a result of their knowledge of HIV/AIDS, because they now always use condoms;
- 11.81% of the respondents indicated that they have not changed their sexual behaviour as a result of their knowledge of HIV/AIDS, because they have always practised safe sex;
- 9.03% of the respondents indicated that they have changed their sexual behaviour as a result of their knowledge of HIV/AIDS, because they now have sex with only one reliable sex mate;
- 8.33% of the respondents indicated that they have changed their sexual behaviour as a result of their knowledge of HIV/AIDS, they now use condoms;
- 5.21% of the respondents indicated that they have not changed their sexual behaviour as a result of their knowledge of HIV/AIDS, because they just try not to think of HIV/AIDS; and

- 3.47% of the respondents indicated that they have not changed their sexual behaviour as a result of their knowledge of HIV/AIDS because they believe that one cannot do anything to prevent being infected.

4.2.22.2 Interpretations

It can be deduced from the findings in the above table that the majority of the respondents have not changed their sexual behaviour because they are not sexually active. An educational and psychological programme can therefore help in reinforcing the virtue of abstinence from sexual intercourse until after marriage.

4.2.23 Open questions

4.2.23.1 Analysis

With the open question of how many sex mates the respondents have had in the recent 4 weeks, they revealed the following:

- 146 respondents reported that they have not had any sex mate in the recent 4 weeks;
- 57 respondents reported that they have had one sex mate in the recent 4 weeks;
- 12 respondents reported that they have had 2 sex mates in the recent 4 weeks;
- 9 respondents reported that they have had 3 sex mates in the recent 4 weeks;
- 7 respondents reported that they have had 4 sex mates in the recent 4 weeks;
- respondents reported that they have had 5 sex mates in the recent 4 weeks;

- 1 respondent reported that s/he has had 2 sex mates in the recent 4 weeks;
- 1 respondent reported that s/he has had 9 sex mates in the recent 4 weeks;
- 2 respondents reported that they have had 10 sex mates in the recent 4 weeks;
- 1 respondent reported that s/he has had 200 sex mates in the recent 4 weeks;
- 1 respondent reported that s/he has had 12 sex mates in the recent 4 weeks; while
- 1 respondent reported that s/he has had 25 sex mates in the recent 4 weeks.

4.2.23.2 Interpretation

The findings of this research highlight the extent of sexual promiscuity among learners. An effective educational and psychological programme can be effective in educating these learners about responsible sex.

4.2.24 Data on the use of condoms

Table 4.18: Data on the use of condoms

Variables	n	f	%
Never	284	136	47.89
Sometimes	284	37	13.03
Half of the time	284	4	1.41
Mostly	284	8	2.82
Always	284	96	33.80

4.2.24.1 Analysis

- 47.89% of the respondents indicated that they never use condoms;
- 33.80% of the respondents indicated that they always use condoms;
- 13.03% of the respondents indicated that they sometimes use condoms;
- 2.82% of the respondents indicated that they mostly use condoms; and
- 1.41% of the respondents indicated that they use condoms half of the time.

4.2.24.2 Interpretation

The majority of the respondents indicated that they never use condoms. This is another indication of irresponsible sexual engagements among learners, which could be discouraged by effective educational and psychological programmes.

4.3 CONCLUSION

The descriptive statistical summary of the data collected during the empirical research was analysed and interpreted in this chapter. The next chapter presents summaries, findings and recommendations of this research.

CHAPTER FIVE

SUMMARY, FINDINGS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this chapter, a summary of the four preceding chapters is presented. Firstly, the summary of the findings from the literature review which were highlighted in Chapters 1 and 2 are presented, followed by a summary of the statement of the problem, aims and methods of research as highlighted in Chapters 1 and 3; and lastly a summary of the findings of the empirical research as revealed in Chapter 4 is presented. The summaries of the literature findings and the empirical research chapters will enable the researcher to formulate recommendations for an educational and psychological programme which schools could adopt and adapt in their dealing with the attitudes of Black learners towards the HIV/AIDS pandemic at their respective schools.

5.2 SUMMARY AND CONCLUSIONS

This section provides a summary and conclusions of this research.

5.2.1 Findings and conclusions from the literature study (see chapters 1 and 2 above)

The literature review revealed that some Black learners believe that HIV/AIDS can be transmitted through various forms of casual contact, such as kissing, sharing a drinking glass, and contact with a toilet seat. The literature also revealed that such misconceptions have the potential of being contributing factors that create discrimination and prejudice against HIV-positive individuals, since learners who believe that HIV can be transmitted in these ways are much more likely to express discomfort about attending schools with those who are infected with HIV/AIDS (see paragraph 1.1).

The stereotypes about HIV/AIDS among Black learners are also linked to cultural beliefs and convictions, for example:

For traditional Africans, illness is not a random event. Rather, every illness is a product of a destiny and has a specific cause. For black Africans, in order to eliminate the illness, it is necessary to identify, uproot, punish, eliminate and neutralise the cause and the agent of the cause of illness. Illness, according to black traditional beliefs, is a result of:

- a disharmony between an ill person and his/her ancestors, deity, spirits, witches and sorcerers;
- natural causes such as being old; and
- a breakdown in social relationships between people (see paragraph 1.1).

This could be the reason for some of them believing that HIV/AIDS is caused by the wrath of ancestors against people who do not appease those of them who have already passed on (see paragraph 1.1 above).

Ancestors are seen as having an integral influence in the lives of the black Africans. They are believed to protect against evil. However, ancestors could purportedly punish people by sending an illness such as HIV/AIDS and bad luck, if people are ignorant of observing traditions that keep the ancestors happy. People can also cause disharmony between themselves and the ancestors if certain social norms and taboos are violated (see paragraph 1.1).

The belief according to Collins and Rau (2000:43) is that ancestors do not always send illness, but through the withdrawal of their protection, people become susceptible to illness, tragedy and spells cast by witches and sorcerers. That is why, HIV/AIDS amongst many rural, poor and uneducated black Africans, is seen as caused by witchcraft. As a result they do very little to try and educate children and adults about HIV/AIDS.

It is clear from the abovementioned paragraphs that traditional black African beliefs come from a tradition in which ancestor worship is the norm and evil spirits cause misfortunes and disease. There are only three reasons for something bad happening to a traditional African person:

- someone has bewitched them and caused this to happen;

- the ancestral spirits are angry with them; and
- Evil spirits are haunting them and making them sick.

A learner who grows up in a community with such belief system will not embrace such notions as 'Human Immunodeficiency Viruses (HIV).' Instead he tends to believe that he/she has been bewitched and poisoned. Such a belief is based on cultural and traditional misconceptions and stereotypes such as that witchcraft medicine was mixed into their food and that is why they have contracted HIV/AIDS. It is the norm for a learner who grows up with such a belief to take revenge for the actions of the person who he/she believes bewitched or poisoned them. Sometimes it means killing the human beings whom he/she is convinced caused harm to him (see paragraph 1.1).

Leclerc-Madlala (1999:365) asserts that as the deadly virus tightens its stranglehold on South Africa, the myth that sex with a virgin cures HIV/AIDS becomes standard received wisdom. This could certainly account for the horrific phenomenon of child rape statistics in South Africa. Justice officials and HIV/AIDS workers say that in KwaZulu-Natal alone at least 5 rapes cases involving girls under the age of eight years are being dealt with daily in every magistrates court in the province. The HIV/AIDS suffering people with this myth in their minds believe that raping a child will cleanse them of AIDS and also acts as a preventive measure to avoid contracting the HIV/AIDS virus from older women. This belief is clearly highlighted in the study of Stadler and Motsepe (1999:56) which reveals that a 23-year-old black respondent told them during their interviews that everybody over twelve years of age in the township might already have contracted the virus, so its better if he goes for the 6 or 8 years olds who are still virgins. Another 20 year-old, in the research of Berman and Hein (1999:44), added that if he has HIV he can just go out and spread it to 100 other people so they can all die together (see paragraph 1.1 above).

Collins and Rau (2000:43) think that the increase in child-rape is directly related to the way HIV/AIDS is understood in the Black communities. The belief is that the cleanliness and pureness of a child will strip the virus away.

Both young girls and boys are being raped in some Black communities because of this belief. Not long ago, South Africa was shocked when a two-year-old boy was discovered near Soweto. His thumbs had been cut off and there has been an attempt to gouge out his eyes. It is a known fact that *muti* (the 'traditional medicine' used by traditional healers) is considered more powerful if the innocent victim is still alive when the parts are removed (Dalrymple, 1999:89). It was also reported that a man had slaughtered his six-year-old child like an animal (at his home in Diepkloof-Soweto). He emasculated him, split open his chest, removed his heart and cooked and ate it. The dead child's genitals were in his pocket when he was arrested. According to Stadler and Motsepe (1999:67) thumbs are used as medicine to call up ancestors, while human eyes are gouged out and ground into a paste which users apply to their foreheads in the hopes of obtaining a 'third eye vision' enabling them to see the spirit world (see paragraph 1.1).

This study, therefore, investigated the attitude of Black learners towards HIV/AIDS from an educational and psychological perspective. The educational-psychological perspective was employed in investigating the problem of this study because of its potential of providing foundational knowledge that every learner should have about HIV/AIDS. This view is premised on the fact that knowledge cannot be equated with behavioural change. However, knowledge is the foundation, and without it, behavioural changes will not occur (Daderman, Wirsen-Meurling & Hallman, 2001:243; Batholet, 2000:8). Since learners spend most of their time in schools, therefore, schools become the most effective site and a wise location and premise in which to implement a large amount of HIV/AIDS educational-psychological programmes (see paragraph 1.1 above).

5.2.2 Findings and conclusions from the empirical research (see chapter 4)

The empirical research findings revealed that the majority of the respondents indicated that :

- they personally believe that the cause of HIV/AIDS is virus;

- people in their communities believe that the cause of HIV/AIDS is the virus (germ);
- they do not know the origins of HIV/AIDS or are not sure;
- people in their communities are unsure about the origin of HIV/AIDS;
- they personally believe that HIV/AIDS is caused by millions of small things (viruses) which are spread throughout the cells of the body;
- people in their communities believe that HIV/AIDS is caused by million of small things (viruses), which are spread throughout the cells of the body;
- they personally think that Sangomas or Inyangas cannot cure HIV/AIDS with their medicine;
- people in their communities think that Sangomas or Inyangas cannot cure HIV/AIDS with their medicine;
- they personally believe that condoms can protect one against HIV/AIDS;
- people in their communities believe that condoms cannot protect one from contracting HIV/AIDS;
- they personally believe that men cannot get rid of HIV/AIDS by having sex with a baby/virgin;
- people in their communities believe that a man cannot get rid of HIV/AIDS by having sex with a baby/virgin;
- they personally believe that women are not powerless in preventing HIV/AIDS infections;
- they do not run the risk of contracting HIV/AIDS because they are not sexually active;
- they personally think that people who do not use condoms and have more than one sex mate run the risk of contracting HIV/AIDS;

- they personally have not changed their sexual behaviours as a result of their knowledge of HIV/AIDS. This could be attributed to the fact that the majority of the respondents revealed that they are not sexually active; and
- they personally had never used condoms.

With the open questions which probed how many sex mates the respondents have had in the recent 4 weeks, some respondents revealed that they:

- have not had any sex mate;
- have had one sex mate;
- have had 2 sex mates;
- have had 3 sex mates;
- have had 4 sex mates; and
- have had 5 sex mates.

This was a revelation of some promiscuity among some learners who participated in this research.

5.3 LIMITATIONS OF THE STUDY

The study may have suffered because of the following limitations:

5.3.1 Missing data

Due to either a lack of a clear understanding of the questionnaires, or a negative attitude towards the questionnaires, some learners failed to complete them fully. This resulted in missing data and an inconsistency in the numbers of sample sizes for the various analyses.

5.3.2 Language medium

The respondents were Sotho speakers while questionnaires were in English. The assumption can be made that learners may not have understood some of

the items on the questionnaire, hence their failure to answer some items of the questionnaire correctly.

5.3.3 Measuring instrument

With relation to instrumentation, it would have been better if the questionnaire was standardized for all South Africans in order to determine the stereotypes and attitudes towards HIV/AIDS of all racial and cultural groups of learners in this country. There is, therefore, a need for a comparative research on the cultural misconceptions and stereotypes among all learners in South Africa, that is, across racial make-up of South Africa.

5.3.4 Available literature

As not much research has been done about the attitudes of Black learners towards HIV/AIDS, it was difficult to review sufficient scientific and academic literature to support the problem statement of this research. The little literature available has been written by authors with secondary knowledge of the attitudes of Black learners towards HIV/AIDS and limited exposure to cultural stereotypes and misconceptions of Black learners towards HIV/AIDS. It would be interesting to read a lot about the cultural stereotypes and misconceptions of Black learners towards HIV/AIDS from the writings of Black writers because of the primary knowledge they have about the culture of sexual relationships in traditionally black communities where males still dominate women in sexual desires and needs. Polygamous sexual relationships, extra-marital affairs, rape of young girls with the belief that young girls who have never had sex (virgins) are cleansing from misfortunes are still prevailing in a minority of Black communities. Such cultural stereotypes and misconceptions psychologically miseducate and mislead learners.

5.4 RECOMMENDATIONS

The analysis and interpretation of both the literature review and empirical research findings have led to this study making the following recommendations which have implications for educational and psychological approaches to dealing with attitudes of learners towards HIV/AIDS:

● Since HIV/AIDS is a health hazard, it is necessary that schools should design and develop health education curriculum which includes:

- the anatomy and physiology of the reproductive system;
- physical, emotional and psychological changes during puberty;
- conception, pregnancy and birth;
- disease-causing agents;
- preventive measures in dealing with sexually transmitted diseases such as HIV/AIDS.

Such a curriculum should entail, among other:

- the origins of HIV/AIDS pandemic, thus dealing with cultural and traditional stereotypes and misconceptions about:
 - where the HIV/AIDS pandemic originated, how it is transmitted; and
 - how an infected person lives with and manage this syndrome in order to remain stronger for longer time.
 - Promotion of personal health such as development of:
 - self-esteem;
 - puberty and developing fertility;
 - code of ethics in sexual relationships and friendships, sex drive, sexual feelings in childhood and adolescence, teenage problems, sex roles;
 - concept of happy families;
-
- marriage issues; and
 - problems related to family-hood.

- Undertaking by schools on HIV/AIDS intervention programmes which can take the form of special projects, such as “The Healthy Lifestyle” and “Preventive Education on HIV/AIDS” which encapsulate:
 - interpersonal relationships;
 - self awareness and self-esteem;
 - problem-solving;
 - effective communication;
 - decision making;
 - negotiation skills;
 - resisting peer pressure;
 - critical thinking;
 - formation of friendships; and
 - apathy.

Such a curriculum can be a platform for schools to educate learners about the immune system of the human body and how the devastation and damaging of this immune system weakens the human body and leaves it prey to opportunistic diseases such as pneumonia, tuberculosis, psychosis and so on which lead to full blown AIDS.

- The challenges that face schools in South Africa today are that sexual and reproductive health education should be a priority if learners are to acquire knowledge, master necessary life skills, and have changes and adaptations in their communities’ value systems and attitudes for behavioural change. Training educators in the appropriate strategies to deal with this touchy and sensitive matter is a necessity. School leadership should be committed and able to set and enforce high standards of respect and responsibility, and provide adequate support for the educators to inculcate good and responsible social values in

learners. Educators as models and mentors should be able to provide a comprehensive and holistic approach to teaching sexuality education. Schools should create a health promoting environment that ensures that teaching is learner-centred, hands-on, and relevant to life and even going to the extent of making various pornographic sites inaccessible to learners.

- Education and sports are unique tools for spreading HIV/AIDS information and awareness. As an already organized infrastructure, it is cost-effective and can reach a large audience of educators and administrative staff, learners and their parents, as well as sportsmen and women outside the education mainstream.
- Since HIV/AIDS is a deadly disease that spreads in conditions of ignorance and silence, the consequences of it are borne by individuals and communities affected by it, again in silence and shame. Only by implementing life skills education can schools bridge the gap between high HIV knowledge and awareness levels and equipping learners with essential knowledge, skills, attitudes and practices that would prepare them for responsible adulthood and responsible and accountable relationships with persons of the opposite sex.
- The use of an inclusive educational and psychological approach is a must if schools are to succeed in effectively dealing with the HIV/AIDS pandemic. Schools should collaborate with the civil society and private business firms in the prevention and care of HIV/AIDS. The involvement of the following organizations can be psychologically educational:
 - Non-Government Organizations;
 - Traditional healers;
 - Psychologists;
 - Community-Based Organizations; and
 - Faith Based Organizations.

This can be a way of involving all social service delivery agents in educating learners about this killer disease. School policy making should put each of the stakeholder on board and reach a wide coverage of the communities. Communities and individual families can be involved in the control, treatment and mitigation of the consequences of HIV/AIDS. An inclusive educational and psychological approach provides teaching and learning processes which take into consideration the psychic, affective and conative aspects of the learner in empowering him/her to develop a healthy and responsible attitude towards HIV/AIDS pandemic and psycho-physical health in general. The inputs of traditional healers in township schools are paramount if schools are to succeed in dealing with the cultural beliefs on witchcraft. Schools should engage psychologists and sociologists in dealing with the misconceptions that having sex with a virgin or a celibate can help an infected male or female to get rid of the HI virus in his or her body.

In working towards lessening the impact of HIV/AIDS on learners, especially with regards to education, it is important for schools to adopt a rights-based approach. This means that children, HIV positive or negative, from AIDS affected households or not, have certain basic rights which are enshrined in the South African Bill of Rights (Chapter 2 of the Constitution), the Convention of the Rights of the Child (1948), and the Dakar Declaration (2000). These documents state that all children have the right to receive an education. Children must be given the opportunity to basic education, whether they are from AIDS affected households or not; and that learners in general have the right to appropriate information on the HIV/AIDS situation in their schools, and they have the right to information on how to protect themselves from HIV. The infusion of the human rights philosophy in the school organizational climate can help schools respect the human dignity of learners irrespective of the attitude they have about HIV/AIDS pandemic and their health status. Consequently, no learner will be stigmatized and discriminated against because of his/her HIV/AIDS status. Schools must, therefore, infuse this 'rights-based approach' in their educational and psychological approach to HIV/AIDS. A school environment in which human rights are respected ensures that:

- vulnerability to HIV/AIDS is reduced;
- those infected with and affected by HIV/AIDS live a life of dignity without discrimination and stigmatization; and
- the personal and societal impact of HIV infection is alleviated.

More research should be conducted by universities and researchers on psychological and educational ways in which Black communities can be helped to understand that cultural beliefs, convictions, philosophy of life, way of life, religion, norms, and values have a significant relationship with responsible psycho-physical wellness. Cultural stereotypes and misconceptions about the HIV/AIDS lead to irresponsible ways of dealing with the pandemic such as believing that having sex with a virgin or celibate will heal a person living with HIV/AIDS.

5.5 CONCLUDING REMARKS

In this research, an educational and psychological perspective was adopted to investigate the attitudes of Black learners towards HIV/AIDS. This was done by means of both the literature review and empirical research. The results of the empirical research were analysed and interpreted. On the basis of both the findings of literature review and empirical research, this study was able to make recommendations with educational and psychological implications for schools. It is the prayer of the researcher that schools will heed what this research exposed and start developing educational and psychological programmes which can help all Black learners develop healthy and responsible attitudes towards HIV/AIDS. It is also advised that such programmes should also be advocated to traditional communities so that people who live in these communities can also be educated about the origins of HIV/AIDS pandemic and how it is transmitted through blood that is infected with the HI virus, either through sex or blood transfusion or any contact with infected blood. Schools can work with community organizations to educate communities.

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ADDENDUM A

OPINIONS ON HIV/AIDS

Section A: Biographical information

Please supply the following information about yourself. Make an X in the appropriate space; encircle the number, which reflects your answer, or answer by writing, where applicable, in the provided space:

1. Age:.....

2. Gender.....

Male	Female
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3. Where do you stay?

City or township near a city	Town near a city	Town in rural district	Plot or farm	Rural district
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4. Ethnic group

Asian	Black	Coloured	White	Other
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5. Level of education

No formal education	Grade 7 (Std 5) or lower	Grade 8-10 (Std 6-8)	Grade 11 (Std 9) or matric	Post-matric / Diploma	Degree
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6. Marital status:

Married	Stable relationship/ living together	Not married	Divorced	Estranged
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Section B: Opinions on HIV/AIDS

7. What is your personal opinion on the cause of HIV/AIDS? (encircle the number, which represents your answer).

1. It is caused by the ancestors.
2. It is caused by witchcraft.
3. It is caused by poverty.
4. It is caused by virus (germ).
5. It is caused by something unknown.

8. What do many people in your community believe the cause of HIV/AIDS to be? (Do not ask other people what they think!) The objective is to determine what your opinion is of the beliefs of your community (i.e. the people around where you live). This need not be the majority of the people in your community.

1. It is caused by the ancestors.
2. It is caused by witchcraft.
3. It is caused by poverty.
4. It is caused by virus (germ).
5. It is caused by something unknown.

9. What is your personal opinion on the origin of HIV/AIDS?

1. It originated somewhere in Africa, hence it spread to the rest of the world.
2. It originated in America.
3. It was manufactured by scientists who spread it intentionally to kill poor people in Africa and in other countries.

4. It was spread intentionally by agents of the previous Apartheid regime.

5. I do not know or am unsure.

10. What do many people in your community believe regarding the origin of HIV/AIDS? (Do not ask other people what they think!) The objective is to determine what your opinion is of the beliefs of your community (i.e. the people around where you live). This need not be the majority of the people in your community.

1. It originated somewhere in Africa, hence it spread to the rest of the world.

2. It originated in America.

3. It was manufactured by scientists who spread it intentionally to kill poor people in Africa and in other countries.

4. It was spread intentionally by agents of the previous Apartheid regime.

5. I do not know or am unsure.

11. Which picture comes to your mind when you think of HIV (the agent causing HIV/AIDS)?

1. It is one large thing, which nestles in one's body (or in one's blood) making one ill.

2. It is a few smaller things, which occur in certain areas of the body.

3. It is millions of small things (viruses), which are spread throughout the cells of the body.

4. It is an evil spirit or demon, which lives in the body of the sick person.

5. I do not know or am unsure.

12. Which picture comes to mind of many people in your community when they think of HIV (the agent causing HIV/AIDS) (Don't ask people what they think)

1. It is one large thing, which nestles in one's body (or in one's blood) making one ill.
2. It is a few smaller things, which occur in certain areas of the body.
3. It is millions of small things (viruses), which are spread throughout the cells of the body.
4. It is an evil spirit or demon, which lives in the body of the sick person.
5. I do not know or am unsure.

13. Do you personally think that traditional healers (Sangomas or Inyangas) can cure HIV/AIDS with their medicine?

1. Definitely yes
2. Yes.
3. Unsure.
4. No
5. Definitely not.

14. Do many people in your community think that traditional healers (Sangomas or Inyangas) can cure HIV/AIDS with their medicine? (Do not ask other people what they think).

1. Definitely yes
2. Yes.
3. Unsure.
4. No
5. Definitely not.

15. Do you personally think that condoms can protect one against contracting HIV/AIDS?

1. Definitely yes
2. Yes.
3. Unsure.
4. No
5. Definitely not.

16. Do some people in your community believe that condoms can protect one against contracting HIV/AIDS? (Do not ask other people what they think).

1. Definitely yes
2. Yes.
3. Unsure.
4. No
5. Definitely not.

17. Do you personally think that a man can get rid of HIV/AIDS by having sex with a baby or a virgin?

1. Definitely yes
2. Yes.
3. Unsure.
4. No
5. Definitely not.

18. Do people in your community believe that a man can get rid of HIV/AIDS by having sex with a baby or a virgin?

1. Definitely yes
2. Yes.
3. Unsure.
4. No
5. Definitely not.

19. Do you think that women are powerless and can do nothing to prevent HIV infections?

1. Definitely yes
2. Yes.
3. Unsure.
4. No
5. Definitely not.

20. Do you think that you personally run the risk of contracting HIV/AIDS? Choose the one option, which is best applicable to you.

1. No, because I am not sexually active.
2. No, because I am involved in a relationship with one person where both parties are faithful to each other.
3. No, because I always use condoms.
4. No, because I mostly use condoms and have sex with a limited number of people.
5. No, because if I haven't contracted it yet, I am hopefully immune to it.
6. No, because the ancestors or God will protect me against infection.

7. Yes, because my sex mate sleeps around.

8. Yes, because sometimes I do not use condoms and have sex with more than one person.

9. Yes, because I mostly do not use condoms and have sex with more than one person.

10. Yes, because I never use condoms and have sex with more than one person.

21. Which of the following persons do you personally think runs the greatest risk of contracting HIV/AIDS?

1. People who don't use condoms and have more than one sex mate

2. "Gay" (Homosexual) men.

3. Women.

4. People who are not religious.

5. People who have been charmed by a witch.

22. Have you changed your sexual behaviour in any way as a result of your knowledge of HIV/AIDS? Choose ONE opinion, which is best applicable to you.

1. No, I am not sexually active

2. No, because I have always practiced safe sex.

3. No, I try not to think of HIV/AIDS.

4. No, because I believe that one can't do anything to prevent getting infected.

6. Yes, I have sex with only one reliable sex mate.

7. Yes, I now use condoms.

23. How many sex mates have you had in the recent 4 weeks?

.....

25. How regularly have you been using condoms in the recent 4 weeks?

1. Never
2. Sometimes.
3. Half of the time.
4. Mostly.
5. Always.

25. "The people in my community say that anti-viral medicine (such as Nevirapine).....
.....
