AN EMPOWERING PROGRAMME OF HIV/AIDS AND LIFE SKILLS FOR ADOLESCENTS

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AN EMPOWERING PROGRAMME OF HIV/AIDS AND LIFE SKILLS FOR ADOLESCENTS

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FOREWORD

This manuscript is submitted in article format in accordance with Regulation A.11.2.5 for the degree MA(SW). The article will comply with the requirements of one of the journals for Social Work, entitled Die Maatskaplike Werk Navorser-Praktisyn / The Social Work Practitioner-Researcher.

Guidelines for authors, as set by this journal, follow:

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The journal serves as an outlet for the publication of original reports of quantitatively orientated evaluation studies: Reports on the development of validation of new methods of assessment for use in practice: empirically based reviews of the practice literature that provide direct application to practice; theoretical or conceptual papers have direct relevance to practice: qualitative inquiries that inform practice and new developments in the field of organized research. All empirical research articles must conform to accepted standards of scientific inquiry and meet relevant expectations related to validity or credibility, reliability or dependability and objectivity or confirm ability.

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SUMMARY

TITLE: A Social Work Empowering Program of HIV/AIDS and Life Skills for Adolescents.

KEY WORDS: HIV, AIDS, Adolescents, Empowering Program, Life Skills

The aim of the research was to investigate the needs of adolescents and to determine their attitude, knowledge and skills regarding HIV/AIDS and life skills. The next step was to develop an empowering program to teach them life skills and to educate them with regard to the HIV/AIDS epidemic.

To meet this aim, the following objectives were formulated:

- To identify the needs of adolescents and extend their knowledge, skills and attitude regarding HIV/AIDS and life skills through empirical research and literature study.
- To design a life skills program through a literature study and empirical research in order to improve the social functioning of the adolescents.

The objectives were achieved by studying the relevant literature and through empirical research. The available literature on the subject was consulted to determine whether any research has been conducted in this field, and whether the subject could be researched. The empirical research was conducted to confirm the previous research findings. The literature study and empirical research were vital for formulating a social work empowering program.

In this research, the survey method was used as a systematic fact–gathering procedure. Data was gathered through a structured questionnaire. The data was used to describe the study sample, since socio-economic status could possibly have an effect on the general health and development of children.

The research data were collected from the adolescents and their families to estimate the prevalence of their living standards, habits and lifestyle, knowledge, attitude and behaviour regarding HIV/AIDS.

The findings of this research reflected that adolescents had an urgent need for more knowledge and information concerning HIV/AIDS and life skills.

In order to address this problem an empowering program was developed and will be presented. In this research the group work method will be used as an effective intervention strategy in empowering young people.

Education is crucial; therefore it seems important to educate young people in certain life skills to empower them to cope with the challenges and demands of life.

OPSOMMING

TITEL: 'n Maatskaplikewerk-bemagtigingsprogram oor MIV/VIGS en Lewensvaardighede vir Adolessente

SLEUTELTERME: MIV, VIGS, Adolessente, Lewensvaardighede, Bemagtigingsprogram.

Die doel van hierdie navorsingsprogram was om ondersoek in te stel na die behoeftes van die adolessente en te bepaal wat die houding, gedrag, kennis en vaardighede is wat bestaan met betrekking tot MIV/VIGS. Die volgende stap was die ontwikkeling van 'n maatskaplikewerk-bemagtigingsprogram om hulle ten opsigte van sekere lewensvaardighede op te lei en in te lig.

Om hierdie doel te verwesenlik is die volgende doelstellings geformuleer:

- Om die behoeftes van die adolessente te bepaal asook die inhoud van hulle kennis, houding en vaardighede ten opsigte van MIV/VIGS en lewensvaardighede deur middel van empiriese navorsing en 'n literatuurstudie,
- Om 'n lewensvaardigheidsprogram deur middel van 'n literatuurstudie en empiriese navorsing te ontwikkel, met die doel om die adolessente se sosiale funksionering te verbeter.

Hierdie doelstellings is deur middel van 'n studie van die relevante literatuur en deur empiriese navorsing verwesentlik. Die beskikbare literatuur oor die onderwerp in hierdie veld is geraadpleeg om vas te stel of enige navorsing reeds oor die onderwerp gedoen is, asook om te bepaal of dit wel lewensvatbaar was. Die empiriese navorsing is gedoen ten einde vorige navorsingsbevindinge te bevestig. Die literatuurstudie en die empiriese navorsing was noodsaaklik vir die formulering van 'n maatskaplikewerk-bemagtigingsprogram.

In hierdie navorsing is die opnameprosedure as 'n sistematiese inligtingsinsamelingsprosedure gebruik. Inligting is ingesamel deur van 'n gestruktureerde vraelys gebruik te maak. Die inligting is benut om die steekproef te beskryf, aangesien die sosio-ekonomiese status van 'n gesin moontlik 'n effek kan hê op die algemene gesondheid en ontwikkeling van adolessente.

Die navorsingsinligting is van die adolessente en hulle families verkry om te bepaal wat hulle lewenstandaard, gewoontes, lewenstyl, kennis, houding en gedrag is rakende MIV/VIGS.

Die bevindinge van die navorsing weerspieël 'n ernstige behoefte aan meer kennis van en inligting oor MIV/VIGS en lewensvaardighede.

Om hierdie probleem te kan aanspreek is 'n bemagtigingsprogram ontwikkel wat aangebied kan word.

In hierdie navorsing is besluit om van die groepwerkmetode in maatskaplike werk as 'n effektiewe intervensiestrategie gebruik te maak ten einde die adolessente te bemagtig.

Opleiding is van kardinale belang en as gevolg daarvan word dit as uiters belangrik beskou om adolessente met lewensvaardighede te bemagtig sodat hulle die uitdagings en eise wat die lewe aan hulle stel, kan hanteer.

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SECTION 1:

1. ORIENTATION OF THE STUDY

1.1 PROBLEM STATEMENT

This study forms part of a project entitled "Physical Activity in the Young (PLAY), of the Institute of Nutrition at the North-West University (Potchefstroom Campus). The study will explore the needs of adolescents to design a life skills program with the view to improve their social functioning.

HIV/AIDS remains a central issue in South Africa and creates a serious problem. HIV/AIDS is by far the largest current crisis in South Africa, says Strydom (2003:59). The pandemic proportions of Aids and the devastating consequences that are wreaking havoc in Sub-Saharan Africa are widely acknowledged. According to Abdool Karim (2005:31), the number of HIV/AIDS-infected people was 40 million worldwide by the end of 2003 with 5,3 million infected people in South Africa by December 2002. According to Fenton (2002:1), an estimated 5,5 million South Africans – one in eight – are infected with HIV. It is estimated that three quarters of all new HIV infections occur amongst those aged between 15 and 25.

A study undertaken shows that an estimate of 6,29 million South Africans were living with HIV by the end of 2004. In the National Survey of the same study the researchers estimated that 10,8% of all South Africans over the age of 25 were living with HIV and that the portion of people between ages 15 and 49 living with HIV was 16,2%. The South African Government and Statistics South Africa published a report on causes of deaths from 1997 to 2002 during which it rose by 57%. In the age group 25 to 49, the rise was 116%. The highest number came from UNAIDS/WHO, and they estimated that AIDS claimed 370 000 lives in 2003 — more than 1 000 a day, (South African Department of Health Study, 2004).

Gallant and Tyndale (2004:1337) mention that, what is not often acknowledged is its impact on the youth. Statistics, as presented by Shisana and Simbayi (2002:7), indicate that the highest HIV prevalence was in the age group 25 to 29 (28%). Strydom (2002:351) points out that late adolescents and young adults are the groups with the highest HIV prevalence rates in South Africa.

An educational campaign, "Love Life", was launched in 1999. Its aim was to reduce teenage pregnancy and turn safe sexual behaviour into a brand in much the same way as Coca-Cola and Nike. Although educational campaigns have been launched throughout the 9 provinces, there is no success rate yet and the epidemic is still a major challenge to everyone. Previous campaigns of sexual health education have largely failed to change sexual behaviour; 90% of people know the dangers but the infection rate continues to rise (UNAIDS, 2004). The government's HIV education campaign, "beyond awareness", which ran from 1998-2000 came from the perception

that national mass media campaigns might inform people, but it seldom had much effect in changing behaviour (UNAIDS, 2004).

Our teenagers seem to be a daunting prospect to social workers when they tackle the complex issues related to HIV/AIDS. Strydom (2002(a):351) states that sexually transmitted infections, including HIV, are common among people aged 15 to 24 and it has been estimated that half of all HIV infections worldwide have occurred among people younger than 25. In research done by Strydom (2003:69), adolescents (school learners) indicated that sex education is lacking and that they need more information on HIV/AIDS.

Roux (2002:299) also found in her research that the lack of knowledge concerning HIV/AIDS seems to be a huge problem and that people have a need to gain more knowledge. According to (Simbayi, 1999:154) prevention involves an educational component and for this reason researchers believe that the only current solution to the problem of curbing HIV lies in the education of potential high-risk groups. Therefore education is crucial; and it is important to educate young people in certain life skills to empower them to cope with the challenges and the demands of life.

Life skills training focuses on helping persons identify and correct deficits in their life-coping response and acquire new appropriate behaviours (Gladding, 1999:30). Young people need to be educated on a wider variety of skills to help them understand the problem of HIV/AIDS and to teach them a way to deal with the disease and how to prevent themselves from getting infected. According to Rooth (1997:6), life skills enable one to know what to do, how to do it and when it is appropriate to do something. Life skills are abilities to behave in a certain manner that is beneficial to capacity building and successful living. In a program on young people and Aids that the University of Natal launched in 2002, they came to the conclusion that, although they increased the knowledge of the youths and changed their attitudes, they had limited success in promoting behavioural change (Campbell & Foulis, 2002:312). Van Heerden (2001:1-3) states in her research that in the present day, the early adolescent is subjected to very high demands called for by a complex modern society, and is expected to function efficiently in this environment. The early black adolescent from a disadvantaged community experiences problems such as decision-making, conflict management and relationships with much more difficulty. There is a need for preventative skills training programmes that will empower the youth to make positive changes. It is important to teach the youth strategies which will enable them to feel confident in their ability to cope with life's challenges.

From the above, the following questions can be formulated:

- What are the needs of adolescents and what life skills, knowledge and attitudes do they need in order to improve their social functioning?
- What needs to be the content of a life skills programme to improve the social functioning of adolescents and their knowledge of AIDS?

1.2 AIMS OF THE STUDY

The aims of the research are:

- To identify the needs of adolescents and extend their knowledge and skills and change their attitudes concerning HIV/AIDS and life skills through an empirical research and literature study.
- To design a life skills program through a literature study and empirical research in order to improve the social functioning of adolescents.

1.3 CENTRAL THEORETICAL STATEMENT

An exploration of the needs of adolescents and of the extension of their knowledge and skills and of changing their attitudes concerning HIV/AIDS will give social workers an understanding of how to develop guidelines for appropriate life skill programmes.

1.4 RESEARCH METHODOLOGY

The method for investigation was a literature study and an empirical research.

1.4.1 Literature Study

A literature study was conducted for all aspects of the study. De Vos *et al* (1998:179) states that a researcher can only hope to undertake meaningful research if he is fully up to date with existing knowledge on this prospective subject.

The central focus of this study is a life skills programme for adolescents in order to improve their social functioning. South African literature on life skills and education is important, and is used in this research because the situation in South Africa differs from that in other countries.

From the literature study and empirical research, guidelines were formulated for a program on HIV/AID and life skills.

1.4.2 Empirical Research Design

Babbie and Mouton (2001:55) define a research design as a blueprint of how the researcher intends to conduct the research. According to Grinnell (2001:183), the survey research procedure is a form of data collection because it provides a useful and convenient way of acquiring large amounts of data about individuals, organizations and communities.

In this research, the data were collected from the adolescents' families to estimate the prevalence of their living standards, habits and lifestyle, knowledge, attitude and behaviour regarding AIDS.

A questionnaire for this study used both open–ended and closed–ended questions. De Vos & Fouché (1998a:89) state that "a questionnaire is an instrument with open- or closed-ended

questions or statements to which a respondent must react". Open ended questions afford the respondent the opportunity of writing any answer in the open space. Closed-ended questions afford the respondent the opportunity of selecting (according to instructions) one or more response choices from a number provided (De Vos, *et al*, 2005:174). According to Grinnell (2001:190), in closed–ended questions, responses can be selected from a number of specified choices. The open–ended questions are designed to permit for responses; they are not forced to choose among alternatives.

Both a qualitative and quantitative research approach was used in this survey. According to Straus and Corbin (1998:10–11), qualitative research refers to research on persons' lives, lived experiences, emotions and feelings, as well as on organizational functioning social movements.

1.4.3 Participants

A convenience sample of scholars N = 206 in grade 9 (13–18 years old) from a high school in Ikageng, Seiphemelo High School, Potchefstroom, in the North West Province, South Africa, was followed up from 2004 as the intervention group. Sixty-four grade 9 children from Boithoko High School in the same township were followed up as the control group. Permission to do this study was obtained from the principals and parents. The schools were visited in order to explain the 2005 protocol to the teachers, parents and children and to obtain permission from the principals and informed consent from the parents of the children. The research was approved by the Ethics Committee of the University, number 04M01.

1.4.4 Data collection

A structured questionnaire was used to obtain demographic data of the adolescents. The data was used to describe the study sample, since social economic status may have an effect on the general health and development of children.

The questionnaire also focused on the knowledge, attitudes, beliefs and opinions of adolescents concerning HIV/AIDS and related matters.

1.4.5 Procedures

The research design steps, as described by De Vos *et al.* (1998:49), were followed as a procedure to develop the program. The quantitative paradigm is based on positivism, which takes scientific explanation (i.e. based on universal laws). Its main aims are to objectively measure the social world to test hypotheses and to predict and control human behaviour (De Vos *et al.* 1998:240).

The research design steps of a quantitative approach as set out by De Vos *et al.*(1998:49) were followed, and it included the following:

STEPS IN THE RESEARCH PROCESS	QUANTITATIVE
STEP 1	CHOOSE A RESEARCH PROBLEM/TOPIC/THEME
STEP 2	IDENTIFY THE PROBLEM
STEP 3	REVIEW THE RELEVANT LITERATURE AND RELATED RESEARCH
STEP 4	FORMULATE THE PROBLEM FORMALLY
STEP 5	FORMULATE A RESEARCH PROPOSAL
STEP 6	DEFINE EACH OF THE CENTRAL CONCEPTS THEORETICALLY AND OPERATIONALLY.
STEP 7	REFORMULATE THE RESEARCH PROBLEM IN THE FORM OF TESTABLE HYPOTHESES
STEP 8	SELECT A RESEARCH DESIGN
STEP 9	SELECT THE DATA COLLECTION METHODS AND MEASURING INSTRUMENTS
STEP 10	CONDUCT A PILOT STUDY
STEP 11	DRAW THE SAMPLES
STEP 12	COLLECT DATA (I.E. EXECUTE THE SELECTED RESEARCH DESIGN)
STEP 13	PROCESS, ANALYSE AND INTERPRET THE DATA
STEP 14	WRITE THE RESEARCH REPORT.

1.4.6 Ethical Aspects

According to Strydom (2002(a):24), ethical guidelines serve as standards and the basis on which each researcher ought to evaluate his own conduct. Approval for this research was obtained from the Ethics Committee of the North-West University; number 04M01. In this research the following ethical aspects received attention:

- It was ensured that the findings do not impact negatively on the adolescents.
- Informed consent was obtained from the adolescents and all the aspects of the research were explained before participation.
- To ensure that all ethics were practiced, the questionnaire was filled out anonymously and the names of the individuals were not disclosed.
- Conditions of privacy and confidentiality were maintained because proper scientific sampling was used and the researcher and a few members of the staff were aware of the identity of participants.
- It also ensures that the information provided will remain confidential because the researcher will watch jealously over the information confided to her.

1.4.7 Data analysis

The data was analyzed. According to De Vos *et al.* (1998:203), the purpose of analyzing is to reduce data to an intelligible and interpretable form so that the relations of research problems can be studied and conclusions be drawn.

1.5 DEFINITIONS OF THE TERMS USED IN THIS RESEARCH

To minimize different interpretations of the same term, it is necessary to define a number of key terms used in this research study.

1.5.1 Adolescents

According to Strydom, (2003:61) adolescence is normally referred to as the life cycle period between childhood and adulthood, beginning at puberty and ending with young adulthood. The life stage of adolescence is often accompanied by rapid growth and physical development, heightened sexual interest/activities and a struggle to find self-identity.

According to Dacey, *et al.* (2004:15-17), different statements regarding adolescents were made at different times (centuries):

- **Ancient times – during the fifth century**

Our youth love luxury. They have bad manners and contempt for authority, show disrespect for their elders and prefer chatter to exercising. They no longer rise when others enter the room. They contradict their parents, chatter before company, gobble up their food and tyrannize their teachers.

- **The Middle Ages**

In medieval society the idea of childhood did not exist. As soon as the child could live without the constant solicitude of his mother, his nanny or his cradle–rocker, he belonged to the adult society.

- **The Age of Enlightenment**

From the 1600s to the early 1900s it was argued that children and youth should be free of adult rules so they can experience the world naturally. In America, 40% of youth then worked in factories for as long as 12-hour periods.

- **The Twentieth Century**

Adolescence, as we know it today, may be said to have started with the onset of compulsory education. The law required children to be in school between ages 6 and 16. More or less since 1914, those who were interested in understanding youth ceased speculating about adolescents and actually began making observations of them.

Since 1950, adolescents were given a reality of their own; they have their own music and enjoy their own dances.

In 1967 it was said that a great many young people were in serious trouble throughout the technically developed world.

- **Today**

In line with the past, some researchers suggest that it is normal for adolescents to be in turmoil for much of the time. Many others, however, find the majority of teenagers to be well balanced, reasonably happy and pleasant to work with.

1.5.2 HIV

HIV refers to Human Immunodeficiency Virus, which is the virus widely accepted as causing AIDS (Becker, 2005:103).

In order to exist, the Human Immunodeficiency Virus (HIV) has to enter a cell in the body and insert into the cell's DNA where it reproduces itself (Whiteside & Sunter, 2000:2).

Buthelezi (2003:19) explains: "HIV attacks and slowly destroys the human immune system by killing the important CD4 and T4 cells that control and support our immune system."

1.5.3 AIDS

According to Becker (2005:103), "AIDS refers to Acquired Immunodeficiency Syndrome".

- Acquired. This means that the virus is not spread though casual contact such as flu. In order to become infected with HIV, an individual has to do something, for example have unprotected sex, or have something done to them, for example receive infected blood which exposes them to the virus.

- I and D — Immunodeficiency. The virus attacks the individual's immune system (the system which fights off infections) and makes it less capable of fighting infections. This means the immune system becomes deficient.

- S — Syndrome. AIDS is not just one disease. It presents itself as a number of diseases that arise as the immune system fails to fight off infections, for example tuberculosis and pneumonia; it therefore presents itself as a syndrome.

1.5.4 An Empowering Program

According to Rooth (1997:1), communities often requested that life skills should be the topics used in workshops for educational programs for groups, with the focus on the development of psychological skills. This means that psychological principles and knowledge are converted into teachable skills which can empower people to respond effectively to the demands and problems

of coping with life. Capacity–building, or developing people's potential, is an essential task, specifically in post-apartheid South Africa.

1.5.5 Life Skills

Life Skills, according to Rooth (1997:2), are the skills necessary for successful living and learning. Life skills are coping skills that can enhance the quality of life and prevent dysfunctional behaviour.

Life skills can also be described as the ability regarding adaptive and positive behaviour that enables individuals to deal effectively with the demands and challenges of everyday life (Visser, 2005:205). By changing how the individual thinks feels or makes decisions, one can also change his behaviour.

1.6 PRESENTATION OF THE RESEARCH REPORT

The research report comprises the following sections:

SECTION 1

ORIENTATION OF THE STUDY

Section 1 is a general introduction to and a brief overview of the research study. It also consists of the problem statement, motivation for the choice of study, aim of the study, central theoretical arguments, research methodology and procedure used during the research process, definitions of the terms, and conclusions and recommendations

SECTION 2

ARTICLE 1 ADOLESCENTS' KNOWLEDGE, SKILLS AND ATTITUDES CONCERNING HIV/AIDS AND LIFE SKILLS

Section 2 is directed at comparing the data collected to the existing literature. It is focused on the knowledge, skills and attitudes of the adolescents concerning HIV/AIDS and life skills. The findings of the empirical research are presented in this program.

SECTION 3

ARTICLE 2 GUIDELINES FOR A LIFE SKILLS PROGRAM FOR ADOLESCENTS

Section 3 focuses on the guidelines for a life skills program for adolescents. It consists of an introduction to the program on HIV/AIDS and a motivation for why there is a need for presenting a group work program. The preparation of the group and administrative aspects and a description of the group work program are also outlined. The content of the 10 sessions is described, along with the activities used for each session.

SECTION 4:

A SUMMARY OF THE MAIN FINDINGS, AND CONCLUSIONS AND RECOMMENDATIONS

Section 4 consists of an explanation of the conclusions and recommendations with regard to the research.

Sections 2 and 3 are written in article format. The author guidelines of The Social Work Practitioner-Researcher were adhered to, with the exception of the following deviations for purposes of this research report:

- Headings are numbered
- The report is typed in 1,5 spacing

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SECTION 2

ARTICLE 1

ADOLESCENTS KNOWLEDGE, SKILLS AND ATTITUDES REGARDING HIV/AIDS AND LIFE SKILLS

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OPSOMMING

MIV/VIGS word beskou as die grootste heersende krisis in Suid Afrika. Om hierdie siekte te beveg en te bestry is dit nodig dat die inwoners van Suid Afrika met die nodige kennis toegerus moet word om hulle houding en gedrag ten opsigte van MIV/VIGS te verander. Die aantal volwassenes wat as gevolg van die virus sterf, het tot gevolg dat 'n substantiewe komponent van die ekonomies produktiewe arbeidsmag uit die samelewing verdwyn. Dit het 'n omvangryke invloed op die huishoudings en die opvoeding van die kinders wat wees gelaat word. Hierdie navorsing is onderneem om die behoeftes van hierdie kinders te bepaal. Daar is ook ondersoek ingestel na die mate van kennis waaroor hulle beskik, asook hulle houding en gedrag met betrekking tot MIV/VIGS. As gevolg van die feit dat 'n leemte in die opvoeding van die jeug bestaan, is ook bepaal wat hulle kennis is in sake lewensvaardighede.

1. INTRODUCTION

HIV/AIDS has reached epidemic proportions in South Africa and has serious consequences for individuals as well as for the country's health resources and economy (Visser, 2005:204). An estimated 5,5 million South Africans – one in eight – are infected with HIV. Approximately three quarters of all new HIV infections occur amongst those aged between 15 and 25. A National survey of teenagers has found that one third of all youths between the ages of twelve and seventeen have had sex. Most children enter the education system HIV negative. A growing number leave school HIV positive and many more become HIV-positive shortly after leaving (Fenton, 2002).

Over the passed two decades various programs have been implemented in South Africa for the youth. According to Visser (2005:204), it was found that the educational programs and campaigns that focus on awareness do not necessarily encourage changed behaviour.

The researcher has therefore decided to use a life-skills approach to the education program of the adolescents. Life skills are the skills necessary for successful living and learning. Life skills are coping skills that can enhance the quality of life and prevent dysfunctional behaviour (Rooth, 1997:2). According to Ginter (1999:199), life-skills are the "learned behaviors that are necessary for effective living." Life-skills essentially represent the basic developmental building blocks of human existence – a client's intrapersonal and interpersonal existence.

Alongside factors such as HIV/AIDS, poverty, violence and unemployment, many teenagers in South Africa grow up without a conscientious and thoughtful caregiver and authority that is present. Furthermore, in conditions of poverty and overcrowding, the child's chances of developing a secure attachment to its primary caregiver are often greatly reduced. In this way, many adolescents have never experienced a trustworthy, consistent and meaningful connection to an adult who is always present and dependable (Becker, 2005:130-131). The majority of children in South Africa do not have the opportunity to learn life skills from their families. It is the school rather than parents that is now responsible for helping these children to develop and learn these life skills (Viljoen 1994:91). As a result, many South Africans feel despair and a sense of powerless concerning their lives. They have low aspirations and a poor self-esteem. To relieve their boredom and frustration, they turn to alcohol, drugs and sex (Basupeng, 2002:16).

The socio-economic impact of HIV/AIDS serves to create a vicious cycle of poverty and disease. As adult members of the household become ill and are forced to give up their jobs, the income of the households will drop, because expenditure on food comes under pressure, malnutrition often ensues, while access to other basic needs such as health care, housing and sanitation may also come under threat (Booysen, 2004:46). As a result of the above-mentioned opportunities for adolescents, both their physical and mental development is impaired.

In research done by Strydom (2002(a):64) 58,4% adolescents indicated that sex education is lacking. Adolescents strongly feel that they need more information.

Education and prevention programs are a necessary step to protect the youth from an unhealthy life style.

Demographic data were collected as part of a household census to estimate the prevalence of the living standards, habits and life styles of the adolescents and their families. The survey questionnaire addresses the adolescents' knowledge of and attitude towards a variety of health risk behaviours.

2. BACKGROUND INFORMATION

To minimize different interpretations of the same term, it is essential to define a number of key terms used in this research study.

2.1 HIV/AIDS

HIV (Human Immuno-deficiency Virus): the virus that leads to Aids.

AIDS (Acquired Immuno-deficiency Syndrome): the complications that follow when a damaged immune system cannot fight infections.

Recent statistics of the Department of Social Development (Anon 2004:6) reveal that South Africa has the second fastest growing epidemic in the world. Late adolescents and young adults are the groups with the highest HIV prevalence rates in South Africa, according to Strydom (2002(a):351). Based on antenatal data, it is estimated that 6,29 million South Africans were living with HIV by the end of 2004, including 3,3 million women and 104,863 babies.

According to a Report of the Education Labour Relations Council (2005:2-3), it is not only the children that drop out of school because of HIV/AIDS, thus reducing demand for educators, but educators, school managers and education policy makers are themselves dying of AIDS, thus reducing supply. Another challenge for the education sector is the orphans of parents who have died because of AIDS. This is because most people become infected between ages 15 and 24. According to the South African National HIV survey 2005, the researchers estimate that 10,8% of all South Africans over the age of 25 years were living with HIV in 2005. People do not die of AIDS but of opportunistic disease and infections which attack the body when immunity is low (Buthelezi, 2003:19).

2.2 ADOLESCENTS

According to Strydom, (2003:61) adolescence is normally referred to as the life cycle period between childhood and adulthood, beginning at puberty and ending with young adulthood. The life stage of adolescence is often accompanied by rapid growth and physical development, heightened sexual interest/activities and a struggle to find self-identity.

This secular trend probably reflects a change in nutrition, health care and living conditions. Youngsters are entering puberty earlier; this means that greater demands are being made on them to manage their emerging sexuality responsibly.

The adolescent period is a time of searching for an identity and clarifying a system of values that will influence the course of one's life. One of the most important needs of this period is to experience success that will lead to a sense of individuality and connectedness, which in turn leads to self-confidence and self-respect regarding uniqueness and sameness (Corey & Corey, 2002:306).

3. METHODS OF RESEARCH METHODOLOGY

The methods for investigation are a literature study and empirical research.

3.1 LITERATURE STUDY

A literature study was conducted on all aspects of the study. De Vos *et al.* (1998:179) stated that a researcher can only hope to undertake meaningful research if he is fully up to date with existing knowledge on this prospective subject.

The central focus of this study is a life skills program for adolescents to improve their social functioning. South African literature concerning life skills and education is important and is used in this research because the situation in South Africa differs from that in other countries.

Guidelines for a program on HIV/AIDS and life skills were formulated from the literature study and empirical research.

3.2 EMPIRICAL RESEARCH

3.2.1 Design

Babbie and Mouton (2001:55) define a research design as a blueprint of how the researcher intends to conduct the research. According to Grinnell (2001:183), the survey research procedure is a form of data collection because it provides a useful and convenient way of acquiring large amounts of data about individuals, organizations and communities.

In this research, the data were collected from the adolescents' families to estimate the prevalence of their living standards, habits and lifestyle, knowledge, attitude and behaviour regarding AIDS.

A questionnaire for this study used both open–ended and closed–ended questions. De Vos *et al.* (1998:89) state that "a questionnaire is an instrument with open- or closed-ended questions or statements to which a respondent must react". Open ended questions afford the respondent the opportunity of writing any answer in the open space. Closed-ended questions afford the respondent the opportunity of selecting (according to instructions) one or more response choices from a number provided (De Vos, *et al.* 2005:174). According to Grinnell (2001:190), in closed–ended questions, responses can be selected from a number of specified choices. The open–ended questions are designed to permit for responses; they are not forced to choose among alternatives.

Both a qualitative and quantitative research approach was used in this survey. According to Straus and Corbin (1998:10–11), qualitative research refers to research on persons' lives, lived experiences, emotions and feelings, as well as on organizational functioning social movements.

3.3 PARTICIPANTS

This study forms part of the PLAY project of the North-West University (Potchefstroom Campus).

A convenience sample of scholars N = 206 in grade 9 (13–18 years old) from a high school in Ikageng. Seiphemelo High School, Potchefstroom in the North West Province, South Africa was followed up from 2004 as the intervention group. Sixty-four grade 9 children from Boithoko High School in the same township were followed up as the control group. Permission to do this study was obtained from the principals and parents. The schools were visited in order to explain the 2005 protocol to the teachers, parents and children to obtain permission from the principals and to obtain informed consent from the parents of the children.

The research, as part of the PLAY project, was approved by the Ethics Committee of the North-West University.

3.4 DATA COLLECTION

A structured questionnaire was used to obtain the demographic data of the adolescents. The data was used to describe the study sample, since social economic status could possibly have an effect on the general health and development of children.

The questionnaire also focused on the knowledge, attitudes beliefs and opinions of adolescents concerning HIV/AIDS and related matters.

3.5 PROCEDURES

The research design steps, as set out by De Vos, *et al.* (1998:49), were followed as procedure to develop the program. The quantitative paradigm is based on positivism, which takes scientific explanation (i.e. based on universal laws). Its main aims are to objectively measure the social world to test hypothesis and to predict and control human behaviour (De Vos *et al.* 1998:240).

The research design steps of a quantitative approach according to De Vos *et al.* (1998:49) were followed, and included the following:

TABLE 1: STEPS OF A QUANTITATIVE APPROACH.

STEPS IN THE RESEARCH PROCESS	QUANTITATIVE
STEP 1	CHOOSE A RESEARCH PROBLEM/TOPIC/THEME
STEP 2	IDENTIFY THE PROBLEM
STEP 3	REVIEW THE RELEVANT LITERATURE AND RELATED RESEARCH
STEP 4	FORMULATE THE PROBLEM FORMALLY
STEP 5	WRITE OUT A RESEARCH PROPOSAL
STEP 6	DEFINE EACH OF THE CENTRAL CONCEPTS THEORETICALLY AND OPERATIONALLY
STEP 7	REFORMULATE THE RESEARCH PROBLEM IN THE FORM OF TESTABLE HYPOTHESES
STEP 8	SELECT A RESEARCH DESIGN
STEP 9	SELECT THE DATA COLLECTION METHODS AND MEASURING INSTRUMENTS
STEP 10	CONDUCT A PILOT STUDY
STEP 11	DRAW THE SAMPLES
STEP 12	COLLECT DATA (I.E. EXECUTE THE SELECT THE RESEARCH DESIGN)
STEP 13	PROCESS, ANALYSE AND INTERPRET THE DATA
STEP 14	WRITE THE RESEARCH REPORT

3.6 ETHICAL ASPECTS

Strydom (2002(b):24) explains that ethical guidelines serve as standards and the basis upon which each researcher ought to evaluate his own conduct. For purposes of this research, the following aspects were identified. Approval was given for this research by the Ethics Committee of the North-West University. In this research the following aspects need attention:

- It was ensured that the findings do not impact negatively on the adolescents.
- Informed consent was obtained from the adolescents and all the aspects of the research were explained before participation.
- To ensure that all ethics are practiced, the questionnaire was done anonymously and the individual was not disclosed.
- Conditions of privacy and confidentiality were maintained because proper, scientific sampling was used and the researcher and a few members of the staff were aware of the identity of the participants.
- It will also ensure that the information provided would remain confidential because the researcher will watch jealously over the information confided to her.

3.7 DATA ANALYSIS

Data collection was analysed. De Vos *et al.* (1998:203) point out that the purpose of analyzing is to reduce data to an intelligible and interpretable form so that the relations of research problems can be studied and conclusions drawn.

3.8 MEASURING INSTRUMENT

A structured questionnaire is used to obtain demographic data of the adolescents. The data is used to describe the study sample, since social economic status could possibly have an effect on the general health and development of children.

4. RESULTS AND DISCUSSION

4.1 DETAILS OF RESPONDENTS

The scholars (N=206) grade 9 and between aged 13 and 18 from the Seiphemelo High School in Potchefstroom was the intervention group. Sixty-four scholars from Boithoko High School in the same township were followed up as the control group. All the children completed the questionnaire.

4.2 BIOGRAPHICAL DATA

People in household

A question was asked about the number of people in the households. They responded as follows:

TABLE 2: NUMBER OF PEOPLE IN HOUSEHOLDS

NUMBER OF PEOPLE	F	%	FX	% (FX)
TWO PEOPLE	7	2,63	14	0,98
THREE PEOPLE	29	10,90	87	6,08
FOUR PEOPLE	68	25,56	272	19,02
FIVE PEOPLE	46	17,29	230	16,08
SIX PEOPLE	50	18,80	300	20,98
SEVEN PEOPLE	33	12,41	231	16,15
EIGHT PEOPLE	18	6,77	144	10,07
NINE PEOPLE	7	2,63	63	4,41
TEN PEOPLE	4	1,50	40	2,80
ELEVEN PEOPLE	2	0,75	22	1,54
THIRTEEN PEOPLE	1	0,38	13	0,91
FOURTEEN PEOPLE	1	0,38	14	0,98
TOTAL	N=269	100	1430	∑FX =100

Table 2 reveals that the largest number of people living in a house is 4 (25,56%). It usually becomes crowded if you are 4 or more people living in that confined space. According to Potgieter (1998:65), rural poverty is characterized by over-crowded living conditions in inadequate housing structures. The urban poor, on the other hand, live in high density shacks under unsafe conditions that provide inadequate shelter. From Table 2 it becomes clear that the highest percentage of people that lived in one house is between nine and fourteen (5,64%). In 50 houses there are 6 people (18,80%) and in 46 houses there are 5 people (17,29%). It seems that a high percentage of the households are overcrowded. A disadvantage of these crowded living conditions is that it causes a negative lifestyle. According to Modise (2005:21), it can also cause additional problems such as financial, emotional and psychological as well as housing problems.

4.2.2 Rooms in the house

A question was asked concerning the number of rooms the house consists of. The following information describes the rooms in each house.

TABLE 3: ROOMS IN HOUSES

HOUSES	F	%	FX	%(FX)
2	1	0.80	2	0.25
36	2	14.34	72	9.02
32	3	12.75	96	12.03
87	4	34.66	32	4.01
34	5	13.55	170	21.30
29	6	11.55	174	21.80
16	7	6.37	112	14.04
6	8	2.39	48	6.02
4	9	1.59	36	4.51
2	10	0.80	20	2.51
1	11	0.40	11	1.38
1	12	0.40	12	1.5
1	13	0.40	13	1.63
TOTAL	N=91	100	798	∑FX = 100

According to the table above, houses with 4 rooms is the most at 87 (34,66%). Only five houses are really big with 10-13 rooms. Overcrowding is a problem due to the size of the house and the number of occupants living in them. The negative effect of this is increased by the poverty rate in some areas. According to Evian (2000:22), poverty creates the conditions and environment which contribute to the spread of HIV such as overcrowding, poor recreation options and poor access to health care.

4.2.3 Rooms for sleeping

A question was asked about the quantity of sleeping room facilities. The respondents answered as follows:

TABLE 4: ROOMS FOR SLEEPING

HOUSES	F	%
122	2	48.61
66	3	26.29
39	1	15.54
21	4	8.37
2	5	0.80
1	6	0.40

A total of 122 houses consist of two bedrooms and 66 houses consist of three bedrooms. That is adequate for good living conditions. A problem may arise if a large family is living in a house

with only two or three bedrooms, as in some instances up to eight or more people are living together in this type of house.

4.2.4 Age distribution

A question was asked about the ages of the inhabitants of the household. The respondents answered as follows:

TABLE 5: AGE DISTRIBUTION

AGE	GENDER	F	%
0 – 1	MALE	16	1.81
	FEMALE	3	0.34
1 – 6	MALE	86	9.71
	FEMALE	30	3.39
7 – 12	MALE	92	10.38
	FEMALE	19	2.14
13 – 18	MALE	148	16.70
	FEMALE	68	7.67
19 – 30	MALE	83	9.37
	FEMALE	40	4.51
31 – 45	MALE	101	11.40
	FEMALE	71	8.01
46 – 60	MALE	80	9.03
	FEMALE	22	2.48
60+	MALE	17	1.92
	FEMALE	10	1.13
TOTAL	MALE	623	100
	FEMALE	263	100
	TOTAL	N=886	100

From the Table 5 it becomes clear that most of the residents are children between birth and 18 years 462 (52,14%). Children and young adults are a vulnerable group of people and should be prepared to handle different situations in their lives. The age group that is most affected by HIV, according to Roux (2002:73) and Whiteside and Sunter (2002:32) is that between fifteen and forty five years of age. If the age of the respondents in this survey is taken into consideration, it is evident that many of the people in these communities are in this age group and is vulnerable to be infected and affected by HIV. This is one of the reasons why effective prevention among young people is essential. This could form a life skill program.

4.2.5 Home language

A question was asked to the respondents about the home language and their ability to read and understand English.

TABLE 6: HOME LANGUAGE

LANGUAGE	F	%
TSWANA	146	58.17
SOTHO	63	25.10
XHOSA	39	15.54
OTHER	3	1.20
TOTAL	N=270	100

From Table 6 it is evident that 146 (58,17%) respondents are Tswana-speaking, 63 (25,10%) are Sotho-speaking and 39 (15,54%) are Xhosa-speaking. The majority of respondents are Tswana-speaking and a Life Skills program could be presented in Tswana.

4.2.6 Language of household head speaks

A question was asked about the language that the head of the household speaks. The respondents answered as follows:

TABLE 7: LANGUAGE OF THE HEAD OF THE HOUSEHOLD

LANGUAGE	F	%
TSWANA	166	75.11
SOTHO	54	24.43
XHOSA	1	0.45
TOTAL	N=270	100

From the results of Table 4, 166 (75,11%) house heads speak Tswana. Fifty-four (24,43%) are Sotho-speaking and 1 (0,45%) are Xhosa-speaking.

4.2.7 Reading and understanding of mother language

A question was asked whether the respondents understand their mother language. The respondents answered as follows:

TABLE 8: READ AND UNDERSTAND MOTHER LANGUAGE

LANGUAGE	F	%
EASY	157	62.80
DIFFICULT	59	35.60
NOT AT ALL	4	1.60
TOTAL	N=220	100

Table 8 clearly indicates that 157 (62,80%) of the respondents can read and understand their mother language. A total of 59 (35,60%) find it difficult to read and understand their mother language. 50 Respondents did not complete the questionnaire. That could result in educational problems because the respondents are in high school already and are supposed to be quite literate at their age.

According to the above-mentioned results it is obvious that life skills and prevention programs on HIV/AIDS should be available in Tswana, Sotho and Xhosa. Children should also be educated in their home language and their specific culture.

4.2.8 Head of the family

The respondents were asked who the head of the family is. A total of 269 households were included. One respondent did not complete the questionnaire.

TABLE 9: HEAD OF THE FAMILY

HEAD OF THE FAMILY	F	%
FATHER	137	50.93
MOTHER	70	26.02
GRAND FATHER	16	5.95
GRAND MOTHER	28	10.41
UNCLE	7	2.60
AUNT	6	2.23
FRIEND	1	0.37
SIBLING	4	1.49
TOTAL	N=269	100

On average, the head of the family is the father 137 (50,93%). In 70 (26,02%) cases the mother was the head and in 28 (10,41%) the grandmother was the head. In 16 families (5,95%) the grandfather was the head of the family. In seven households (2,60%) an uncle was the head of the family and in six households (2,23%) an aunt was the head of the family. At four households (1,49%) siblings were the heads, and in one household a friend (0,37%) was the head of the family.

In this study it was found that the father is still the head of the family, but that four (1,49%) siblings are the heads of their families, and this should be noted. Children infected/affected by the death of their parents are faced with the challenge of taking care and supporting the younger siblings, and as a result of that experience a heavy responsibility. Drower (2005:102) points out that the impact of HIV/AIDS is " seen at the level of the family where poverty and the number of child headed households increase with the illness and death of the breadwinner, community support structures and coping mechanisms are laced under severe strain".

4.2.9 Breadwinner in the household

A question was posed as to who the breadwinner in the household is? Some of the 270 respondents give more than one breadwinner in a household. The respondents answered as follows:

TABLE 10: THE BREAD WINNER

BREADWINNER	F	%
FATHER	45	14,24
MOTHER	89	28,18
BOTH	65	20,57
GRAND FATHER	12	3,80
GRAND MOTHER	21	6,65
UNCLE	26	8,23
AUNT	21	6,65
FRIEND	2	0,63
SIBLING	35	11,05
TOTAL	N=316	100

The amount of money that people earn in their different occupations serves as an indication of the families' overall living standards. According to Table 10, eighty-nine mothers (28,18%) were the breadwinners in most of the households and secondly the father at 45 (14,24%). The households where both parents received an income are 65 (20,57%) and it is fairly high. Regarding gender, Table 10 indicates that in 21 (6,65%) households the grandmother has a higher working percentage than the grandfather 12 (3,80%). The working rate of the 35 (11,05%) siblings show a high percentage, which is of grate concern.

The survey shows that the main financial support in the households is the females and that there is a high percentage where a brother or sister or both support the family. The high unemployment rate of the father figure results in more pressure on the female breadwinner.

4.2.10 Profession of the breadwinner

In the survey done from 270 questionnaires of the profession of the breadwinner, the following responses were received.

TABLE 11: PROFESSION OF THE BREAD WINNER

PROFESSION	F	%
PROFESSIONAL	19	4.91
OWN BUSINESS	11	2.84
OFFICE WORKER	7	1.81
FACTORY WORKER	75	19.38
DOMESTIC WORKER	122	31.52
OTHER	115	29.72
NOT WORKING	38	9.82
TOTAL	N=270	100

In the survey done from 270 questionnaires concerning the profession of the breadwinner it is revealed that the largest proportion, namely 122 (31,52%), is working as cleaners. People in other professions is 115 (29,72%), factory workers 75 (19,38%) and people in professional jobs is 19 (4,91%). Eleven people (2,84%) have their own businesses, and office workers were seven (1,81%). In thirty-eight (9,82%) households the unemployment rates are high and it can be expected to have a serious impact on health, through both negative material impacts and negative social factors. Work in private households, including domestic work predominantly done by females, accounted for the highest percentage. In an assessment of child poverty in South Africa (Dieden & Gustafsson, 2003:337), a conclusions was drawn that two-thirds of South Africa's poorest children live in households lacking a regular wage and that the possibility of being poor increases if the household head is a female.

4.2.11 Age of the breadwinner

A question was asked about the age of the breadwinner, and the respondents answered as follows:

TABLE 12: AGE OF THE BREADWINNER

AGE	F	%
19	2	0.53
20 – 30	59	15.78
31 – 40	139	37.17
41 – 50	115	30.75
51 – 60	47	12.57
61 – 70	8	2.14
71 – 80	3	0.80
81 – 90	1	0.27
TOTAL	N=270	100

The highest percentage 37,17% (139) of the household is between ages 31 and 40, followed by the age group 41 to 50 with 30,75% (115). The third group is between 20 to 30 years, with 15,78% (59) and the fourth group between 51 to 60 with 12,57% (47). The fifth group is between 61 and 70 years (2,14%) with eight. The age group 71 to 81 is (0,80%). The inhabitants that resort under the age group 31-50 can be seen as the most vulnerable in the household. Mashologu-Kuse (2005:380) says that the AIDS pandemic affects the family economically; income drops if the HIV/AIDS sufferer was a breadwinner before contracting the virus/disease. The situation leads to child headed families. In this survey it becomes clear that the persons between 31 and 50 are the breadwinners in the household. If they become ill and die, it will seriously affect the children. Recent statistics show that South Africa has the second fastest growing epidemic in the world with nearly 5 million people already infected. This implies that there will be vast differences in family composition as a result of an increase in the number of HIV/AIDS-related death reports (Modise, 2005:21.) This information clearly indicates that the respondents are affected in their earliest years of development.

4.2.12 Grants received in households

The respondents were asked whether the household received any grants. The total number of persons in the household that answered yes was 160 and of those who answered no were 110. The type of grants consisted of old age pension, disability grant and child support grant. Because the questionnaire was completed by adolescents, it is possible that they are not fully informed about the amount and type of grants that were received in the household. It could be much more than they know of. A social grant plays an important role in alleviating poverty, and occasionally it is the only source of income for a family. Arlington and Lund (1995:65) point out that pensions are often the lifeline of the South African poor and that 50% of households that received a pension were kept out of the low or destitute groups. The socio-economic impact of HIV/AIDS serves to create a vicious cycle of poverty and disease. As adult members of the household become ill and are forced to relinquish their jobs, household income will fall (Booysen, 2004:46). South Africa has a well developed system of social security. According to Barrett-Grant et al. (2001:274), "(t)he South African Government accepts that it has a

responsibility to care for people who cannot take care of themselves". Mashologu-Kuse (2005:384) states that research shows that the most HIV/AIDS infected and affected people come from large families that are unemployed and live on child support grants, which brings about "coping" with desperate financial problems.

It became clear that these households experience an enormous burden of morbidity and mortality because of the high level of chronic illness, the orphan crisis and poverty.

4.3 HOUSEHOLD DATA

Potgieter (1998:69) mentions that the White Paper for Social Welfare (1997) saw social welfare as "an integrated and comprehensive system of social services, facilities and programs and social security to promote social development, social justice and the social functioning of people. Social Welfare forms part of a whole range of services and mechanisms that aim to achieve social development and to include health, nutrition, education, housing, recreation, rural and urban development land reform.

4.3.1 Household type

Two hundred and fifty-one responded to questions pertaining to household matters.

A question was asked about the type of household they live in.

TABLE 13: HOUSEHOLD TYPE

TYPE	F	%
HUT	15	5,98
MAKUKU	99	39,44
BRICK	131	52,19
OTHER	6	2,39
TOTAL	N=251	100

The highest percentage 52,19% (131) of the respondents and their families live in brick homes and 39,44% (99) in informal building structures (makuku.) A total of 5,98% (15) lived in a hut and 2,39% (6) in other forms of housing. The reason why this question was asked was to establish the circumstances the children and family have to live in. One hundred and twenty (60,56%) live in homes which are unsafe and provide inadequate shelter. The data indicate that these children are at risk and vulnerable due to their living conditions, and most of the time, this situation results in a negative life style. According to Poku (2001:203) social and economic problems create a particular vulnerability to the devastating consequences of the AIDS Epidemic.

4.3.2 Sources of drinking water

A question was asked about the source of drinking water in the household:

A total of 249 respondents responded to the question of the availability of drinking water.

TABLE 14: SOURCES OF DRINKING WATER

SOURCE	F	%
WATER IN HOUSE	73	29,32
BOREHOLE	4	1,61
TAP IN YARD	137	55,02
PUBLIC TAP	34	13,65
WATER CARRIER	1	0,40
TOTAL	N=249	100

The information above indicates that 73 (29,32%) households have taps in their houses for the purpose of drinking water and 137 (55,2%) have access to a tap in the yard. A total of 34 families (13,65%) make use of a public tap. Although a high percentage of households 73 (29,32%) have access to water in their houses, there is a large total of 137 (55,29%) that experienced inconvenience in the sense that there is no water in the house. For 34 (13,65%) it is even more inconvenient because they have to walk a distance and carry the water back to the house.

4.3.3 Time to get to drinking water

According to a question asked about the time it takes them to get to drinking water, the responses were as follows: A total of 164 responded to the question. The reason why only 164 respondents answered the question was that 73 have water in their houses and thirty three did not complete the questionnaire.

TABLE 15: TIME TO GET TO DRINKING WATER

TIME	F	%
1-4 MINUTES	133	81,10
5-7 MINUTES	17	10,37
10-15 MINUTES	10	6,10
20-30 MINUTE	4	2,44
TOTAL	N=164	100

From the survey it becomes clear that for a total of 133 families (81,10%) it takes between 1- 4 minutes to get to drinking water. For seventeen families (10,37%) it takes 5–7 minutes, for ten (6,10%) it takes between 10 and 15 minutes and for four (2,44%) it takes from 20 to 30 minutes. This indicates that most of the people have enough water at close proximity.

4.3.4 Toilet facilities

When the respondents were asked about the type of toilet facilities they use, only 249 complete the questionnaire. The 249 respondents answered as follows:

TABLE 16: TOILET FACILITIES

FACILITY	F	%
FLUSH	140	56.22
FLUSHED SHARED	52	20.88
BUCKET	16	6.43
PIT	33	13.25
NO	7	2.81
OTHER	1	0.40
TOTAL	N=249	100

Data collected on the question concerning toilet facilities revealed that 140 (56,22%) of the households have a flush toilet at their disposal, and 52 (20,88%) of them share a flush toilet near the house. Thirty three (13,25%) make use of a pit toilet and sixteen (6,43%) make use of the bucket system and seven (2,81%) did not have access to a toilet. It is known that diseases and sickness are often due to insufficient sanitation facilities. In this instance it is clear that adequate sanitation is provided to most of the families. A total of fifty-seven families (22,89%) make use of unhygienic toilet facilities, which can lead to infections and diseases. According to Roux (2002:213-217), good hygiene is important to prevent infections and to care for the HIV/AIDS-infected person.

4.3.5 Cooking facilities

A question was asked as to what the household uses for cooking?

A total of 192 respondents answered the question as follows:

TABLE 17: COOKING FACILITIES

FACILITY	F	%
ELECTRICITY	155	80.73
GAS	2	1.04
PARAFFIN	34	17.71
WOOD	1	0.52
TOTAL	N=192	100

As displayed in Table 17, 80,73% of the households (155) make use of electricity. Thirty-four (17,71%) use paraffin. A total of two families (1,04%) use gas in the household and one (0,52%)

uses wood. There is proper electrical infrastructure available in the area, but it is not always affordable to all the people.

4.3.6 Floors

The respondents were questioned on the kind of material used for floors in their homes. A total of 251 responded to the question.

TABLE 18: FLOORS

MATERIAL	F	%
CARPET	57	22.71
WOOD	1	0.40
CEMENT	131	52.19
EARTH SAND	7	2.79
VINYL	25	9.96
CERAMIC TILES	29	11.55
OTHER	1	0.40
TOTAL	N=251	100

The data indicate that the highest percentage 52,19% of households (131) have cement floors and 22,71% (57) also have carpets on the floor. The third group 11,55% (29) have ceramic tile floors and 9,96% (25) have vinyl floors. A total of 3,19% (8) houses have a type of inadequate flooring. This information indicates a relatively high standard of living conditions.

4.3.7 Walls

A question was asked about the main material used for building the house to obtain a better idea of the living conditions of the people. The respondents answered as follows:

TABLE 19: WALLS

MATERIAL	F	%
PLASTER	3	1.20
CEMENT	13	5.18
OTHER	2	0.80
CORRUGATED IRON	110	43.82
PREFAB	6	2.39
BARE BRICK	109	43.43
PLASTIC	1	0.40
MUD	7	2.79
TOTAL	N=251	100

The data illustrated in Table 19 indicate that most of the houses 43,82% (110) are built from corrugated iron and 43,43% (109) were built with bare bricks. In thirteen (5,18%) cement was used, and for 2,79% (7) houses, mud walls were also used to a certain extent. Six houses (2,39%) were built from prefab material. In exceptional cases they made use of plaster, plastic and other materials. From this data it is evident that half the respondents live in adequate and safe houses and the others in unacceptable circumstances because makukus pose unsafe living conditions.

4.4 HOUSEHOLD FACILITIES

4.4.1 Household appliances

To a question concerning the household facilities they use in the household the respondents answered as follows:

TABLE 20: HOUSEHOLD APPLIANCES

TYPE OF APPLIANCES	F	%
ELECTRICITY	241	96.02
RADIO	223	88.84
TELEPHONE	54	21.51
CELL PHONE	154	61.35
REFRIGERATOR	190	75.70
WASHING MACHINE	63	25.10
COMPUTER	6	2.39
	N=251	

A variety of answers could be given in this question. The households have many appliances that are needed to make life easy and comfortable. The fact that 223 (88,84%) have radios indicates that radio programs can be use to educate people regarding HIV/AIDS. A high percentage of households, namely 190 (75,70%), indicated that they do have a refrigerator. This means that

they can buy fresh meat, vegetables and fruit which could improve their living standard and especially their diet.

4.4.2 Transport

A question was asked about the transport they own for private use. The respondents answered as follows:

TABLE 21: TRANSPORT

TRANSPORT	F	%
CARS	68	27.09
MOTOR CYCLE	13	5.18
BI-CYCLE	138	54.98
NONE	51	20.32
TOTAL	N=270	100

According to the data in Table 21 most of the households 138 (54,98) use a bicycle. Families who owned a vehicle are 68 (27,09%) which is fairly high for that type of community. There are 51 (20,32%) families that have no means of transport, and public amenities are their only way of transport.

4.5 HEALTH INFORMATION

4.5.1 Health and access to Health care services

A key policy goal of the new Government was to achieve universal access to primary health care, a shift of knowledge to be progressive, poor-friendly and sensible, in that it focuses on prevention rather than cure. The Government is also committed to prioritize the health needs of vulnerable groups such as rural, peri-urban and urban poor, and woman and children (May & Govender, 1998).

Provision of primary health care services is still a major challenge in developing countries where poor geographical accessibility adversely affects the use of medical services and consequently the health of the local population. Due to the afore-mentioned it was important to do the research on health care in this specific area with the 270 respondents.

4.5.2 Nearest clinic

In the Ikageng Township where this survey was done, seven clinics are available to the community. The data was collected from 240 households. Thirty questionnaires were not completed. The reason why they did not answer the question might be because they do not know where the clinics are situated

TABLE 22: CLINIC FACILITIES

NAME OF CLINIC	F	%
TOP CITY	141	58,75
STEVE T	32	13,34
LESEGO	26	10,83
POTCHEFSTROOM	21	8,75
PROMOSA	11	4,58
BOIKI	6	2,50
MOHADIN	3	1,25
TOTAL	N=240	100

There are seven clinics available in the area where the participants live and the one that is most used is the Top City Clinic where 141 (58,75%) of all the participants make use of the services. The reason for this might be because it is the nearest clinic for the households who took part in the study.

According to Tsoka and Le Sueur (2004:239), equal accessibility to clinic services for the entire population has been incorporated with a decentralized district health system in South Africa. Access to a clinic is important for every family and thereof the distance from homestead to clinic should not be more than 5 km.

4.5.3 Time to walk to the nearest clinic

A question was asked about the time frame connected to the distance between the household and the clinic. The respondents responded as follows:

TABLE 23: TIME TO WALK TO THE NEAREST CLINIC

MINUTES	F	%
1 TO 5 MINUTES	19	7.92
6 TO 10 MINUTES	10	4.17
11 TO 20 MINUTES	38	15.83
21 TO 30 MINUTES	103	42.92
31 TO 45 MINUTES	20	8.33
46 TO 60 MINUTES	33	13.75
61 TO 120 MINUTES	4	1.67
DON'T KNOW	13	5.41
TOTAL	N=240	100

According to the survey, one-hundred and three of the families (42,92%) have to walk between 21 to 30 minutes to a clinic. Thirty-eight (15,83%) people have to walk between 11-20 minutes. A total of 33 (13,75%) families have to walk 46 to 60 minutes and 20 (8,33%) have to walk 31 to 45 minutes to the nearest clinic. From the data it is clear that the distance from the health

facility to the homestead is not the ideal time limit. That means that most of the participants traveled more than the world health organizations recommended 5 kilometers for the location of a health facility (Tsoka & Le Sueuer, 2004:330). It indicates that accessibility is inadequate. The health care system of South Africa is clearly overburdened and poorly equipped to handle health problems (Demmer, 2004:61). It is clear that there is a shortage of clinics in this township and that much effort must be put into planning facilities and providing health.

4.5.4 Transport used

The question was asked about transport used to visit a health facility. The reason why this question was asked was to determine what type of transport the families use to visit a health facility.

TABLE 24: TRANSPORT USED

TRANSPORT	F	%
WALK	210	87,50
TAXI	24	10,00
OWN CAR	6	2,5
TOTAL	N=240	100

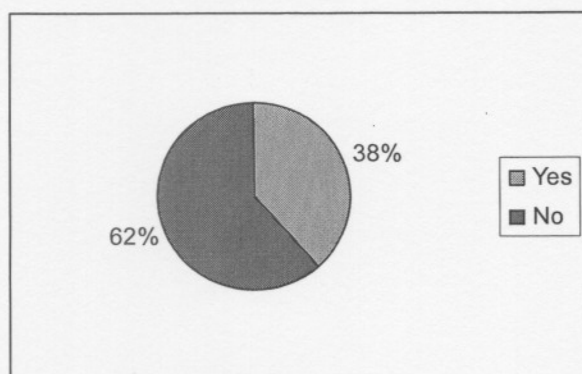
As seen from the results in Table 24, the number of families that make use of transport is much less than the 210 (87,50%) who have to walk to a health facilitation for medical attention. From this data it is clear that primary health care is within walking distance but it is still not adequate, because the walking distance is more than the required 5 kilometers. Only 24 (10%) are able to afford a taxi fare and six families can travel with their own car. It became clear that the needs of the participants are only being partially met by the formal health sector. Seyama (2006:19) also indicates in her research that it is obvious that the clinic plays an important role in the community in helping people to cope with the HIV/AIDS pandemic.

- **Total of deaths**

The question was asked whether anyone in the household had died in the past twelve months. A total of 237 responded to the question.

In the group that completed the survey a total of 91 (38%) respondents answered yes to the question and 146 (62%) answered no.

FIGURE 1: TOTAL OF DEATHS IN THE PAST 12 MONTHS



A total of 237 respondents answered the question and the response was that 91 (38%) family members of the respondents died in the past twelve months. It is obvious that the total of death's that had occurred in the families is exceptionally high. The emotional toll on these families and other loved ones is enormous. Demmer (2004:299) points out that they have to cope with shock, sadness, frustration and helplessness, as they witnessed the decline of their loved ones. Geballe *et al.* (1995:101) stated that the role children, particularly older children, are assumed in caring for parents becoming increasingly ill and for surviving siblings, children (even young children) may be expected to function as primary caregivers. After a parental death, children's needs for love, support and care are enormous. Meeting their basic physical and emotional needs is a necessary precondition to permit mourning. If these needs are unmet, mourning may be inhibited because anxiety leads them to deny loss (Bar & Elford, 1998:265.) The survey shows that the respondents are in need of emotional support due to the total of deaths in the households.

- **Reason for death**

To a question regarding the reason of death, they answered as follows:

TABLE 25: REASON FOR DEATH

REASON	F	%
DIARRHEA	6	6.59
TB	14	15.38
SICK\LUNG	40	43.96
HEART	2	2.20
OLD AGE	5	5.49
BABIES	3	3.30
ACCIDENTS	9	9.89
CANCER	12	13.19
TOTAL	N=91	100

It is clear from Table 25 that the largest cause of deaths, namely 40 (43,96%), was "sickness" and lung diseases. If one correlates these statistics with the statistics in figure 1, it becomes clear

that the deaths in these figures might have been caused by AIDS. Due to the fact that the HIV virus attacks the immune system it is clear that lung diseases and also TB are related to AIDS deaths. A report released by the South African Medical Research council in July 2001 indicates that AIDS had become the leading cause of death in South Africa, and it was estimated that 40% of all adult deaths were now due to AIDS (Dorrington, Bourne, Bradshaw, Laubscher & Timaeus, 2001:4). Bradshaw and Nannan (2001:55) emphasize that the Aids epidemic has fuelled the TB epidemic and has also resulted in increased deaths due to pneumonia, diarrhea and other indicator conditions. As the immune system weakens, new infections occur in increasing frequency, severity and duration until the person dies (Becker, 2005:104). In this research 152 (64,14%) of the children did not know the cause of the death in the families. This correlates with the research of Modise (2005:29) that there is still no open communications between family members regarding issues like HIV/AIDS.

5. SPIRITUAL NEEDS

5.1 CHURCH

A question was asked as to whether they belonged to a church, and they responded as follows:

It became clear that most people belong to a church. Out of 270 families, 265 (98,15%) answered yes and only 5 (1,85%) no. Spirituality can be seen as important in the lives of these people. It is therefore of paramount importance for a social worker to determine a client's view on the matter to ensure an accurate and comprehensive assessment (Kruger & Williams, 2003:349). The current research confirms the theory which acknowledges that spirituality fosters a sense of meaning, purpose and mission in live. Spirituality, to a great extent, determines a person's perception of his or her self-image and relationship with the natural world as well as with a metaphysical domain (Pellebon & Anderson, 1999:230), and provides meaning and purpose to life, regardless of a person's social standing (Gotterer, 2001:192).

5.2 NAME THE CHURCH

From Table 26 it becomes clear that most of the families 53 (19,63%) belong to the Roman Catholic Church. The fact that only five (1,85%) respondents indicated that they did not belong to a church is important.

TABLE 26: CHURCHES

NAME OF CHURCH	FREQUENCY	%
APOSTOLIC	38	14,07
ROMAN CATHOLIC	53	19,63
ANGLICAN	29	10,74
AME	22	8,15
Z.C.C.	15	5,56
METHODIST	16	5,93
REFORMED	34	12,59
OTHER	58	21,48
NO CHURCH	5	1,85
TOTAL	N=270	100

What is of major importance is the fact that 98,15% of the respondents belong to a church. Van Dyk, 2002:320) points out that all religious institutions should be encouraged to become involved in HIV/AIDS care and counseling in an organised manner by, for example, financially and physically supporting existing hospices or (when necessary) by founding such caring facilities. In the face of the HIV/AIDS pandemic, religious institutions will have to redefine their usual way of 'caring for the poor'. It has become clear that there is a need to engage in prevention in education programs while paying attention to the spiritual and physical need of people who suffer from HIV/AIDS.

5.3 SPECIFY WHY YOU HAVE SPIRITUAL NEEDS

The qualitative nature of this research seemed appropriate as it provides reason as to why families think they need God and the church in their lives. The following responses serve as an illustration of their reasons.

A Total of 86 (31,85%) respondents answered that they need God in their life. Sixty three respondents answered that it is essential to serve God in the way you live. Ninety-one respondents answered that they need to pray to God for He is the creator of everything and you cannot live without Him. Twenty-five respondents answered and gave reasons pertaining to the importance of God and mentioned that they derive hope through their spirituality, resulting in their coping capacity being enhanced. It is clear that they believe in God as a supreme power and that one needs God in your life and also that prayer is important to heal, to help, to forgive sins, to trust and to believe in. Only five respondents (1,85%) answered that they do not have spiritual needs.

5.4 SPIRITUALITY

The respondents were asked where they go when they need Spiritual help? They answered as follows:

TABLE 27: SPIRITUALITY

SPIRITUAL NEED	F	%
CHURCH	162	60
PARENTS	82	30,37
GOD	12	4,45
TEACHER	4	1,48
FRIENDS	2	0,74
NO ONE	8	2,96
TOTAL	N=270	100

From Table 27 it becomes clear that most of the participants 162 (60%) and their families go to church when they need spiritual help. It also indicates that the adolescents see their parents as their second choice 82 (30,37%) when they need spiritual help. Twelve (4,45%) indicated that they turn to God for spiritual help. The rest go to teachers and friends and eight (2,96%) do not seek spiritual help at all.

In this research it is clear that a church offer the community the necessary support. It places an enormous responsibility on the church to play a more important role in taking care and empowering its members. The church offer norms and standards for behaviour but also support in a community where adolescents have to deal with the tragedy of sickness and death that HIV/AIDS creates. The fact that they believe that one has spiritual needs shows that they believe in God as a supreme power and that they need God in their lives and also that prayer is very important.

According to Hodge (2001:211), the feeling of strength derived from spirituality is seen by many as most important or at least significant. Research done by Damianakis (2001:24) has indicated many positive characteristics associated with spirituality, amongst others, coping capacity, feelings of empowerment, resilience, capacity to deal with poverty, increased levels of interpersonal influence on relationships, life satisfaction and physical and emotional health. Exploring the value of spirituality in their lives can highlight possible spiritual resources and provide inspiration, security and guidance (Hodge & Williams, 2002:591). It is also evident that parental influence on religious beliefs applies in this survey. Spirituality has a positive effect in the sense that a person feels that he is not alone in his suffering; that there is a higher being with them.

6. HABITS AND LIFESTYLE

The socio-economic impact of HIV/AIDS combines to create a vicious cycle of poverty and HIV/AIDS in which affected households are caught up. As adult members of the household became ill and are forced to relinquish their jobs, household income will fall. To be able to cope with a change in income and a need to spend more on health care, children are often taken from school to assist in caring for the sick or to work so as to contribute to household income, because

expenditure on food comes under pressure, malnutrition often results while access to other basic needs such as health care, housing and sanitation also comes under threat (Booysen, 2003:419).

6.1 STARVATION

To a question as to whether people in the household go hungry, a total of 251 respondents responded as follows:

TABLE 28: STARVATION

	FREQUENCY	%
OFTEN	60	23.90
SOMETIMES	112	44.63
SELDOM	19	7.57
NEVER	60	23.90
TOTAL	N=251	100

As many as 44,63% (112) indicated that they sometimes go to bed hungry. Sixty (23,90%) indicated that they often go hungry and nineteen (7,57%) indicated that they seldom go to bed hungry. Only 60 (23,90%) claims that they never go hungry in their household. The fact that 172 (68,52%) occasionally or often go to bed hungry is an indication that poverty exists in the households of the research group. Most of the time, low income per household causes malnutrition, which makes people vulnerable to infections (Roux, 2002:209-217). Defilippi (2004:162) points out that " the link between poverty and AIDS is undisputed. The malnutrition associated with poverty implies a compromised immune status and exposes people to infections such as TB and AIDS.

6.2 DOES SOMEONE IN THE FAMILY BELONG TO A FEEDING SCHEME?

To the question as to whether anyone in the family belongs to a feeding scheme, the following responses were given:

- 22 (9%) respondents indicated that they do indeed belong to a feeding scheme
- 229 (91%) indicated that they do not belong to a feeding scheme

These statistics prove that only 22 (9%) of the participants, presumably school-going children, belong to a food program which is available only at certain schools. The other inhabitants of the household do not belong to a feeding scheme because it is not available to them. That makes them extremely vulnerable. Even though there are 160 (63,74%) households where Government grants were received as financial assistance the families still experience financial difficulties. The other fact is that the breadwinners are the mothers and are employed as domestic workers whose wages are not sufficient to cope financially because they have to support the entire family.

6.3 MALNUTRITION

When asked whether they have to cut meals, 251 responded as follows:

TABLE 29 : MALNUTRITION

	F	%
OFTEN	**88**	**35.06**
SOMETIMES	**91**	**36.25**
SELDOM	**16**	**6.37**
NEVER	**56**	**22.31**
TOTAL	**N=251**	**100**

A total of 88 (35,06%) respondents answered that they often had to cut meals. A total of 91 (36,25%) answered that they had to cut meals answered and 16 (6.37%) answered that they seldom had to cut meals. Only 56 (22,31%) never have to cut meals. These statistics again indicate that the inhabitants of the households experience some form of hunger; therefore poverty exists in the families. According to Demmer (2004:301), more or less 40% of South Africa's workforce is unemployed, which results in widespread poverty. It is therefore clear that the inhabitants of this survey are inadequately fed. A balanced diet with all the necessary nutrients that is essential for healthy living is not available.

Tables 28 en 29 above indicates that most of the residents experience some form of hunger.

6.4 FOOD GARDEN

The 251 participants were asked whether they had a food garden, to which they responded as follows:

- 127 (50,60%) indicated that they did indeed have a food garden.
- 82 (32,67%) answered that they did not have a food garden
- 61 (16,73%) did not answer at all.

6.5 REASON FOR NOT HAVING A FOOD GARDEN

When the respondents were asked why they did not have a food garden, the following responses, as indicated in Table 30, were received.

TABLE 30: REASONS FOR NOT HAVING A FOOD GARDEN

REASONS	F	%
SOIL BAD	9	10,98
DON'T WANT IT.	9	10,98
MONEY/SEED/WATER	20	24,39
DON'T KNOW	10	12,19
SPACE	25	30,48
MAINTENANCE/LAZY	9	10,98
TOTAL	N=82	100

A total of 25 (30,48%) indicated that they did not have enough space available for a food garden. Twenty (24,39%) indicated a lack of money/seed/water. Nine (10,98) indicated bad soil and nine (10,98%) indicated that they are too lazy to take care of the maintenance. The reasons are acceptable, considering the lack of space and money. However, a certain number of people simply are too lazy to maintain it. The situation does not help the families to improve their standard of living and especially their diet that needs the necessary vitamins.

6.6 SUBSTANCES USED

When the respondents were asked to indicate their substance use, the following answers were received from 254 respondents:

TABLE 31: SUBSTANCES

SUBSTANCE	F	%
CIGARETTES	133	52,36
TOBACCO	16	6,3
SNUFF	95	37,40
CHEWING TOBACCO	3	1,18
DAGGA	7	2,76
TOTAL	N=254	100

According to Table 31, it is clear that among the adults in this survey, smoking cigarettes is fairly high at 133 (52,36%) people. The use of snuff is also very high at 95 (37,04%). It is not clear whether any of the respondents in the research survey use alcohol or snuff or whether it is the adults only. According to Malaka (2003:387), snuff can cause cancer. Besides curing headaches, snuff is regarded as providing relief of a variety of other conditions such as stress, high and low blood pressure and toothache. Although marijuana (dagga) is an illicit substance in South Africa, the trend in using it still prevails.

Van Heerden (2005:104) points out that social norms have an important influence on the behaviour of young people and further, that the initial or experimental use of substances often

results from a combination of peer pressure, curiosity and availability; therefore the substances that adolescents are most likely to first experiment with are cigarettes. Socialization models emphasize the role of Socialization agents (such as parents, friends and the media) as important influences on the adoption of substance use by adolescents.

6.7 ALCOHOL USE

A question was asked about alcohol use in the household and the respondents responded as follows:

One-hundred and thirty-two (48,89%) answered yes to the use of alcohol in the household, one-hundred and thirty-one (48,52%) answered no and seven (2,59%) did not respond.

From the information above it becomes clear that alcohol use is a normative behaviour among adults. According to Van Heerden (2005:105), alcohol is a socially accepted drug. When used in large quantities it suppresses your inhibitions and you forget about your problems. Alcohol can also contribute to car accidents, committing crimes, high risk sexual behaviour and family problems such as poverty and abuse.

6.8 AVERAGE BOTTLES OF ALCOHOL USED IN A WEEK

The respondents were asked to indicate the average bottles of alcohol that are used in the household in the course of a week. They responded as follows:

TABLE 32: ALCOHOL

BOTTLES	F	%
1-5	73	55.30
6-10	32	24.24
11-15	18	13.64
16-20	2	15.52
21-25	2	15.52
26-30	1	0.76
31-35	3	2.27
46-50	1	0.76
	N=132	100

It should be noted that the limited knowledge on the variety of alcohol drinks among the respondents should be considered when the number of bottles described is considered.

From table 32 it is clear that alcohol abuse is a factor in some of the households. It is noted that children observe their parents drinking habits and that they are influenced by them. Parents mostly do not teach their children about the dangers involved in alcohol abuse. Unstable home situations such as the absence of parents because of Aids deaths add to the lack of education.

Rocha Silva (1997:74) explains that youths may start by only experimenting and then later proceed to developing uncontrollable habits of misuse and even abuse of alcohol. Alcoholism, which in most cases is found in poor communities, leads people to forget about their problems (Evian, 2000:21).

6.9 TO THE QUESTION ASKED ABOUT EXERCISING HABITS, THE FOLLOWING ANSWERS WERE GIVEN:

One hundred and sixty 160 (60,61%) answered yes and 104 (39,39%) answered no. It becomes clear that many of the adolescents recognize the value of sport participation. There are factors that contribute to lack of participation such as funds and transportation. Participation in sport can be a significant factor for self-esteem development as well as physical development and improvement of the total well- being. Unfortunately there are still too many adolescents who do not see the necessity to participate in a sport codes. To do exercise and take part in sport activities is important and in this regard, Detroyer (2000:37) said the following: " In the past, exercise has been overlooked as a therapy to treat complications associated with HIV/AIDS because of the fear that it might decrease immunity......" Roux (2002:218-219) emphasises that exercise is important in the treatment of HIV infected people.

6.10 SPORT ACTIVITIES

The respondents were asked which exercise they practice. The following is a summary of their responses.

TABLE 33: SPORT ACTIVITIES

SPORT	F	%
NET BALL	36	20.22
SOCCER	63	35.39
ATHLETICS	41	23.03
GYM	29	16.29
OTHER	9	5.06
TOTAL	N=178	100%

It becomes clear that soccer is the most important sport 63 (35,39%), and the second most important is athletics 41 (23,03%). Netball is also a favorite sport with 36 (20,22%). They also like to participate in gym activities at a total of 29 (16,29%). The fact that more than 50% of the respondents indicated that they participate in a sport of their choice shows that they understand the importance of exercise.

7. SEXUAL BEHAVIOUR

The findings of this survey were based on a sample size of (N= 206) because the experimental school of 64 learners did not complete this section.

The first three questions addressed knowledge and attitude regarding high risk behaviour of sexually related matters.

7.1 When asked whether they had sex during the past 12 months, the following responses were received:

* Forty eight (23,30%) of the respondents indicated that they were sexually active.

* One hundred en eighty five (76,70%) indicated that they abstained from sex.

7.2 When asked whether they sleep with one partner only, the following responses were received:

* Twenty one (43,75%) indicated that they had sex with one partner only

* Twenty seven (56,25%) indicated that they had sex with more than one partner.

From the information above it becomes clear that 48 (23,30%) of the participants have been sexually active and that 158 (76,70%) abstained from sex. To the question whether they slept with one partner only, a mere 21 (43,75%) participants answered that they have sex with one partner only and 27 (56,25%) answered that they have sex with more than one partner. This situation highlighted vulnerability of young people to HIV/AIDS (Harrison, 2005:262-264).

7.3 The second question the respondents were asked was about their knowledge of a sexually transmitted disease. The answer suggests that they do have some knowledge of a disease. One hundred and seven (52,45%) answered yes and 97 (47,55%) no. It indicates that only about half the participants are aware that a disease exists that is sexually transmitted and the other did not possess a great deal of information. That can only mean that there is a need for the youth to be educated on the pandemic HIV/AIDS. Strydom (2003:69) mentions that there is an urgent need among adolescents for more knowledge and information on sexuality and HIV/AIDS in general.

7.4 The question that was asked concerning their knowledge of HIV/AIDS shows that 109 (52.91%) is definitely aware of the AIDS disease. Ninety seven (47,09%) reported that they do not know about a disease called HIV/AIDS. The results confirm that the youth of our country has a basic knowledge of HIV/AIDS. In these modern times of media coverage and school education programs there is still a lack of knowledge of HIV/AIDS, because 100% of all the participants should have knowledge of the disease. Strydom (2003:60) points out those programs will need to focus on increasing awareness, on communicating the correct knowledge and on encouraging subsequent behaviour change.

Knowledge of the existence of condoms was tested. One hundred and sixty nine (82,04%) answered yes and 37 (17,96%) answered no.

7.5 The following question was: Did you use a condom when you last had sex? Of the 48 participants who answered the question, 22 (45,83%) answered yes.

According to Visser (2005:204) and Bennell (2003:204) who did a survey in secondary schools as a strategy to combat the spread of HIV/AIDS amongst young school going people in South Africa, they found that the prevention program in South Africa needs to be a priority. Given the lack of vaccine or cure, prevention of the spread of the virus is the only way to combat the disease.

According to Gallant and Tyndale (2003:1338), it is necessary to have several strategies for decreasing infection rates of HIV/AIDS and one of them is school based programs starting as early as primary school to protect the general population from further infection.

To the question: "Do you know where to get a condom? 153 (80,53%) answered yes and 37 (19,47%) answered no and sixteen (7,77%) did not complete the questionnaire. The life stage of adolescents is often accompanied by rapid growth and physical development, heightened sexual interest/activities and a struggle to discover self–identity. Interest in the opposite sex intensifies and they often become involved in sexual relationships (Strydom, 2003:61).

7.6 On a question to the 270 respondents if they ever had an HIV /AIDS test done, twenty (4,21%) of the respondents answered yes to the question and 250 (95,79%) answered no.

7.7 The next question focused on the testing of HIV/AIDS. The survey group was (N = 270).

The survey indicates that 130 (48,20%) know where to go for HIV/AIDS tests. 140 (51,74%) do not know where to go. According to Becker (2005:105), people in South Africa who are most vulnerable to HIV are the poor, woman, young adults, adolescents and children. It is important to know your HIV status, because with the development of effective antiretroviral therapies, people infected with HIV can expect to live for a longer period of time and there is the possibility that aids may become a manageable disease (Whiteside & Sunter, 2000:9).

7.8 Ways of prevention

The question was asked how people can protect themselves from HIV/AIDS and the respondents answered as follows:

TABLE 34: WAYS OF PREVENTION

	YES		NO		DON'T KNOW		TOTAL	
	F	%	F	%	F	%	F	%
HAVING A GOOD DIET	153	(77,27)	23	(11,62)	22	(11,11)	N=198	(100)
STAYING WITH ONE FAITHFUL PARTNER	181	(81,16)	18	(8,08)	24	(10,76)	N=223	(100)
AVOIDING PUBLIC TOILETS	24	(13,64)	127	(72,16)	25	(14,20)	N=176	(100)
USING CONDOMS DURING SEXUAL INTERCOURSE	206	(86,56)	8	(3,36)	24	(10,08)	N=238	(100)
AVOIDING TOUCHING SOMEONE WITH HIV/AIDS	10	(5,68)	136	(77,27)	30	(17,05)	N=176	(100)
AVOID SHARING RAZOR BLADES	118	(67,05)	30	(17,05)	28	(15,90)	N=176	(100)

Table 34 focused on knowledge of the fact that everyone is at risk of getting HIV/AIDS and how one can prevent oneself from becoming infected. The table suggests the adolescence do indeed have some knowledge of HIV/AIDS. They were well informed about the use of condoms used during sexual intercourse. Having a good diet will not prevent you from becoming infected, but if you are already living with HIV a healthy and nutritious diet is very important. However, a total of 153 participants answered that they do not know the answer to the question as to how to protect themselves against HIV/AIDS. It is clear that there is a large group of participants that do not have the necessary knowledge about the disease and how to protect them against it. From the data above it is obvious that important knowledge is lacking and that there is an urgent need for development programs.

7.9 Information

The respondents were asked who they would prefer to get the information on HIV/AIDS from. The respondents answered as follows:

TABLE 35: FROM WHOM DO YOU PREFER TO GET THE INFORMATION ON HIV/AIDS?

VALUABLE	F	%
DOCTOR	32	13,91
CLINIC	58	25,22
SISTER	5	2,17
PARENTS	45	19,57
TEACHER/FRIEND	48	20,87
TV/NEWSLETTERS	40	17,39
RELIGIOUS PEOPLE	2	0,87
	N=230	100

The table above indicates that fifty eight (25,22%) of the respondents prefer to get their information at a clinic and 48 (20,87%) prefer to get their information from a teacher or friend. Forty five (19,57%) wish to get the information from their parents. Forty (17,39%) prefer to read about it in a newsletter or learn about it from TV programs. Thirty-two prefer to get their knowledge from their doctor.

7.10 Trust

A question was asked to the 230 respondents as to why they trust the information they received from the above-mentioned. Only 110 answered as follows:

TABLE 36: TRUST

REASON	F	%
CLINIC PERSONNEL	20	18.18
WHAT THEY SEE	36	33,73
THEIR OWN KNOWLEDGE	54	49,09
	N=110	100

One of the most important developmental tasks of adolescents is to develop a personal value system or a clear view about what is right and what is wrong. In order to develop a personal value system, adolescents have to question existing values, decide which values are acceptable to them, and then incorporate these values with their personal value system (Van Dyk, 2002:183): "Our future lies with our children". This saying has never been so resonant with meaning as it is now – in an area when HIV/AIDS is ravishing countless human lives, but none more so than in sub-Saharan Africa. If we cannot stop the current progress of the disease, we can at least try to ensure an AIDS-free future for our children. We should empower our children with education and life skills – not only so that they can prevent themselves from being infected, but also so that they can have the opportunity to learn to become compassionate, caring members of society that will be struggling with the aftermath of HIV/AIDS for a long time to come.

Being better informed will encourage adolescents to be responsible and will enable them to make more informed choices.

8. CONCLUSION

This chapter examines the lifestyle, living conditions, knowledge, behaviour and attitude of adolescents and their families regarding HIV/AIDS and a healthy living standard.

The 270 adolescents who participated in this study survey lived in the same township in the North-West Province and formed part of PLAY project of the Institute of Nutrition of the North-West University (Potchefstroom Campus).

HIV/AIDS in South Africa is infecting and affecting a number of people every second in a number of ways. The impact is becoming obvious day by day. The purpose of this dissertation therefore was to investigate and identify the needs of adolescents and to test their knowledge, attitude and skills.

The questionnaire used in this research was structured to investigate a number of socio—economic concepts and situations. A few decades ago a terrible disease that was previously unknown to the human race began to kill people in the most alarming and terrifying circumstances. It was as though some primeval beast had surfaced in the collective bloodstream of the human race. Now the beast has a name – AIDS (Adler, 1988:84–88).

The study indicated that the respondents came from large families and that their living conditions are below average. The unemployment rate is high and in most households the women are the breadwinners of the house. Domestic workers constitute the highest income group, but this is not sufficient to cover the financial expenses. The mother is not only the caretaker but also the breadwinner, resulting in additional pressure. The respondents have access to health care, although they have to walk long distances. Their spiritual needs are well provided for.

Young people in this research have information on HIV/AIDS and life skills but there is still a huge need for more education. Many parents are no longer living long enough to educate their children to reduce high risk behaviour. Children are left vulnerable and financially desperate.

The initial response of stakeholders such as government, health authorities, welfare etc. to cope with this epidemic was to give information hoping that this would persuade people to change their behaviour. Providing information is not enough to change behaviour, much more needs to be done.

9. RECOMMENDATIONS

Since it is evident that the adolescents in the survey group live in difficult circumstances and experience several complex problems related to HIV/AIDS and life skills, several recommendations can be made following the outcome of the study.

* Communities need to be made aware of the effect of HIV/AIDS in South Africa.

* The government and its counterparts such as NGOs are faced with a responsibility of transmitting proper education. This may result in the employment of more social workers to cope with the workload.

* The challenges facing our youth are numerous and that is why they are the target population in need of support. It is necessary that the youth must be empowered with a life skills program that consists of various topics.

* The life skills program will enhance the level of knowledge so that they will be well informed about reliable resources in the community.

* The youth need to be intensively educated and efforts should be made that education reaches everybody in every school in rural areas as well as urban areas.

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SECTION 3

ARTICLE 2

GUIDELINES FOR AN EMPOWERING PROGRAM FOR ADOLESCENTS

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OPSOMMING

Dit is nie moontlik om in Suid Afrika te woon en nie bewus te wees van MIV/VIGS wat tot 'n pandemie gelei het nie. Persone in die ouderdomsgroep 25–49 jaar is diegene wat die meeste geraak word. Hierdie statistiek staaf die feit dat 'n groot aantal ouers sterf en miljoene weeskinders daardeur agtergelaat word. Kinders word op verskeie maniere deur MIV/VIGS geraak. Ekonomiese en sosiale probleme ontstaan as gevolg daarvan. MIV/VIGS is 'n siekte wat verlies meebring, die jeug emosioneel oorweldig en ook geestelik demoraliseer. Die jeug word dus gekonfronteer deur die feit dat hulle sonder ouers agtergelaat word wat doeltreffende en noodsaaklike opvoeding moes gegee het. Daar is dus 'n verlies aan leiding en opleiding vir die nodige vaardighede.

Hierdie navorsing is onderneem met die doel om die behoeftes van adolessente te bepaal en om hulle kennis, vaardighede en houdings rakende MIV/VIGS te ontwikkel en 'n vaardigheidsplan te ontwerp aan die hand waarvan hulle bemagtig kan word. In artikel een is die omstandighede van adolessente ondersoek. Daar is tot die slotsom gekom dat adolessente wel tot 'n mate kennis van MIV/VIGS asook lewensvaardighede het, maar hierdie kennis is geensins voldoende nie. Die doel met artikel twee is om deur middel van 'n groepwerkprogram riglyne daar te stel om in hierdie behoeftes van die adolessente te voorsien.

1. INTRODUCTION

The pandemic proportion of AIDS in South Africa is a fact and an exceptionally severe problem that prompted attention throughout the world. Barnet and Blaikie (1992:2) postulate that the advent of the HIV/AIDS phenomenon seems to have caught countries unawares, and that there has been virtually no plan to curb and/or prevent this pandemic. An estimate has been made that by the year 2010 sub-Saharan countries will be home to approximately 50 million orphaned children (UNICEF, 2005).

Young people occupy a place of central concern in contemporary society, hence risk-taking behaviour such as substance abuse, certain kinds of sexual behaviour, crime, violence and delinquency are important issues that continue to affect their lives Malaka (2003:381).

According to Stro ng, De Vaultand, and Sayad (1998:31) protecting children and adolescents from experiencing or even knowing about this risk taking behaviour, became a major part of child rearing.

According to Van Heerden (2005:90), the investment in the well-being, education and skills development of children is fundamental to the economy, prosperity, political stability and environmental integrity of Africa.

All the children participating in this survey lived in low–income living areas. A structured questionnaire was used to obtain demographic data because socio–economic status has an effect on the general health and development of children. Although South Africans have better access to health care and an improved quality of live, the number of people who die before they reach the age of 50 has almost doubled in the past ten years (Strydom, 2002:346). The problem of HIV/AIDS remains a central issue in South Africa and creates a serious problem. The demographic impact of aids results in the fact that many children lose their parents and have to grow up without parental care. That again results in the fact that they are sometimes left without their basic rights to education and proper guidance. According to Dacey, Kenny and Margolis (2004:31), the successful completion of the developmental tasks of adolescents are critical to the young person's future life. Supportive parents, good schools and a caring community provide the best insurance of healthy growth and a competent entry into young adulthood. There are many reasons why the process of development of life skills in the home environment fails. However, it is possible to rectify this deficiency by means of an empowering program.

The researcher has therefore designed a program that will focus on the prevention of high-risk behaviour with the view to develop young people's knowledge and the skills they need to effectively deal with the demands of their everyday life. Group work is the treatment of choice for this program. Becker (2005:11) found that South Africa faces enormous challenges in managing the many factors that impact on the well-being of its citizen's — such factors as events, transitions such as loss and change, and a lack of resources. Against this background, group work as a method of practice is utilised by helping professionals and social development workers to promote individual and social change.

It is also true that South Africans and also our youth are confronted with death and loss. Becker (2005:100) sums it up in the following words: "Increasing numbers of South Africans are confronting the personal experience of grief and loss through witnessing the deteriorating health and death of family members, friends and colleagues. All areas of life are being intimately affected by the ravages of this disease." The youth experience various losses when a family member is deceased. They lost the person they loved as well as social, financial and emotional support and often their dreams for the future. As a result, survivors become emotionally overwhelmed, physically exhausted or spiritually demoralized (Manlinson, 1999:167).

2. OBJECTIVE OF THE RESEARCH

The main objective of the research is to compile a social work empowering program for adolescents with the focus on increasing knowledge regarding HIV/AIDS and skills needed to improve their social functioning.

3. RESEARCH METHODOLOGY

3.1 RESEARCH DESIGN

Babbie and Mouton (1998:74) define a research design as a blueprint for the manner in which the researcher intends to conduct the research.

According to Grinnell (2001:183), the survey research procedure is a form of data collection because it provides a useful and convenient way to acquire large amounts of data about individuals, organizations and communities.

In this research the data was collected from the adolescents and their families to estimate the prevalence of their living standards, habits and lifestyle, knowledge, attitude and behaviour concerning AIDS.

A questionnaire for this study used both open–ended and closed–ended questions.

Both qualitative and quantitative research approaches were used in this survey. According to Grinnell (2001:190), responses in closed–ended questions can be selected from a number of specified choices. The open–ended questions are designed to permit for responses; respondents are not forced to choose between alternatives. Straus and Corbin (1998:10–1) explain that qualitative research refers to research on persons' lives, lived experiences, emotions and feelings, and on organizational functioning social movements.

3.2 RESEARCH PROCEDURE

The research design steps, as described by De Vos, Strydom, Fouche, Poggenpoel and Schurink (1998:49), were followed as a procedure to develop the program. The quantitative paradigm is based on positivism, which takes scientific explanation (i.e. based on universal laws). Its main aims are to objectively measure the social world to test hypotheses and to predict and control human behaviour (De Vos, *et al.* 1998:240).

The research design steps of a quantitative approach according to De Vos, *et al.* (1998:49) were followed and included the following:

STEPS IN THE RESEARCH PROCESS	QUANTITATIVE
STEP 1	CHOOSE A RESEARCH PROBLEM/TOPIC/THEME
STEP 2	IDENTIFY THE PROBLEM
STEP 3	REVIEW THE RELEVANT LITERATURE AND RELATED RESEARCH
STEP 4	FORMULATE THE PROBLEM FORMALLY
STEP 5	FORMULATE A RESEARCH PROPOSAL
STEP 6	DEFINE EACH OF THE CENTRAL CONCEPTS THEORETICALLY AND OPERATIONALLY.
STEP 7	REFORMULATE THE RESEARCH PROBLEM IN THE FORM OF TESTABLE HYPOTHESES
STEP 8	SELECT A RESEARCH DESIGN
STEP 9	SELECT THE DATA COLLECTION METHODS AND MEASURING INSTRUMENTS
STEP 10	CONDUCT A PILOT STUDY
STEP 11	DRAW THE SAMPLES
STEP 12	COLLECT DATA (I.E. EXECUTE THE SELECTED RESEARCH DESIGN)
STEP 13	PROCESS, ANALYSE AND INTERPRET THE DATA
STEP 14	WRITE THE RESEARCH REPORT.

3.3 RESEARCH RESPONDENTS

A convenience sample of scholars N = 206 in grade 9 (13–18 years old) from a high school in Ikageng, Seiphemelo High School, Potchefstroom in the North West Province, South Africa, was followed up from 2004 as the intervention group. Sixty-four grade 9 children from Boithoko High School in the same township were followed up as the control group. Permission to do this study was obtained from the principals and parents. The schools were visited in order to explain the 2005 protocol to the teachers, parents and children and to obtain permission from the principals and to obtain informed consent from the parents of the children.

The research was approved by the Ethics Committee of the University.

3.4 MEASURING INSTRUMENT

A structured questionnaire was used to obtain demographic data of the adolescents. The data was used to describe the study sample, since socio – economic status may have an effect on the general health and development of the children. The adolescents' knowledge, attitudes beliefs and opinions concerning HIV/AIDS, social habits and other related matters are also measured.

Guidelines for a life skill program for adolescents will be presented. According to Rooth (1997b:6) "Life skills are essential skills that make life easier, and increase the possibility of us realising our potential and becoming productively involved in the community". Life skills not only make life easier, it also help to prevent and cope with needs and problems like HIV/AIDS, communication, assertiveness, self-awareness, conflict handling and developing empathy (Rooth, 1997b:7).

4. GROUP WORK

According to Toseland and Rivas (2001:12) group work can be described as "Goal–directed activity with small treatment and task groups aimed at meeting socio-emotional needs and at accomplishing tasks. This activity is directed at individual members of a group and at the group as a whole within a system of service delivery.

Adolescents can benefit from life skills education (Rooth, 1997b:41). According to Toseland and Rivas (2005:23-24) individuals like adolescents can achieve skills through educational groups.

4.1 PREPARATION OF THE GROUP

Henry (1992:50) maintains that it is very important that all potential participants would be prepared for the group process. The primary aim is to determine the participants' level of motivation, to discuss the aim of the group sessions and to introduce the methods and procedures that will be used during the program presentation.

Group members need to be motivated and involved in the process to ensure that they attend the sessions and be responsive and contributive.

4.2 PREPARATION OF ADMINISTRATIVE ASPECTS

It is important that the facilitator of the group work program incorporates preparations of the administrative aspects in the planning phase such as venue, time and duration, number of sessions, open or closed group, size and functional resources. According to Gazda, Ginter and Horne (2001:237), the group setting is the physical environment within which the group's therapeutic task takes place. The therapist supplies, creates and maintains the setting throughout the group's life. According to Zastrow (2001:12), the preparation and the process of establishing and conducting groups vary significantly, depending on the type of group and the specific purposes to be achieved. However, for a group to reach its maximum potential there are still some unifying or common elements to be addressed prior to establishing the group.

VENUE

The setting for the group have a profound effect on the behaviour of group members and the conduct of group meetings, the room size, space, seating arrangements, furnishings and atmosphere should all be considered (Toseland & Rivas, 2001:178) According to Gazda *et al.*

(2001:286–287), the atmosphere created by any given setting will influence the emotional state of the group. For this reason the setting is very important.

TIME AND DURATION OF SESSIONS

Duration addresses the life span of the group and frequently the pattern and length of group meetings. The influence of duration and frequency of group experiences on individual behaviour and consequently on the group process has been well documented (Becker, 2005:35).

The length of the sessions can be two hours each. According to Phillips (2001:106), there is general consensus that after two hours a point of dismissing is reached and the group becomes tired and inefficient.

GROUP SIZE

When determining the size of groups the social worker or facilitator should consider how the members will be affected, how many members are needed to accomplish the tasks efficiently and effectively and the advantages and disadvantages inherent in different group sizes. Larger groups offer more ideas, skills and resources but there is less individualized attention. Overall, decisions regarding the number of members to include in a group should be based on the purpose, needs and ability to contribute to the work of the group (Toselant & Rivas, 2001:171). In a life skills program for adolescents the group size must not include more than ten to twelve members.

OPEN OR CLOSED GROUPS

The group can be of a closed nature because it has a short life and the group and individual goals are thought to be best achieved through intensive and stable relationships. A closed-ended group can often function more effectively because it has a relatively constant population and often operates within a specified time frame (Zastrow, 2001:14).

Corey and Corey (2002:109) are of opinion that a potential of open groups is that rapid changing of members can result in a lack of cohesion, particularly if too many members leave or too many new ones are introduced at once. Therefore the researcher decided on a closed group in this group work program. According to the Becker (2005:35), closed groups refer to constant membership, which creates a stable forum for the emergence of group process and development.

5. GROUP WORK PROGRAM

According to Brander and Roman (1999:165), the nature of the program must be geared to the cultural, developmental and environmental needs and common problems that bring the participants together. Most important, however, the choice of program and how it is successfully implemented is determined by the worker's capacity for inspiration, imagination and improvisation and by his skills.

The development of a group work program formed part of a project entitled "Physical activity in the young (PLAY) of the Institute of Nutrition at the North-West University (Potchefstroom Campus).

The main motivation for developing or designing this program was the belief that the adolescents of today are subjected to the high demands in society and it is expected of them to function accordingly. They are not efficiently equipped for the task and therefore need to be guided with a group work program to be able to function optimally.

Becker (2005:113) holds that four (4) groups of helping processes and skills are identifiable with special significance for empowering skills and have the following empowering functions.

- To bolster motivation, gaining resources, attending to presenting problems and own personal strengths, enlisting energy in changing events
- To maintain physic comfort and self-esteem, facilitate members to share and validate one another's experiences, reducing self-blame.
- To enhance problem solving and to promote self-direction, brain storming, sharing possible solutions, challenge strengths and creativity.
- To promote social change, making clear mutual contact that bridges the personal, political and social change focus, reaching for maximum participation.

5.1 DESCRIPTION OF THE EMPOWERING PROGRAM

The program has been designed according to results discussed in article one and guidelines of life skills books and articles. In planning the program, the researcher has explored the knowledge of different authors such as Rooth (1997), Becker (2005) and Campbell and Foulis (2002). The researcher recommended music, collages, group activity, video's, questionnaires and play as program activities throughout the presentation of the program.

According to Toseland and Rivas (2001:18), several writers have suggested that group treatment has advantages over individual treatment. Groups help members realize they are not alone with their problems. They also give members the opportunity to help one another by being supportive, giving feedback, making suggestions and providing useful information.

Roux (2002:184) argues that the program helps with the cohesion of the group, the group norms, structure, the relationships and the climate of the group. The aim with the group work program is to empower adolescents to reach their potential as individuals through making the right choices and becoming productively involved in their communities. Empowerment is a concept central to the strength perspective. It has been defined as: " the process of helping individuals, families, groups and communities increase their personal, interpersonal, socio-economic and political strength and develop influence toward improving their circumstance" (Barker, 1999:135). Hepworth and Larson (1993:495) explain that "(t)he helper enables them to gain the capacity to interact with their environment in ways that enhance their need gratification, well-being and satisfaction and is closely linked to competence, self-esteem, support systems and belief that

individual actions or actions in concert with others can lead to improvement in one's life situation."

According to Toseland and Rivas (2001:259), the procedure to select a program is the following:

FIGURE 1: PROCEDURE FOR SELECTING A PROGRAM

1. SPECIFY PROGRAM ACTIVITIES THAT ARE CONSISTENT WITH GROUP PURPOSES AND GOALS.
2. SPECIFY THE OBJECTIVES OF THE PROGRAM ACTIVITY.
3. SPECIFY PROGRAM ACTIVITY THAT CAN BE DONE/GIVEN, AVAILABLE FACILITIES, RESOURCES AND THE TIME AVAILABLE.
4. LIST POTENTIALLY RELEVANT PROGRAM ACTIVITIES BASED ON MEMBERS' A. INTERESTS AND MOTIVATION B. AGE C. SKILL LEVEL D. PHYSICAL AND MENTAL STATE E. ATTENTION SPAN
5. CLASSIFY PROGRAM ACTIVITIES ACCORDING TO: A CHARACTERISTICS OF THE ACTIVITY, E.G., LENGTH, STRUCTURE, ETC. B PHYSICAL REQUIREMENTS OF THE ACTIVITY, E.G. FINE MOTOR COORDINATION, AND STRENGTH C SOCIAL REQUIREMENTS OF THE ACTIVITY, E.G. INTERACTIONAL, VERBAL AND SOCIAL SKILLS D PSYCHOLOGICAL REQUIREMENTS OF THE ACTIVITY, E.G. EXPRESSION OF FEELINGS, THOUGHTS AND MOTIVES E COGNITIVE REQUIREMENTS OF THE ACTIVITY, E.G. ORIENTATION TO TIME, PLACE AND PERSON.
6. SELECT THE PROGRAM ACTIVITY THAT IS BEST SUITED TO ACHIEVE THE OBJECTIVE SPECIFIED.

(Toseland & Rivas, 2001:259)

The procedures in Figure 1 can be used as a guide to help social workers select program activities for any type of treatment group.

In a group work program for adolescents, different life skills can be included. The program must fit into the needs of the group members. After studying the results of the research in article one, about the adolescents' knowledge, skills and attitudes regarding HIV/AIDS and life skills, guidelines for a group work program was designed.

Guidelines for a group work program for grade 9 adolescents will be given in table 1.

TABLE 1

THE GROUP WORK PROGRAM AS PLANNED FOR GRADE 9 ADOLESCENTS.

NO OF SESSION	DURATION	AIM OF SESSION	ACTIVITIES AND RESOURCES FOR SESSION
1	ONE SESSION	**ORIENTATION** TO HELP MEMBERS TO WORK TOGETHER IN A CO-OPERATIVE AND PRODUCTIVE WAY TO MAKE SURE MEMBERS KNOW EACH OTHER TO OUTLINE AND CLARIFY THE PURPOSE OF THE GROUP TO CREATE ATMOSPHERE OF WARMTH, ACCEPTANCE, HUMOUR AND ENJOYMENT. TO ESTABLISH GROUND RULES / SET GOALS TO COMPILE A CONTRACT FOR THE GROUP TO COMPLETE PRE-GROUP QUESTIONNAIRE.	INTRODUCTION NAME GAME GROUP RULES ICE BREAKER FEELINGS BALL GAME QUESTIONNAIRE CONTRACTING
2	ONE SESSION	**ENHANCE SELF–CONCEPT AND SELF–ESTEEM** TO TEACH PARTICIPANTS TO DISCOVER THEIR POSITIVE QUALITIES. TO DISCOVER EXCEPTIONAL QUALITIES TO IDENTIFY WITH IMAGES AND PICTURES. POSITIVE AFFIRMATIONS TO HELP THEM WORK TOWARDS AN INCREASINGLY POSITIVE SELF–CONCEPT. TO DISCOVER THEIR POSITIVE QUALITIES, TALENTS AND POTENTIAL IN ORDER TO HELP THEM IMPROVE THEIR QUALITY OF LIFE.	QUESTIONNAIRES GAMES COLLAGES DRAWING MUSIC FEEDBACK GROUP DISCUSSION
3	ONE SESSION	**DEVELOP ASSERTIVENESS** TO EDUCATE THEM ON THE TOPIC OF ASSERTIVENESS TO DEVELOP STRATEGIES TO MANAGE ASSERTIVENESS TO HELP THEM TO REALISE, FEEL AND ACT ON THE ASSUMPTION THAT ONE HAS THE RIGHT TO BE ONESELF AND TO EXPRESS FEELINGS FREELY.	QUESTIONNAIRES MUSIC ROLE PLAY

4	One session	**Develop Democracy** To define democracy To educate them on human rights To teach them about their rights and responsibilities To teach them about parents' rights and responsibilities To encourage them to continue looking for strategies that the democratic process in South Africa could grow and improve	Music Role play Create musical instruments Feedback Activities Dance
5	One session	**Awareness of HIV/AIDS** To educate adolescents on high-risk behaviour To present facts about HIV/AIDS to the adolescents in a straightforward manner To provide statistics To convey values about responsibility for oneself and the well-being of others To learn them how to protect themselves and others To educate them on the stages and symptoms of AIDS	Questionnaire Music Collage Pictures Posters Video material Educational talk Feedback
6	One session	**To Raise Awareness of Psychological and Social Issues of HIV/AIDS** To educate them on matters concerning behaviour and attitude about AIDS To teach them about the following issues: Family structure Misunderstanding Financial burden Stigma Discrimination Emotional responses Stages of death Stages of interactive fluids	Questionnaire Music Collage Pictures Posters Video material Educational talk Feedback

7	One session	**To Raise Awareness of the Importance of Communication** To define communication and the different communication patterns To raise awareness of the importance of communication skills in relationships with significant people in their lives To define the process that is taking place whenever people share ideas, thoughts and feelings	Role play Collages Music Activities Questionnaires
8		**To Develop Empathy as an Essential Life Skill** To define empathy To learn how to develop empathy for other people To learn how to understand another person's feelings and behaviour	Questionnaires Games Exercises Activities Music
9	One session	**To learn how to handle Conflict** To define conflict and provide and explain attitudes related to conflict management To provide enough space to the adolescents to analyse their own conflict resolution styles. To help them practise different ways of solving and managing conflict	Music Discussions Role play and Practice Disturbing music while they paint Soft music with an activity
10	One session	**To Terminate the Group work Process** To consolidate with the adolescents what they have learnt during the sessions To discuss each session by giving and receiving feedback To use evaluation scales to assess outcomes To be sensitive as a group facilitator to the group's feelings and deal with it in the best possible way To use the strength perspective in dealing with the group To help them gain and develop knowledge and the ability to realize the social and legal impact on their lives To promote social change and the learning of empowering skills	Music Completing the evaluation questionnaire Closing ritual

5.2 DESCRIPTION OF THE GROUP WORK SESSIONS

In the following section the group sessions will be described as formulated according to the guidelines of a life skills program.

5.2.1 SESSION 1: ORIENTATION

OBJECTIVES

- To help members to work together in a cooperative and productive way.
- To make sure members know one another.
- To outline and clarify the purpose of the group.
- To create atmosphere of warmth, acceptance, humour and enjoyment.
- To establish ground rules/set goals.
- To compile a contract for the group.
- To complete the pre-group questionnaire.

PROGRAM ACTIVITIES

When the participants arrive, the social worker should introduce the members to one another. Even if the participants are known to one another they are not known to the social worker. The introduction can provide members with a starting point for interaction. Therefore the information that is shared should attempt to bring out commonalities. This process helps members feel at ease with one another. It also helps develop group cohesion and demonstrates to members that they are not alone with their problems and concerns (Toseland & Rivas, 2001:191).

The social worker should inform the group about the content of the program and impress on them that their co-operation will be needed. A game will also be played (ice breaker) to let them feel comfortable and to express their feelings. According to Zastrow (2001:22), the social worker has the initial responsibility of seeking to create an atmosphere in which members feel comfortable. The social worker should then establish ground rules and compile a contract with group members so that they are fully aware of what is expected of them. In a group, contracts are mutual agreements that specify expectations, obligations and duties (Toseland & Rivas, 2001:208).

There will always be a need for assessing the functioning of the group. A standardized assessment instrument for instance a questionnaire will be used. According to Toseland and Rivas (2001:281), monitoring and evaluating progress provides feedback for social workers and members which is useful in developing, modifying and changing treatment plans.

5.2.2 SESSION 2: ENHANCEMENT OF SELF-CONCEPT

OBJECTIVES

- To teach participants to discover their positive qualities.
- To discover exceptional qualities.
- To identify with images and pictures. Positive affirmations.
- To help them work towards an increasingly positive self–concept.
- To discover their positive qualities, talents and potential to help them improve their quality of life.

PROGRAM ACTIVITIES

The social worker should teach group members about self-concept enhancement. According to Dacey, Kenny and Margolis (2004:174), the term self-concept answers the question "Who am I?" and self-esteem answers the question "How do I feel about who I am?" Self-esteem is related to self-concept. A well defined self-concept leads to high self-esteem, which in turn leads to successful behaviour especially when handling the problem of HIV/AIDS. Persons with high self-esteem like and accept themselves. They do not feel that they are perfect or better than others; rather they are aware of their limitations and work towards correcting them. According to Van Heerden (2005:61), self-esteem is the belief that you are a worth while individual. Related concepts are **self-efficacy** which means seeing yourself as capable of accomplishing what you set out to do and **self-respect** which means that you approve morally of the way you are living your life.

The social worker should use different games and activities in the program to teach the group about their feelings and how to grow from negative to positive self-concept. Brainstorming exercises, according to (Rooth, 1997:8), will help to consolidate the session with relevant topics such as:

- What can we do to become more confident?
- What can we do to believe in ourselves?
- What can we do to counter negativity and put-downs?
- What can we do to help others to become confident?

This session is most useful when adolescents do it in a collage and also during a feedback session.

5.2.3 SESSION 3: DEVELOPING STRATEGIES TO MANAGE ASSERTIVENESS

OBJECTIVES

- To educate them on the topic of assertiveness

- To develop strategies to manage assertiveness
- To help them to realise, feel, and act on the assumption that one has the right to be oneself and to express feelings freely.

PROGRAM ACTIVITIES

For most adolescents it is difficult to be assertive because they lack self-confidence in the past and then because of that they behaved in a non-assertive manner. During this session participants should be given a questionnaire to fill out individually and to measure their assertiveness. The social worker should use music to ease the tension during the session. The questions and answers should be discussed in the group to measure the outcomes.

According to Zastrow (2001:330, 351) assertiveness problems range from extreme shyness, introversion and withdrawal to inappropriate rages that can alienate others. Assertiveness training is designed to lead one to realize, feel and act on the assumption that one has the right to be oneself and express one's feelings freely. According to Van Heerden (2005:65), assertiveness means standing up for yourself and what you believe is right. For a young person , assertiveness often means choosing to stay sober when your friends want you to drink. It is sticking to a resolution to abstain from sex until you are married. Assertiveness is being strong and standing up for what you believe to be right or important to you. This help to prevent the adolescent to be infected with the HI-virus.

As part of the training the members should learn alternative assertive approaches that will help them in situations. According to Zastrow (2001:353), the members should practise their chosen strategy until they feel ready to use it when problematic situations occur again. Learning to be assertive is a continuing process, and the joy and pride obtained from being able to fully express oneself assertively is nearly unequalled.

5.2.4 SESSION 4: DEVELOPING DEMOCRACY

OBJECTIVES

- To define democracy.
- To educate them on human rights.
- To teach them about their rights and responsibilities.
- To teach them about parents' rights and responsibilities.
- To encourage them to continue looking for strategies that the democratic process in South Africa could grow and improve.

PROGRAM ACTIVITIES

The social worker will divides the participants in groups and let them participate in the activities. Music can be used to create a certain atmosphere. Democracy is still a new phenomenon in

South Africa and life skills facilitators working with the concept of democracy are offering participants valuable skills in democratic principles (Rooth, 1997:133).

One of the ideas is to create a variety of musical instruments. According to (Rooth, 1997:135), the children create the instruments and after several activities they will discuss their observations. This exercise will help them to respect one another and create willingness to compromise and find out what other people want. The social worker should let the participants work in smaller groups and let them discuss what they understand by democracy. They can use paint and crayons to draw a picture that represents democracy and one completely lacking democracy. Music will be used in this session and a group dance session will also take place to express the joy of democracy (Rooth, 1997:149).

The social worker will teach the group members about rights. There are children's' rights and parents' rights, but they must learn that rights are accompanied by responsibilities.

5.2.5 SESSION 5: AWARENESS OF AIDS

BJECTIVES

- To educate adolescents on high-risk behaviour.
- To present facts concerning HIV/AIDS to the adolescents in a straightforward manner.
- To provide statistics.
- To convey values about responsibility for oneself and the well-being of others.
- To teach them how to protect themselves and others.
- To educate them on the stages and symptoms of AIDS.

PROGRAM ACTIVITIES

The social worker should outline the impact of HIV/AIDS in South Africa and give all the necessary statistics and information. The information will be written on posters and displayed so that the learners can see what it looks like (Roux, 2002:203). The learners will also complete a questionnaire to establish what their knowledge of the topic is. Learners will share their knowledge and talk about their feelings and ideas concerning the disease.

The social worker will present a poster containing the facts of how to prevent HIV, testing for HIV and medicine available – antiretroviral treatment. Evian (2000:7) identified HIV/AIDS as follows: "This all means that some of the most important cells of the body's immune or defense system are destroyed. The immune system is very well established and is very powerful. It takes the HI virus a number of years to destroy enough of the immune system to cause immune deficiency and immune incompetence ... When a person is immune-defiant; the body has difficulty defending itself against main infections and some cancers." The learners will have to learn about the fact that the HIV virus destroys the immune system and causes many illnesses through infections. According to Van Heerden (2005:94), AIDS cannot be cured, but the opportunistic diseases associated with AIDS can be treated and cured. There are also

medications that can control the levels of the HIV virus in infected people. Antiretroviral (ARV) treatment blocks the replication of the virus and slows down the progression of HIV. According to Zastrow (2001:503), the learners should be taught about the high–risk behaviour and should know specifically which behaviours are most dangerous and that they should take responsibility for their own safety. A video tape will be shown to teach the learners facts regarding HIV/AIDS.

The learners should form groups of five and find pictures, words and images in magazines and make collages of what they have learned about HIV/AIDS and protection.

5.2.6 SESSION 6: ORIENTATION TO HIV/AIDS

OBJECTIVES

- To educate them on matters concerning behaviour and attitude concerning AIDS.
- To teach them about the following issues:
- Family structure;
- Misunderstanding;
- Financial burden;
- Stigma;
- Discrimination;
- Emotional responses;
- Stages of death and
- Stages of interactive fluids.

PROGRAM ACTIVITY

The importance of psychological and social issues will be discussed. Ross (2001:21–26) identified a number of psychological issues which arise amongst individuals and families living with HIV/AIDS, such as:

➢ <u>Family Structure</u>

The impact on family structure is that many people no longer live in what used to be regarded as a traditional family structure. An increasing concern is child–headed households.

➢ <u>Misunderstanding</u>

Misunderstandings often occur concerning the causes of HIV/AIDS, and an individual that discloses his status to family members may receive responses such as anger, rejection, fear, guilt and acceptance.

➢ <u>Financial Burdens</u>

This burden is often beyond the capacities of the family unit.

➢ Stigma

A stigma is attached and may result in isolation and a decrease in support.

➢ Discrimination

They face discriminatory attitudes at school and in the workplace.

➢ Emotional Responses

It may evoke negative emotions, also frustration, powerlessness, anger and depression which serve to further drain the personal resources of those who care for people with HIV/AIDS. According to Kaplan *et al.* (1997:67, 80-91), research indicates that people recently diagnosed with HIV display high levels of distress and anxiety. When a person learns that he or she has HIV, it is an intense, life–shattering experience, one of the most devastating things that can happen to anybody.

A questionnaire can be completed to test knowledge and feelings. Pictures and posters should be used to display the devastating implications of the disease on people's lives.

According to Barker (1999:467), strategies are carefully designed and implemented procedures that an individual or group uses to bring about long-term changes in another individual or group. Techniques are "the knowledge based skills, methods and procedures purposefully used to achieve explicit goals" (Barker, 1999:482).

5.2.7 SESSION 7: IMPROVING COMMUNICATION SKILLS

OBJECTIVES

- To define communication and the different communication patterns.
- To raise awareness of the importance of communication skills in relationships with significant people in their lives.
- To define the process that is taking place whenever people share ideas, thoughts and feelings.

PROGRAM ACTIVITIES

According to Caughlin (1981:303–305) language is symbolic, and meaning often rests more in people than in the words themselves. Moreover, each word in any language can be interpreted in a variety of ways, which often leads to misunderstanding. In 1945, a word was misunderstood and lead to dropping an atomic bomb that killed thousands of people needlessly. According to Toseland and Rivas (2005:66), a social worker who is knowledgeable about communication skills and interventions can "intervene in the patterns that are established to help the group achieve desired goals and to ensure the socio-emotional satisfaction of members

This session will be about what communication skills are and the different ways to communicate such as verbal and non-verbal communication. The techniques used can be a collage, picture

story, role cards or music while they draw pattern pictures and symbols. Following this, a discussion session should take place during which they can identify their poor communication skills and reflect on experiences during the group work session.

The social worker should then educate them on effective communication skills. Zastrow (2001:143) maintains that a receiver can better interpret the information if non-verbal and verbal messages match; double and often contradictory messages are sent when non-verbal and verbal messages do not agree. He also states that you must "own" your messages by using personal pronouns such as "I" to say that you take responsibility for your thoughts and feelings. According to Egan (1990:111), active listening is about the other person being "present psychologically, socially and emotionally".

Non-verbal communication is slightly more difficult to understand. It is the things or feelings you usually try to hide from other people. If you can develop the skill to read the non-verbal cues you will be more aware of people's feelings. Zastrow (2001:154–157) lists the following facts of non-verbal expressions and behaviour: eye contact, gestures such as facial expressions and touching convey a variety of messages, clothing conveys several different messages, personal boundaries, territoriality, voice, physical appearance and environment.

According to Rooth (1997: 51), the social worker must make sure that the participants know practical exercises they can use in their day-to-day lives to improve their own and other peoples ability to communicate effectively especially about matters like HIV/AIDS.

5.2.8 SESSION 8: DEVELOPING EMPATHY AS AN ESSENTIAL LIFE SKILL

OBJECTIVES

- To define empathy
- To learn how to develop empathy for other people
- To learn how to understand another persons feelings and behaviour

PROGRAM ACTIVITIES

Barker (1991:73) defines empathy as "the act of perceiving, understanding, experiencing and responding to the emotional state and ideas of another person." In this session the social worker will try to teach the participants how to be able to empathise with other people. Rooth (1997:85) explains that to empathise means to understand — without judging or using preconceived ideas — the reason for a person's feelings and behaviour. It does not mean that we have to agree with the person's behaviour, just why it is occurring. The social worker will use games, exercises and activities to increase the group members' level of empathy. The first activity will be to create a collage. Rooth (1997:89) recommends that they choose the object they want to focus on, for instance they are adolescents who need to gain information on certain life skills. The social worker can ask them to use topics that they learnt more about during the group sessions. The collages can then be affixed to a wall and discussed by the group. According to van Heerden

(2005:77), no social skill is more important than empathy. Some people are seen as more accepting and less critical or judge mental than others, they are easy to talk to therefore enable us to "open up". Being empathetic – being a true friend – is a cherished gift to offer; it is offering an open heart.

In this session every person must choose the person who he wants to become and must then behave like that person. You can also use an exercise called "walk the walk" where you walk and perform an action like a person in one of the following situations, as set out by Rooth (1997:95):

- you are dying - you are depressed
- you are drunk - you are helpful
- you are ecstatic - you are lonely
- you are just learning to walk - you are old
- you are taking your last step - you are afraid
- your house has burnt down - you are filled with joy

At the end of this role play (game) members should evaluate the game by means of discussion and especially explore their feelings. The social worker should also make use of music in this session.

At the end of the session members should be able to know that empathy is the ability to tune into what others are subjectively experiencing and to see the world through their eyes (Corey & Corey, 2002:135). This is a very important skill in helping the HIV/AIDS infected person.

5.2.9 SESSION 9: CONFLICT MANAGEMENT

OBJECTIVES

- To define conflict and provide and explain attitudes related to conflict management.
- To provide enough space to the adolescents to analyse their own conflict resolution styles.
- To help them practice different ways of solving and managing conflict.

PROGRAM ACTIVITIES

In this session, the social worker should educate them on the topic of conflict and focus on life skills that should help them to manage conflict and to solve it. According to Van Heerden (2005:46), conflict arises when two or more values, perspectives and opinions are contradictory in nature and have not yet been aligned or agreed on. Conflict itself is not necessarily a bad thing. It is when we do not manage it well that we give it power to do as it pleases with us. Rooth (1997:100) maintains that conflict is a reality of life. In itself it can provide healthy opportunities for learning and growth. However, if we do not know how to deal with it, conflict may become counter productive. There are many different ways of dealing with conflict and the

group should have enough space in which to analyse their own conflict. The group should identify various stages of conflict because it is a process that develops over time:

- Potential conflict refers to a situation in which different preferences are forced to share the same space.
- Conscious conflict occurs when you become aware of these differences and realise that a disagreement takes place.
- Experienced conflict happens when you start to feel and experience the effect that these differences are starting to have.
- Visible conflict happens when the actual conflict takes place. It is at this stage that you may try to resolve the conflict by arguing or discussing or physically fighting.
- The Conflict Route depends on how you handle the conflict. If you use good management skills, both the parties involved are usually left with positive experiences and future areas of conflict will be handled with ease.

The group should know that conflict is part of normal life because the values, beliefs and interests of individuals differ. The group will make use of games and do exercises and activities to help them learn about the conflict in their lives and what they should do to handle and resolve it.

In this session, the social worker will use the strategies recommended by Rooth (1997:110) in her book on life skills. The group will draw a circle of their conflict situations. The social worker will use music that will create a disturbing atmosphere. The participants should then share their drawings and feelings and give one another advice on how to change their situations. Rooth (1997:17) states that the participants should be given the opportunity of reviewing the major conflicts in their lives, their usual reactions to conflict and their habitual conflict solving strategies and new methods for resolving these conflicts.

Zastrow (2001:175) points out that conflicts are not only a natural part of any relationship within a group; they are also desirable because, when handled effectively, they have a number of pay-offs such as producing lively discussions, defining issues more sharply, leading to personal growth and encouraging creativity.

5.2.10 SESSION 10: TERMINATION OF THE GROUP

OBJECTIVES

- To consolidate with the adolescents what they have learnt during the sessions.
- To discuss each session by giving and receiving feedback.
- To use evaluation scales to assess outcomes.

- To be sensitive as a group facilitator to the group's feelings and to deal with it in the best possible way.
- To use the strength perspective in dealing with the group.
- To help them gain and develop knowledge and the ability to realize the social and legal impact on their lives.
- To promote social change and teach empowering skills.

PROGAM ACTIVITIES

In this session, the workshop (or group sessions) is terminated. Rooth (1997:161) maintains that termination is usually difficult, and fraught with emotional interactions. The reason for this is that the participants work closely together over an extended period of time in a safe environment and develop strong bonds. Termination may also mean ending as well as affirming a beneficial experience and then to return to the harsh realities of problematic relationships and challenging environments.

During this session, the social worker should let the group members create a collage of the course and the important aspects. They should be creative and, for example, use a tree with various objects of the course hanging from it, pictures on a t-shirt, pictures on a washing powder or cereal box, a basket full of good things, a mix of pictures, objects and words (Rooth (1997:166). It is then useful that they share their work with the group and the meaning of the course for them.

Another of the techniques used by Rooth (1997:107) is designing a poster that advertises the life skills they learnt and applying it to practical reality. During the two techniques the social worker should use music that is lively and creates a warm atmosphere

Zastrow (2001:296) contends that the ending phase of a group frequently offers the greatest potential for powerful and important work. Corey and Corey (2002:258) maintain that the phase of a group's evaluation is also vital, since members are afforded the opportunity to clarify the meaning of their experiences in the group, consolidate the gains they have made and decide what newly acquired behaviours they want to continue transferring to their everyday lives.

6. CONCLUSION

South Africa has been particularly hard hit by HIV/AIDS. It has the largest number of people living with HIV/AIDS in the world and a large proportion of its citizens have already died of aids. It is also estimated that all new infections occur amongst those between 15 and 25.

According to reports released by numerous research findings, AIDS has become the leading cause of deaths in South Africa. AIDS is a very serious disease that devastates individuals and societies. The AIDS pandemic in South Africa is still a huge problem. It is also found that the adolescent group of South Africans occupy a place of central concern because of high-risk behaviour.

The challenges facing our youth are numerous and that is why they are the target population most in need of support. Research shows that their knowledge and skills are not sufficient or effective to live a life of quality.

It is essential that these children be empowered by means of a life skills program that consists of various topics such as the following:

- Enhance Self–concept and Self-esteem;
- Develop Assertiveness;
- Develop Democracy (teach them about rights and responsibility);
- Awareness of AIDS;
- To Raise Awareness of Psychological and Social Issues of HIV/AIDS;
- To Raise Awareness of the Importance of Communication;
- To Develop Empathy as an Essential Life Skill and
- To Learn How to Handle Conflict.

The future role of social work in addressing the HIV/AIDS problem in South Africa is daunting but a challenge, and that is why this program has been developed.

7. RECOMMENDATIONS

There are a number of reasons why HIV/AIDS education for the youth should be an urgent priority in Social Work in South Africa.

- HIV/AIDS has reached alarming proportions in South Africa and demands attention.
- The youth play an important role because they are high-risk persons.
- Traditional forms of sex education within extended families are not sufficient.
- The adolescents are not equipped with life skills to ensure a better life style.
- The current situation bears testimony that the youth formerly did not have the knowledge to protect themselves especially against HIV/AIDS infection.
- It is recommended that the purpose of the social workers should be to present life skills training in an effort to change the attitude and behaviour of the youth.

It is therefore necessary to evaluate this program on HIV/AIDS and life skills and to establish whether the adolescents benefited from the group sessions and whether the goals were reached.

It is further recommended that this type of program be implemented as a group work method by social workers in South Africa because of the current context of HIV/AIDS.

An additional recommendation is that the program be evaluated and tested to determine whether or not the aims and objectives planned to empower the youth were successful.

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SECTION 4: GENERAL SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

1. INTRODUCTION

This chapter institutes the final steps of the research report. Research was conducted to investigate the knowledge, skills and behaviour of adolescents about HIV/AIDS and life skills in an urban area. To accomplish this aim, the following objectives were formulated:

- To identify the needs of adolescents and extend of their knowledge, skills and attitudes towards MV/AIDS and life skills through an empirical research and literary study.
- To design a life skills program through a literature study and empirical research, in order to improve the social functioning of adolescents.

1.1 SURVEY PROCEDURE

The survey procedure can be conducted in different ways. In this research the following steps were followed:

- A convenience sample of high school learners in grade 9 were selected from a school in Ikageng near Potchefstroom.
- Data was collected by the researcher through a structured questionnaire during interviews with the high school learners.

2. CONCLUSION

2.1 AIM OF THE RESEARCH

The aim of this research was accomplished through a study of the relevant literature and through empirical research. The literature consulted indicated that HIV/AIDS in South Africa have an enormous impact on all the people in South Africa. The study proves that families affected by HIV/AIDS are faced with multiple health care as well as psychosocial problems. Communities with a high prevalence of HIV/AIDS are experiencing a disadvantage that is even more worsened by poverty, a limit access to important services and poor infrastructures. The loss of parents is enormous and the most common effect on children is that they loose their support system in a vulnerable time of their lives. Children need love, discipline and security. They also experienced emotional trauma as well as the loss of their financial support system. Children also need to be intensively educated about life skills to enhance their standard of living. The living conditions of the children in the townships often results in a negative life style because of certain needs that is not fulfilled. The children did not receive the necessary information about the disease, and therefore has a lack of knowledge or limited knowledge. The exploration of the needs of adolescents and extend of their knowledge, skills and attitudes towards HIV/AIDS will

give an understanding to social workers, in order to develop guidelines for appropriate life skills programs. The program will be used to educate adolescents and to influence their attitude towards HIV/AIDS and reduce high risk behaviour.

2.2 SURVEY PROCEDURES

- The study managed to reveal the level of knowledge concerning demographic data. The data was used to describe the study sample, since social status may have an effect on general health and development of children.
- There is a need for preventative skills training programs that will empower the youth and help them to feel confident in their ability to cope with the challenges of life.
- There is an urgent need among adolescents for more knowledge and information on HIV/AIDS.

It seems that there is a shortage of professional services to adolescents in the black urban areas.

3. RECOMMENDATIONS

The following recommendations can be made following the outcome of the study:

- The problem of AIDS remains a central issue in South Africa. The pandemic proportions of AIDS and the consequences for all the people, young and old, are widely acknowledged. It is recommended that:
- A program is developed to educate adolescents about HIV/AIDS in an objective and factual manner.
- Adolescents are also not equipped with life skills to ensure a better life style. The challenges facing our youth are numerous and that is why it is necessary to also educate them by means of a group work program consisting of various life skills topics.
- Material and facilities like videos, films, flipcharts, books and posters are indispensable in a program and should be used.
- Efforts should be made that the education reaches everybody in every school and community throughout the country.
- It is recommended that programs about HIV/AIDS and life skills should be linked and that the Government must give their financial support.
- Looking at the situation in the black urban areas like Ikageng there is not enough professional services available and that is the reason why children become vulnerable victims of circumstances. They largely depend on the advice from people who are not educated and information is often misleading.

- This program must be evaluated and tested to see if the aims and objectives planned to empower the youth were successful.
- The findings of the research indicate that the main focus should be on education and used continuously in South Africa.

4. CONCLUDING REMARKS

In conclusion, the aims that were highlighted for this research were accomplished in that the needs of the children were identified. It was also established that social work services have not been appropriately rendered to address the needs of children affected by HIV/AIDS in Ikageng.

The recommendation provided in this research allows that further research can be conducted in the same field.

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SECTION 6: ANNEXURES

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11 Februarie 2004

Prof HH Vorster
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NWU (Potchefstroomkampus)

Geagte prof Vorster

GOEDKEURING VIR EKSPERIMENTERING MET MENSE

Hiermee wens ek u in kennis te stel dat u projek getiteld

Physical Activity in the Young (PLAY-project)

op 11 Februarie 2004 goedgekeur is met nommer 04M01. Gebruik asseblief laasgenoemde nommer in alle korrespondensie rakende bogenoemde projek en let daarop dat daar van projekleiers verwag word om jaarliks in Junie op die voorgeskrewe vorm (wat voorsien sal word) aan die Etiekkomitee verslag te doen insake etiese aspekte van hulle projekte asook van publikasies wat daaruit voortgespruit het.

Goedkeuring van die Etiekkomitee is vir 'n termyn van hoogstens 5 jaar geldig (volgens Senaatsbesluit van 4 November 1992, art 9.13.2). Vir die voortsetting van projekte na verstryking van hierdie tydperk moet opnuut goedkeuring verkry word.

Die Etiekkomitee wens u alle voorspoed met u werk toe.

Vriendelike groete

ESTELLE LE ROUX
NAMENS SEKRETARIAAT

DEMOGRAPHIC AND HEALTH SURVEY: PLAY STUDY

IDENTIFICATION		
Number of participant::		
Date of interview:		
Household address:		
Total in household		
Children 1 – 6 years	**Male**	**Female**
Children 7 – 12 years		
Children 13 – 18 years		
Total adults 18 – 30		
Total adults 31 – 45		
Total adults 46 – 60		
Total adults 61 years +		
Children under 1 year		

LANGUAGE AND ACCULTURATION				
Home language of respondent	Tswana1	Sotho2	Xhosa3	Other:4/5/6
Household head speaks:	Home language only 1	Home language + English/Afrikaans 2	English/Afrikaans only 3	

Can YOU read and understand a letter or newspaper in your home language easily, with difficulty, or not at all? Mark the answer.	Easily =1
	With difficulty =2
	Not at all =3
Can YOU read and understand a letter or newspaper in your English easily, with difficulty, or not at all? Mark the answer.	Easily =1
	With difficulty =2
	Not at all =3

NEAREST CLINIC		
NAME OF CLINIC	WALK (How many minutes)	Mode of TRANSPORT (Walk1Taxi/2Own car3/Other……………….)
Potchefstroom clinic 1		
Steve Tshwete 2		
Top City 3		
Boiki Tlapi 4		
Lesego 5		
Promosa 6		
Mohadin 7		

HOUSEHOLD SCHEDULE (Now we would like some information about the people who usually live in your household or who are staying with you now)															
No	**USUAL RESIDENTS AND VISITORS**	**RELATION -SHIP TO HEAD OF HOUSE-HOLD**	**RESIDENCE**				**SEX**		**AGE**	**WORK**				**GRANTS/PENSION**	
	Please give me the names of the persons who usually live in your household and guests of the household who stayed here last night, starting with the head of the household	What is the relationship of **(NAME)** to the head of the household?	Does **(NAME)** normally live here?		**Who is the breadwinner in your home?** **1=father** **2=mother** **3=both parents** **4=grandparent** **5=uncle/aunt** **6=sibling**		Is **(NAME)** a male or a female? 1=male 2=female		How old is **(NAME)**?	Did **(NAME)** work for any pay during the last week?		What kind of work does (NAME) do? 1=professional 2=own business 3=office work 4=factory/trade 5=cleaner/house 6=informal other……………		Does **(NAME)** receive a child maintenance grant, disability grant or a pension from the government?	
			Yes	No	Yes	No	Male	Female		Yes	No	Yes	No	Yes	No
1															
2															
3															
4															
5															
6															
7															
8															

NO	USUAL RESIDENTS							
	Write the name if it is necessary (when the question apply to the name)	Has **(NAME)** ever been to school?		What is the highest level of school **(NAME)** completed?	Is **(NAME)** still in school? Applicable to all persons that is still in school (also pre-school). If the answer is NO with a child, give reason		What is the distance that **(NAME)** must travel to school (also pre-school)?	What type of transport does **(NAME)** use to get to school (also pre-school)? 1=walk 4=family car 2=taxi other………. 3=bicycle
		Yes	No		Yes	No		
1								
2								
3								
4								
5								
6								
7								
8								

GENERAL QUESTIONS ON HOUSEHOLD

What type of house do you live in: Traditional hut Mokuku Brick house Other:...................

What is the source of drinking water for members of your household?

Option	Code	
Piped water (tap) in dwelling	1	
Piped water in yard	2	
Public tap	3	
Water carrier/tanker	4	
Borehole/well	5	
Dam/River/Stream/Spring	7	
Rain-water tank	8	
Other / Remarks	9	

Question	Answer
How long does it take you to get the water and come back?	...........minutes

What kind of toilet facility does your household have?

Option	Code	
Flush toilet (own)	1	
Flush toilet (share)	2	
Bucket latrine	3	
Pit latrine	4	
No facility/Bush/Field	5	
Other / Remarks	6	

What does your household use for cooking and heating? Record all mentioned.

Option	Code	
Electricity	1	
Gas	2	
Paraffin	3	
Wood	4	
Coal	5	
Animal dung	6	
Other / Remarks	7	

What is the main material of the floor? ~~Record observation.~~

Option	Code	
Earth/Sand/Dung	1	
Bare wood planks	2	
Cement	3	
Vinyl	4	
Carpet	5	
Ceramic tiles	6	
Other / Remarks	7	

What is the main material in the walls? ~~Record observation~~.

Option	Code	
Plastic/Cardboard	1	
Mud	2	
Cement and mud	3	
Corrugated iron/Zinc	4	
Prefab	5	
Bare brick/Cement block	6	
Plaster/Finished	7	
Other / Remarks	8	

Question	Answer
How many rooms are in your household?	...........rooms
How many rooms in your household are used for sleeping?	...........rooms

GENERAL QUESTIONS ON HOUSEHOLD (CONTINUE)				
Do you or someone in the household belong to a feeding scheme?			Yes-1	No-2
How many of the people in this household belong to a feeding scheme?			……….people	
Do you have a food garden? Yes=1/No=2 (circle) If answer is NO ask reason. ………………………………………………………… ……..				
Would you say that the people in your household often, sometimes, seldom or never go hungry? Mark the answer.	Often 1	Sometimes 2	Seldom 3	Never 4
Would you say that the people in your household have to cut meal size because there is not enough food? Mark the answer.	Often 1	Sometimes 2	Seldom 3	Never 4

Does your household have one or more of the following:			
Electricity	1	Yes-1	No-2
Radio	2	Yes	No
Television	3	Yes	No
Telephone (land-phone)	4	Yes	No
Cell-phone	5	Yes	No
Refrigerator	6	Yes	No
Washing machine	7	Yes	No
Personal computer	8	Yes	No

Does any member of your household own one or more of the following:			
Car	1	Yes	No
Motorcycle	2	Yes	No
Bicycle	3	Yes	No
Donkey/Horse	4	Yes	No
Sheep/Cattle	5	Yes	No

GENERAL HEALTH INFORMATION OF THE HOUSEHOLD MEMBERS											
JSUAL RESIDENTS Vrite the name if it is ıecessary (when the ղuestion apply to the name)		GENERAL HEALTH			**Is anyone in the household covered by a Medical Aid/Medical Benefit Scheme?** **(Any scheme that helps you pay for health drug service)**		Has any person **(NAME)** in the household been ill/sick the past year? If YES specify illness of **(NAME)** (Probe for the reason why the person is bedridden if so)		Is any person in the household terminally ill? If YES specify who **(NAME)** is taking care of the terminally ill person	
ı	**Name**	**Good**	Average	Poor	Yes	**No**	**Yes**	**No**	**Yes**	**No**

CHRONIC AND OTHER DISEASES		
s any person in the household been ill/sick past 6 months? he illness one of the following? 'ES, ask the name of the person and let the pondent explain the illness. ther disease than mentioned, specify	ILLNESS	NAME of PERSON with illn
	High Blood Pressure	
	Stroke	
	Diabetes/Blood Sugar	
	Asthma	
	Cancer	
	Lung infections e.g. Bronchitis/Pneumonia/TB /Flu	
	Sexual transmitted disease (discharge, sores on penis/vagina,HIV?AIDS)	
	Other	

OTHER HEALTH INFORMATION		
Has anyone in the household died in the last 12 months?	Yes =1	No =2
In the last 12 months how many people in your household died?	……….. people died	

What was the cause of the death? Specify for each one of the members that died.	

SPIRITUAL NEEDS		
Do you belong to a church? Yes=1/No=2		
If 'yes' what is the name of your church? AME=1, ZCC=2, Anglican=3, Methodist=4, Catholic=5, Gereformeerde=6, Apostolic=7, Other: …………………………………………………………………8/9/10		
Do you believe that a person have spiritual needs? Specify why you say YES/NO	Yes =1	No =2
Where do you go for spiritual help?		

HABITS AND LIFESTYLES Now we would like to ask questions about the household's diet and some other habits of persons in the household that you could observe.		
Have you or the other members of the household smoked or use some of the following?	TYPE	AMOUNT
	Cigarettes	
	Tobacco/Pipe	
	Snuff	
	Chewing tobacco	
	Dagga	

Does any person in the household drink alcohol? Also homemade beer.	Yes=1	No =2
If the answer is YES, probe for the average that is drunk during one week. Ask if it is one bottle/day? Or is it more than one bottle/day.	……….bottles/week	
Where do the persons in the household drink their alcohol? Specify		
Do you or anyone else in the household do exercises?	Yes =1	No =2

If the answer is YES, ask what exercises do they do. Specify.

……
……

Now we are going to ask you questions on some social behavior. Please remember that this information will be kept strictly confidential and that this is only to test your knowledge.		
Do you have a boyfriend/girlfriend	Yes =1	No =2
Do you only sleep with one partner?	Yes =1	No =2
Have you ever heard of sexual transmitted diseases?	Yes =1	No =2
Have you ever heard about the disease called HIV/Aids?	Yes =1	No =2
Do you know what a condom is?	Yes =1	No =2
The last time you had sex did you use a condom?	Yes =1	No =2
In the last 12 months with how many men/women did you had sex?	..........Men/Women	
Do you know where you can get a condom?	Yes =1	No =2
Do you use a condom?	Yes =1	No =2
If the answer is NO ask why don't the person use a condom? RECORD ALL MENTIONED		
Have you ever had a HIV/Aids test done?	Yes =1	No =2
Do you know where to go for a HIV test?	Yes =1	No =2

How can people protect themselves from HIV/Aids?	Yes	No	Don't know
Having a good diet 1			
Staying with one faithful partner 2			
Avoiding public toilets 3			
Using condoms during sexual intercourse 4			
Avoiding touching someone with HIV/Aids 5			
Avoid sharing razor blades 6			

From whom do you get information on HIV/Aids?		
	Friends 1	
	Parents 2	
	TV 3	
	Radio 4	
	Newspapers5	
	Magazines 6	
	Clinic 7 sister/Doctor	
Other: 9/10/11	Religious leaders 8	
	Politicians 9	

	Teacher 10		
Do you trust the information that you get? Specify	Yes =1		No =2
From whom would you prefer to get correct information on HIV/Aids? The person can mention more than one. Write down all the person mentions (use codes in previous question)			
How would you prefer to get information on HIV/Aids? (They can mention more than one)	Personally (mouth to mouth) 1		
	Read about it 2		
	See on TV or in magazine 3		
	Listen on the radio 4		
Do you know any organisation/NGO, etc. that provides information/lecturers on HIV/Aids? If YES ask for the names	Yes =1		No =2

Thank you for taking part in this survey. If you have any questions we are willing to answer them now if it is possible.

How do you feel about this visit?

....

....

INTERVIEWERS OBSERVATIONS
Comments about the Respondent/s:... .... Comments on Specific questions:... .... Any other comments:... ....

Compiled by Mada Watson (Senior Lecturer: PU for CHE) and recommendations from the Potchefstroom Wellness Forum and Cornelia Wessels.