A study of perceptions, attitudes and knowledge as it pertains to susceptibility to HIV/AIDS among Grade 11 pupils in Grahamstown.

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ABSTRACT

HIV/AIDS has emerged as the leading cause of death in South Africa, with young people being the most affected. Awareness of HIV/AIDS is quite high, yet prevalence rates have not stabilised and are still climbing. Lack of sexual behavioural change among young people is a major factor which explains why prevalence rates are still on the increase among this population. Sexual behaviour change is influenced by perceptions and attitudes, most notably perceived susceptibility. Information on the psychological factors that affect perceived susceptibility can provide an important base for the development of programmes aimed at reducing further transmission among young people. A survey, using a self-administered, anonymous questionnaire with close-ended questions to collect data, was conducted among Grade 11 learners (n = 318) in Rini, Grahamstown, South Africa. One of the constructs (namely Perceived Susceptibility) in the Health Belief Model informed the data collection. The data generated were first analysed descriptively, providing percentages for responses. Secondly cross-tabulations were calculated. The results showed that knowledge about HIV/AIDS is sufficient, young people receive accurate and non-conflictual messages about sex and HIV/AIDS, they are not discriminatory towards People Living With HIV/AIDS, they have adequate access to healthcare and their perceived susceptibility to HIV/AIDS is high. All these are factors which are favourable and conducive for positive sexual behavioural change. However, the study also found that there was little behaviour change among young people especially regarding regular condom use and decreased sexual activity.

DECLARATION

I hereby declare that the work connected to this thesis was exclusively carried out by myself, under the supervision and guidance of Mr Gary Steele, and that the whole thesis, unless specifically indicated to the contrary, is my own work.

This thesis has never been submitted for a degree at any other university.

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Chapter 1 – The Context

Over the past twenty years Acquired Immune Deficiency Syndrome (AIDS) has emerged as one of the most serious epidemics known to man. When it first emerged, no one could have predicted how it would spread across the world and how many millions of lives it would change. Governments and the medical fraternity had no real idea as to its origins and what caused it and no real idea how to protect against it. Now it is known that AIDS is caused by the HI virus and that it has devastating effects on families, communities and whole continents. Freddriksson and Kanabus (2005, p. 45) state "...this pandemic has knocked decades off countries' national development, widened the gulf between rich and poor nations and pushed already stigmatised groups closer to the margins of society." HIV/AIDS has proved to be the first truly 'international' epidemic, easily crossing oceans and international borders. Research figures from around the world show a horrifying picture; more than 20 million people around the world have died of AIDS-related diseases (Freddriksson & Kanabus, 2005). In 2004, 3.1 million men, women and children died. Around twice the amount of people who have died until now – almost 40 million – are now living with HIV and most of these are likely to die over the next decade or so. The most recent UNAIDS/WHO estimates show that in 2004 alone 4.9 million people were newly infected with HIV (Freddriksson & Kanabus, 2005). In sub-Saharan Africa an almost universal awareness of the serious consequences of AIDS and of the sexual transmission of HIV co-exists together with a reluctance in adopting consequent preventive measures, in the form of protected sexual intercourse. This is a result of (among other things) different attitudes and perceptions that exist among some young people. These perceptions and attitudes impact on their susceptibility to HIV/AIDS which then plays a role in the current situation that exists concerning HIV resulting in a cycle of hopelessness and death (Hackney, 2002).

1.1) What are HIV and AIDS?

There is a distinction between the HIV virus and AIDS, being HIV positive does not mean one has AIDS. HIV is the Human Immunodeficiency Virus (Khomanani, 2005). It is transmitted through blood, semen and vaginal fluids. Once the virus has infected a person it uses CD4 cells of the body's immune system to replicate itself, and in the process destroys these cells. CD4 cells are vital because they co-ordinate the body's immune system, protecting it from illness. As the amount of HIV in the body increases, the number of CD4

cells decreases, weakening the immune system even further. AIDS is the Acquired Immune Deficiency Syndrome. It is a collection of opportunistic infections and diseases that are 'acquired' from HIV once the immune system is no longer able to protect the body from illness. When a person's immune system has deteriorated so much that he or she starts becoming ill with life - threatening and often unusual illnesses, he or she is said to have AIDS. Quicker AIDS progression can also be brought on by psychological factors such as depression, which can cause a person to avoid eating thus weakening their immune system. The AIDS pandemic has occurred differently and has taken different characteristics in different regions of the world (Freddriksson & Kanabus, 2005).

1.2) HIV in the regions of the world

Every country has been affected by the HIV/AIDS pandemic, but in different ways. In high-income nations, HIV infections have historically been concentrated principally among Injecting Drug Users (IDUs) and gay men (Marais & Stanecki, 2004), however, research figures in several Western European countries reflect that a significant proportion of new HIV diagnoses are occurring through heterosexual intercourse. The virus had spread widely before it was even identified and had established a firm grip on the gay male population by the early 1980s. The rate of new infections dropped significantly during the mid and late 1980s, however, recent information suggests that risky behaviour may be increasing again in some communities (Marais & Stanecki, 2004). IDUs in high-income countries have proven to be a high-risk group with high prevalence rates. Many countries have failed to start or maintain needle exchange and other prevention programmes due to different reasons, and this has resulted in continuing high prevalence rates among this population (Marais & Stanecki, 2004).

The HIV rates in Eastern Europe are reflecting that this is the fastest growing arm of the HIV pandemic. A total of 1.4 million people were living with the virus in 2004 and it claimed 60 000 lives. The epidemic in Eastern Europe is driven by injecting drug use and the fact that this practice is criminalised makes it difficult to gain an accurate picture of the proportion of drug users who are HIV positive (Marais & Stanecki, 2004). The route of heroin smuggled into the West crosses through a number of Eastern European countries and its path is marked by a high concentration of IDUs and a high HIV prevalence (UNAIDS, 2004).

The epidemic in Asia and the Pacific is of a more recent origin and many Asian countries lack accurate systems for monitoring the spread of HIV. Around 1.2 million people in Asia and the Pacific acquired HIV in 2004 bringing the number of people living with HIV to an estimated 8.2 million. A further 540 000 people are estimated to have died of AIDS in 2004. National adult prevalence is still under 1% in the majority of the region's countries. That figure, though, can be misleading. "Several countries in the region are so large and populous that attention is only drawn to major urban areas, which may obscure serious epidemics in smaller provinces and states" (Marais & Stanecki, 2004). Even though Asia has high prevalence rates in general, the epidemic is centred among particular high-risk groups – men who have sex with men, IDUs, sex workers and their partners. The epidemic has already spread beyond these groups into the general population.

Latin America also has rapidly rising HIV prevalence rates. Around 1.7 million are living with HIV in Latin America. In 2004 around 95 000 people died of AIDS and an estimated 240 000 people were newly infected (Marais & Stanecki, 2004). Most transmission in Central American countries and countries on the Caribbean coast occurs through sex between men and women but there are also very high rates of infection among men who have sex with other men and IDUs. The countries with the highest prevalence rates in the region tend to be found on the Caribbean side of the continent. This might be due to the fact that HIV prevalence rates in this region are the second highest in the world after sub-Saharan Africa (Marais & Stanecki, 2004). A combination of poor governance, poverty and conflict has fuelled high prevalence rates in most of the countries in this region. In the most affected countries of the Caribbean, the spread of HIV infection is driven by unprotected sex between men and women, although infections associated with injecting drug use are common in some places, such as Puerto Rico (Freddriksson & Kanabus, 2005).

1.3) HIV situation in sub-Saharan Africa

The HI virus has had the most severe impact in sub-Saharan Africa. Figures show that one-tenth of the people aged 15-49 in sixteen countries are infected with HIV (Marais & Stanecki, 2004). Infection rates are steadily increasing and an estimated 3.1 million people in this region were newly infected in 2004, the most recent year for which data is available (World Bank, 2004). This means that there are now an estimated 25.4 million people living with HIV/AIDS in this region. 2.3 million people died of AIDS in 2004, it has orphaned 12 million children and around 2 million children under 15 are living with HIV. The large

number of people who got infected 7-10 years ago are now becoming ill and the extent of the epidemic is now becoming clearer. Due to the fact that effective prevention, treatment and care programmes are lacking, the AIDS death toll is expected to continue rising before peaking around the end of the decade (Freddriksson & Kanabus, 2005). This means that the worst of the epidemic's impact will be felt in the course of the next 10 years and beyond and it has already had an enormous impact on many parts of society. Southern Africa has been the most affected region, more especially South Africa. Negative attitudes and perceptions towards people living with HIV/AIDS and negative attitudes towards taking the necessary precautionary measures could be the cause of the high HIV prevalence rates (Hackney, 2002).

1.4) HIV/AIDS and the youth in South Africa

South Africa is a large country with an estimated population of around 40 million. 28% of people in South Africa have been affected by HIV/AIDS and 13% of all the people in the world living with HIV can be found in South Africa (Berry, Freddrikson & Noble, 2005). UNAIDS estimates that at the end of 2003 there were 5.3 million people in South Africa living with HIV, which is 21.5% of the population. It is estimated that about 600 people die of HIV-related illnesses each day. A large number of people living with the HI virus consist of the youth.

The terms 'adolescents' and 'young people' are defined by the World Health Organisation (WHO) as the age-group 10-19 years and 10-24 years, respectively. There are 1.2 billion adolescents and 1.7 billion young people in the world today (WHO, 2003). In general terms the meaning of adolescence is considered a time of transition from childhood to adulthood during which there are physical changes associated with puberty (WHO, 2003, p3). The WHO report (p. 34) further states:

> Adolescence is both a period of opportunity as well as a time of vulnerability and risk. It is a time when new options and ideas are explored. As such it is a phase in life marked by vulnerability to health risks, especially those related to unsafe sexual activity and related reproductive health outcomes (e.g. unwanted pregnancy) and by the obstacles to the exercise of informed reproductive choice.

At least a third of the 30 million people living with HIV/AIDS in the world are reported to be less than 24 years of age (UNAIDS, 2000). The AIDS pandemic has reached epic proportions and young people are the most affected. 60% of all young people who acquire HIV become infected before they turn 25 years of age (WHO, 2003). Sub-Saharan Africa's populations are young (over 50% of the region is estimated to be under 18 years of age) and the high HIV/AIDS prevalence rates result in a concentration of new infections among the youth. It is also estimated that within sub-Saharan Africa, at least a third of 15 year-olds will die of AIDS. Young women are particularly vulnerable: biological, social and economic factors place them at a greater risk of infection. Young men are also vulnerable: peer pressure and cultural imperatives make them engage in risk-taking behaviour. High infection rates reflect the extent to which the disease has spread among the youth. Despite the high levels of awareness of HIV/AIDS among the South African youth, many continue to be exposed to high-risk situations and many are still unaware of how to protect themselves.

Research findings have reflected that youth in South Africa are even more susceptible to HIV/AIDS than in other countries. Govender, Bhana, Pillay, Panchia, Padayachee and De Beer (1992) state: "Many South African youth underestimate their risk for contracting HIV. Perceptions of risk are unrealistically low among the youth who, in some instances, have high rates of sexual activity and low condom use" (p. 2). This is aggravated by the factors that reduce perceived susceptibility such as the tendency to deny the presence of HIV/AIDS in one's own community, particularly in rural areas where there is still great stigma attached to AIDS (Richter, 1996). Fewer than half of South African youth in the 1990s perceived any risk to themselves and fewer than 20% perceived HIV/AIDS as a high risk (Govender et al., 1992). Many still have limited knowledge and hold negative attitudes and perceptions about the pandemic, this results in the youth perceiving themselves as being less susceptible to the virus (Richter, 1996).This happens when for instance a young person believes that a healthy-looking person cannot be infected by the HI virus. This is an example of limited knowledge that can lead to that young person having unprotected sexual intercourse with a person who seemingly is not infected. Research carried out in South Africa does indicate that higher perceived susceptibility about personal risk is linked to greater intended or actual sexual behavioural change (Govender et al., 1992). That is why there is an urgent need for researchers to investigate these perceptions and attitudes, so as to obtain answers that will help in combating its spread among the youth. Perceived susceptibility to the HI virus seems to be an underlying factor in the prevalence of the virus. It is important, however, to analyse

the history of HIV/AIDS in South Africa and to know how it has influenced the way young people perceive themselves to be susceptible to HIV/AIDS.

1.5) The history of HIV/AIDS in South Africa

Many people have asked this fundamental question: Why does South Africa have one of the highest HIV rates in the world? The answer to this question lies in how South African society has developed in the past and the impact that this has had on the HIV/AIDS pandemic. Past apartheid government policies have weakened community resilience (Walker, Reid & Cornell, 2004). Communities often lack the social resources to manage and curb the spread of disease. This is referred to as Social Capital (Walker et al., 2004). Putnam, Leornadi and Nannetti (1993) define Social Capital as "The existence of community networks, civic engagement (participation in these community networks), local identity and a sense of solidarity and equality with other community members and finally norms of trust and reciprocal help and trust". The existence of Social Capital in any community is linked to positive health outcomes (Walker et al., 2004). Young people who feel that they are in command of their lives and are supported by trusted networks and positive role models are more likely to heed warnings about condom use and other safe-sex practices. However, the majority of young people live in communities where there is an absence of these factors and this becomes an obstacle to HIV prevention programmes. Walker et al. (2004) state: "In a context where violence, substance abuse and social divisions are the order of the day, social cohesion and a sense of community are stifled and prevention programmes are unlikely to gain wide acceptance." Communities of this nature such as the Cape Flats in Cape Town arose out of the governments' policies of forced removals and the Group Areas Act (Walker et al., 2004).

Social cohesion, which exists in areas where there is Social Capital, plays an important role in the way people deal with the psychological aspects of poverty and HIV/AIDS. Fajinzylber, Lederman and Loayza (1998, p.23) state: "Social cohesion counters the psychological isolation created by poverty in two ways:

- It affirms the humanity of poor people even in the most degrading physical and economic circumstances.
- It increases their access to resources via those same social connections."

The psychological strains of people living with HIV/AIDS in areas where there is little Social Capital are more evident. This is because the absence of social solidarity and emotional support from community members leads to a faster progression of the HI virus to full-blown AIDS (Fajinzylber et al., 1998). A lack of social cohesion also results in more negative attitudes and perceptions towards aspects of HIV/AIDS (Civil Society Initiatives, 2002). This is especially true among young people who might not have positive role models in the community and support structures who might reinforce appropriate attitudes.

A combination of repressive urbanisation policies, acute housing shortages, the recession and conditions in homelands and farming areas all contributed to produce large numbers of shack settlements. This meant that there were large numbers of people living in abject poverty without running water, electricity and adequate healthcare. This provided fertile ground (in the 1980s) for the HI virus to spread unchecked. The migrant labour system is and was a pivotal factor that exacerbated the pandemic (Walker et al., 2004). Large numbers of people moved from rural areas to urban areas to provide cheap labour as miners, farm workers, domestic servants and factory workers. The long-term separation of migrant men from their wives and families resulted in unhealthy social relationships. The separation of spouses led to extra-marital affairs where HIV/AIDS would spread rapidly. State sponsored violence intensified in the dying days of apartheid. A low intensity war waged within and beyond South Africa's borders further unsettled communities, especially in Kwa Zulu Natal and Gauteng. Walker et al. (2004, p. 54) state: "War creates the perfect conditions for the spread of AIDS: the movement of combatants across national borders, acts of rape and sexual violence that are associated with war, the presence of commercial sex workers and transient sexual relations". Political volatility and turbulence masked the progress of HIV/AIDS. As the virus progressed in the early 1990s, there was a missed opportunity for curbing its spread. Walker et al. (2004, p.86) point out that: "...the immediate concerns of political transition overshadowed all other issues. The intangible and unseen HIV/AIDS epidemic receded in the face of immediate political considerations". The transition to democracy called for a re-organisation of government departments. The fourteen departments of Health that had existed in the apartheid government had to be incorporated into one department. Walker et al. (2004, p.67) state: "Health officials who had begun to notice changing patterns of morbidity and causes of death (due to HIV/AIDS) became embroiled in bureaucratic restructuring. Thus a vital moment in the progression of the epidemic was overlooked".

Poverty has always been a major factor in the prevalence and spread of diseases, it has had a major role in the present HIV/AIDS crisis.

1.6) Poverty and its role

Recently, there has been a recognition that individual behaviour needs to be considered within its economic, social and cultural context (Health Systems Development Unit, 1997). This will improve the chances that efforts to alter it succeed. The HIV/AIDS pandemic has a very close relationship with poverty; one reinforces the other. Statistics demonstrate how a large number of people affected or infected by HIV/AIDS live in poverty. President Thabo Mbeki highlighted poverty as a factor contributing to the epidemic (Health Systems Trust, 2004). In light of this fact, implications of prevention efforts need to be understood. A disproportionate number of people affected by the pandemic live in the poorer countries of the world. Health Systems Trust (2004) states: "...at the global level there is a positive correlation between HIV prevalence and poverty, whether this is measured by Gross Domestic Product per person, income inequality or Human Poverty Index." However, it is important to also note that in Africa, HIV prevalence has been shown to be positively correlated with national income, with many of the continent's wealthiest countries such as South Africa and Botswana, having the most extensive epidemics (Fenton, 2004). There are several explanations for these findings. National statistics mask the inequalities that occur within countries, and it is likely that the poorest sectors of the population are still the most severely affected. This is most definitely the case in South Africa, which is a country that has been described as having two economies. Another explanation that has been suggested is that in the early stages of the epidemic more wealthy populations were vulnerable to infection because for example, of greater opportunity to travel (Fenton, 2004). Health Systems Trust (2004) goes on to state: "...as awareness of the epidemic has grown, however, wealthier populations have been more able to access prevention messages and the means of prevention and the pattern of infection might be shifting towards those with lower socio-economic status". Where there is poverty, there is often a lack of education. Illiteracy rates in impoverished communities are usually high, which means that messages regarding risk and prevention are inaccessible. Where knowledge of the risks exists, the cost of prevention may be too high. People's options are restricted and they are left with few options but to undertake high-risk behaviours.

Poverty increases susceptibility to HIV/AIDS (Fenton, 2004). Two distinctions have been made regarding susceptibility to HIV/AIDS: there is biological and social susceptibility. Medical scientists have argued that poverty increases biological susceptibility to HIV/AIDS in the same way it does many other infectious diseases. Health Systems Trust (2004, p.45) points out: "Malnutrition, parasitosis and lack of access to healthcare among the poor, undermine epithelial integrity and immunity and increase the likelihood of having untreated STIs. All of these influences can increase susceptibility to HIV infection and progression." The other type of susceptibility is social susceptibility. Perceived susceptibility or perceived risk can be affected by the problems that the individual is facing presently and the probable aspects of the future. Health Systems Trust (2004, p.58) mentions: "When the future is bleak and immediate survival is in question, the ability to take a long-term perspective on risk might seem like a luxury." So it will be unlikely that people living in poverty will consider whether they are at risk or not before engaging in sexual activities.

1.6.1) How does poverty exacerbate HIV?

People's socio-economic circumstances largely determine their sexual behaviour (Khomanani, 2005). For instance, people living in poverty are more likely to migrate to urban areas in search of work. In some cases this might lead them to have unprotected sex with new partners as well as their stable partners, making them and their partners vulnerable to HIV infection. In most cases, people living in poverty do not have easy access to health services. The costs of getting to a clinic for an HIV test, treatment for STIs or even free condoms may be great, especially if one is unemployed or earning very little (Khomanani, 2005). Women living in poverty are also more likely to engage in prostitution so that they can survive and support their families. People living in poverty might also not have access to information about sexual health, and thus may not know how to protect themselves and their partners from HIV.

1.6.2) How does HIV increase poverty?

When people fall ill, HIV increases poverty in a number of ways. Illness leads to high rates of absenteeism. This may lead to them losing their jobs and their families being pushed deeper into poverty (Freddriksson & Kanabus, 2005). People who are HIV positive have to spend their money on health needs, such as healthy nutritious food, vitamin and mineral supplements, immune boosters and anti-retroviral medication. This results in the neglect of

other basic needs such as warm clothes for the children (Freddriksson & Kanabus, 2005). Poverty is increased as well when breadwinners die prematurely of AIDS and the elderly have to use their pensions to care for their grandchildren. Children, especially girls, are forced to leave school to care for relatives who are ill. They are denied an education, which results in them living in poverty as adults. Unscrupulous relatives might deny children and their mothers of their inheritance and they may be forced out of their homes once the father or husband dies (Save The Children, 2005).

Health Systems Trust (2004, p.34) states: "Poverty plays a role in creating an environment in which individuals are particularly susceptible and vulnerable to HIV/AIDS, poverty reduction will undoubtedly be at the core of a sustainable solution to HIV/AIDS". HIV/AIDS policy formulators need to be aware of the role that poverty plays in the pandemic.

1.7) The Health Belief Model

The Health Belief Model was developed in the 1950s by psychologists in the United States Public Health Service who were attempting to understand why people failed to participate in programs designed to prevent or detect disease (Rosenstock, Stretcher, & Becker (1994). It was developed further in the 1970s and 1980s in order to predict behavioural responses to treatment and also to predict preventive health behaviours in acutely and chronically ill patients (Ogden, 2004). It has been used extensively by many health researchers and probably has been used more than any other health behaviour change model over the past decades (Peterson & DiClemente, 2000).

The model is a value-expectancy model which is used in explaining and predicting an individual's health behaviour based on their attitudes, perceptions and knowledge. The *value* is regarded as the wish to avoid illness and to maintain good health. The *expectancy* is that certain behaviours will prevent illness (Harvey, 1997). It is based on the understanding that a person will take a health-related action (e.g. use of a condom) if that person perceives a threat to his/her health (perceived susceptibility), perceives his/her condition as serious, perceives that there are benefits of preventive action, perceives that he/she has the ability to effect change and perceives that there are few barriers to him/her taking the required preventative action (Peterson & DiClemente, 2000). For the purposes of this study, the Health Belief Model will be relied on as a guiding framework and one construct which is a

part of this model will be utilised. The benefit of utilising this model as a guiding framework is that it clearly explains how a person's perceptions can influence the type of behavioural decision they might take. The model identifies a number of factors or constructs that function to either promote or inhibit the adoption of healthier behavioural options. One of these constructs is 'perceived susceptibility'. Perceived susceptibility is one's opinions of chances of getting a condition (in this case HIV/AIDS). This factor or construct in the model goes on to state that a person's willingness to take a health-related action or behaviour (e.g. use condoms during sexual intercourse) will be determined by his/her opinion of chances of contracting HIV/AIDS. Govender et al. (1992) state "The Health Belief Model stresses the importance of perceptions about one's susceptibility or vulnerability to a health threat as a key determinant to health behaviour" (p. 2). It further asserts that an individual's perceived susceptibility to a particular health problem may lead them to change their behaviour concerning their health (Richter, 1996). This places critical importance on an individual's attitudes and perceptions as a determinant to their behaviour. What makes the model particularly useful for this study is that it explains how perceptions, attitudes and knowledge influence health behaviour. It also asserts that people will change their health behaviour depending upon their perceptions, attitudes and knowledge (Rosenstock et al., 1994).

Perceived susceptibility affects behaviour in two ways. Firstly if an individual perceives that he/she is not susceptible to HIV/AIDS or they have a perception that their susceptibility is low to the disease, then they are likely to engage in risky behaviour and they will not undertake to change their health behaviour for the better (e.g. by using condoms). On the other hand, if he/she has a perception that they are susceptible to HIV/AIDS or they have a perception that their susceptibility is high, then they are more likely to change their health behaviour for the better or to engage in behaviour that will protect them from contracting the disease.

Perceptions, attitudes and knowledge in turn influence perceived susceptibility in the sense that when an individual has different perceptions and knowledge regarding HIV/AIDS, this might influence the way in which that individual perceives him/herself to be to be susceptible to HIV/AIDS. For instance if a young person has a perception that it is impossible for a healthy-looking person to be living with HIV, it is possible that, that person can allow him/herself to have unprotected sexual intercourse with a healthy-looking person thinking that they are HIV negative.

Perceptions, attitudes and knowledge are in turn influenced (in varying degrees) by knowledge about HIV/AIDS, access to healthcare and conflicting messages about sex and HIV/AIDS. These will be explained in the next section.

The importance of determining young people's attitudes and perceptions as they pertain to susceptibility to HIV/AIDS can never be underestimated. Perceived susceptibility to the HI virus is a major underlying factor fuelling the high prevalence rates, it is crucial that every individual accepts that they may be susceptible to it. This is a very important initial step in the process of adopting the necessary personal precautions to reduce the threat (Harvey, 1997).

This particular model has been chosen because research that has been done in South Africa indicates that higher perceived susceptibility about personal risk is linked to greater intended and actual sexual behaviour change (Govender et al., 1992). Another reason why this model has been chosen is because it identifies 'perceived susceptibility' as a primary concern in the investigation of how attitudes influence sexual behaviour. This is beneficial for this study because perceptions and attitudes are one of the main determinants to any positive decisions that young people may take to lessen their risks of infection.

Perceived susceptibility is one's opinions of chances of getting a condition (in this case HIV/AIDS). Each individual has his/her own perception of the likelihood of experiencing a condition that would adversely affect one's health. Individuals vary widely in their perception of susceptibility to a disease or condition. (Brown, 1999) states:

> Those at the low end of the extreme deny the possibility of contracting an adverse condition. Individuals in a moderate category admit to a statistical possibility of disease susceptibility. Those individuals at the high extreme of susceptibility feel there is a real danger that they will experience an adverse condition or contract a given disease (p.45).

The model has been criticized for placing a lot of emphasis on the individual and overlooking the roles that the social and economic environments may play in predicting or explaining an individual's particular behaviour. Other models have been developed to address these limitations. The Health Belief Model will be used, however, because unlike other models that are difficult to operationalise methodologically, the Health Belief Model

represents a methodologically succinct attempt to operationalise variables (Ogden, 2004). In addition, this model has been used widely in HIV research on attitudes (Harvey, 1997).

1.8) Young people's susceptibility to HIV/AIDS

Various studies have shown that young people do not perceive themselves to be at risk nor do they see themselves susceptible to HIV/AIDS (Hartell, 2005). A study done by Matthews, Kuhn, Metcalf, Joubert and Cameron (as cited in Hartell, 2005) found that few adolescents perceive themselves to be at risk. Students from four Cape Town township high schools did not acknowledge that AIDS could affect them directly. They attributed the problem to prostitutes, promiscuous people and to white people (Hartell, 2005). Harvey's (1997) study among adolescents in Kwa Zulu Natal revealed that although most students acknowledge the severity of the disease, few reported feeling personally susceptible, playing down the immediacy of the threat. Perceived self-efficacy in preventive behaviour was low and the benefits of adopting preventive behaviours were not acknowledged.

Another study by CASE (1995) concluded that the level of knowledge of HIV/AIDS among adolescents is high, but few perceive themselves to be at risk and few take the need for safe sex seriously. Similar results in a study by Visser (1995) among 314 students from 10 secondary schools showed that although students have basic knowledge of AIDS, they did not view AIDS as a personal threat. Similar findings have come up in various other studies (Hartell, 2005).

There are different factors that have an influence on the type of health behaviours that young people decide on carrying out. As discussed in the previous section, whether a young person decides to carry out a negative or positive health behaviour, will be dependent on their perception of their levels of susceptibility to HIV/AIDS. This 'perceived susceptibility' is in turn influenced by varying perceptions, attitudes and knowledge that the particular young person might have (these have been discussed in the previous section).

The perceptions, attitudes and knowledge are in turn influenced by three factors. These are: The type and amount of knowledge about HIV/AIDS that young people have, the level of access to healthcare they might have, and the different and often conflicting messages they have about sex and HIV/AIDS. Each of these three factors affects and influences perceptions, attitudes and knowledge in different ways.

Knowledge about HIV/AIDS affects perceptions, attitudes and knowledge in the sense that young people who might not have adequate knowledge and facts pertaining to

HIV/AIDS might feel that they are not susceptible when in fact they might be (Pinkerton & Raphael, 2000). Young people who have negative attitudes and perceptions towards condoms and condom use might be more at risk than young people who use condoms regularly.

Access to healthcare also affects perceptions, attitudes and knowledge in the sense that a majority of young people do not have adequate access to healthcare; this results in them not being able to access accurate and complete information on HIV/AIDS. This leads to them to misjudge their level of susceptibility to HIV/AIDS (Govender et al., 1992).

Conflicting messages about sex and HIV/AIDS influence young people's perceptions, attitudes and knowledge in the sense that they receive incorrect information from their peers and other uninformed parties. They might get information, which makes them think that they are not susceptible to the virus when in fact; they might be susceptible (Hartell, 2005). This all happens against a background of poverty (which has been discussed) and gender inequality (which will be discussed in the next section).

As discussed in the previous section, these varying perceptions, attitudes and knowledge then have an influence over young people's susceptibility which then has an impact on the type of health behaviour they will decide to carry out.

In this particular study the Health Belief Model has been utilised as a framework to establish the existing perceptions, attitudes and knowledge regarding susceptibility to HIV/AIDS among young people. A focus has been placed on the three above-mentioned aspects because they impact on young people's attitudes and their perceived susceptibility to HIV/AIDS. This in turn influences them to decide on whether to adopt positive or negative health behaviours.

1.8.1) Gender

Gender relations also influence young people's perceived susceptibility to HIV/AIDS. Gender refers to the beliefs or norms deemed by society about the roles and responsibilities that are appropriate for women and men (Kiragu & Pulewitz, 1999). More than half of HIV positive people in sub-Saharan Africa are women. In 2001, 6-11% of women aged 15-24 were living with HIV/AIDS compared to 3-6% of young men (Gupta, 2003). Throughout sub-Saharan Africa HIV infection rates among teenage females are over five times higher

than rates for teenage males (Gupta, 2003). HIV/AIDS imposes a disproportionate burden of HIV/AIDS on women. Gupta (2003) states:

> The physical vulnerability of young girls, the difficulties women face in accessing information and services necessary to protect themselves from infection, the near impossibility of obtaining treatment in most developing countries and the extraordinary burden of care assumed by women, as governments watch and wax eloquent about the wonders of home-based care – all these factors combine to make HIV a virus that hits women – especially young women – the hardest (p.7).

Half of all new HIV infections worldwide are occurring in those aged 15-24 years with the epidemic inflicting an especially heavy toll on girls and young women living in sub-Saharan Africa (UNAIDS, 1998). Irving (1998, p.87) states: "HIV surveillance data gathered in sub-Saharan Africa reveal that the region's girls and young women are often more susceptible to acquiring the HIV virus at younger ages than are boys and young men." This has been attributed to "biological and immunological factors that possibly make young women especially susceptible, as well as the subordinate status of females in many societies" (UNDP, 1992, p.56).

It is in South Africa, more than in any other country, where young women are the most infected or affected by the HI virus. It is important to understand why this pattern occurs. In order to get a clear understanding of this pattern, it is important to understand how men and women interact socially and sexually. Sex is social – who a person has sex with, how and where they have sex and their views about sexual morality are not necessarily individual choices. The environment in which people live influences the extent to which they are able to control these choices (Walker et al., 2004). In South Africa, as in most of Africa, sex is also about power. Men usually have power to initiate sex, make the decisions and decide whether a condom will be used or not. In order to understand the epidemic, the social context and power dynamics that inform sexual behaviour need to be understood as well as the sexual relationships and gender inequalities between men and women.

1.8.2) Young men's susceptibility to HIV/AIDS

The global AIDS epidemic is driven by men (Walker et al., 2004). This is more so in sub-Saharan Africa. Men usually determine the circumstances of intercourse; and men often refuse to protect themselves and their partners (Foreman, 1999). Ironically men's greater social power places them in a position of vulnerability regarding HIV infection. There are different factors that lead to young men being susceptible to the HI virus. Most of these factors are related to attitudes and perceptions which are mostly brought on by societal norms concerning masculinity. Men are expected to be all-knowing and experienced about sex, this results in them being prevented from seeking the right information and thus experimenting with sex in unsafe ways. Some societies also see sexual domination over women and a man having multiple partners as a defining characteristic of male sexuality. Gupta (2003, p.21) states: "these ideals of male sexuality seriously challenge AIDS prevention messages that call for partner co-operation, fidelity in relationships or a reduction in the number of sexual partners". There are a number of reasons why men have multiple sexual partners. A study of youth in the Western Cape found that men believed that they could not survive physically or psychologically for an extended period without sex (Walker et al., 2004). Some young people also see male sexuality as uncontrollable. A young boy from the Limpopo in a study by Collins and Stadler (2001) stated:

> When you are 15 years old, your blood may start working and you will fail to control it. Even if your blood wants sex while you don't have anything (a sexual partner) it is no use to resist. What I am saying is that when you are 15 your feelings can rise up and you will be ready to sleep with the girl. You cannot wait until you are 20 years old. It may be possible but it will be very difficult (p.5).

Such attitudes lead young men, even those with steady girlfriends, to have secret and hidden sexual partners called 'roll-ons' (Walker et al., 2004). Some young men believe that condoms should be used with 'roll-ons' and not with the main partner. The word 'roll-on' refers to a stick of deodorant and is a metaphor for a secret sexual partner; it is used to denote something that a person hides.

Cultural norms are used by some young men and women to explain why it is appropriate for African men to have many partners. In a study of student identities and AIDS in tertiary institutions in Southern Africa, female students who were interviewed spoke about what they construed as the 'cultural' and historical expectations for men to cheat (Pattmann, 2001). Men in Kwa Zulu Natal always suggest that multiple sexual partners are part of Zulu culture. Walker et al. (2004) mention, "The image of the traditional 'polygamous patriarch' is usually used to suggest that multiple sexual partners are the norm" (p. 56).

Studies carried out among young boys in Kenya provide rich insights into the perceptions, behaviours and motivations of young males with regard to sexual activity and susceptibility to HIV/AIDS infection. Nzioka's (2001) findings revealed that failure to have sex was seen as carrying the risk of losing status among their peers.

The boys said that peer-group norms favoured premarital and unsafe sex and that they experienced conflicting pressure to conform to these norms and on the other hand had to conform to adult norms favouring sexual abstinence (Nzioka, 2001). They also mentioned that they felt misunderstood and that nobody trusted them. One participant stated, "You cannot tell people, including your own parents, about your sexual problems without raising eyebrows. It is as if we are not expected to have sex." The boys also felt the need to conform to social norms of male prowess, with sexual activity starting early and having more than one partner. Contracting STIs but not HIV/AIDS seemed acceptable as part of the process of gaining experience and thus in keeping with the dominant view of masculinity (Nzioka, 2001). Condom use was associated with a host of negative perceptions: Condoms are acceptable for use only by adults or promiscuous boys. They were also perceived to be ineffective. The boys were reluctant to seek condoms in public areas for fear that condom use would reveal a hidden sexual history or sexual intentions. Their preferred strategies to protect themselves against STIs were unsafe – choosing young girls to have unprotected sex with or avoiding "thin and sickly-looking girls, who could be HIV carriers" (Nzioka, 2001). These findings point to the fact that the attitudes and perceptions of adolescent boys play a huge role in the increase of their susceptibility to HIV/AIDS.

1.8.3) Young women's susceptibility to HIV/AIDS.

Gender inequality, which is maintained by societal norms, plays a key role in increasing women's vulnerability. Attitudes and perceptions brought on by societal norms construct the roles and responsibilities of women and men – dictating what women can or cannot do as

compared to men. This greatly affects the way in which they can protect themselves from infection, cope with illness once they are infected or care for those who are infected (Gupta, 2003). National policies based on gender norms greatly restrict women's access to productive resources such as land, income, education, and credit. For instance in Swaziland, a woman cannot acquire land without a male relative co-signing the title-deed. If the husband is deceased, the law requires that a son, even if he is a minor, should co-sign (S.W. Matsebula, personal communication, January 18 2004). This was the case in South Africa as well until about nine years ago. This creates an economic and social imbalance in power between men and women. Women become economically vulnerable and dependent on men. This makes it more likely that women will sell or exchange sex for money, goods or favours, less likely that they will be able to negotiate safer sex with their partners and less likely that they will be able to leave relationships that they perceive to be risky (Gupta, 2003).

Societal definitions of male and female sexuality greatly affect both women and men's susceptibility to HIV infection. For instance societal norms often dictate that 'good' women must be ignorant about sex and passive in sexual interactions. This makes it hard for women to be pro-active in negotiating safer sex options. This contributes to young women's susceptibility to HIV/AIDS. Young women are more susceptible to HIV infection than young men (Khomanani, 2005). Post (2005) states:

> As with other STIs, women are more susceptible to acquire the infection from an infected male partner. Empirical evidence shows the rate of transmission from male to female to be 2-5 times higher than from female to male (p.43)

1.8.3.1) Gender violence.

Violence against women is one of the main factors that contribute to women's susceptibility (especially young women) to HIV/AIDS infection. It is widespread and it is the most obvious manifestation of gender inequality that exists in the country. According to Walker et al. (2005), since the transition to democracy these inequities have been challenged by the state and the legal system. The Constitution guarantees equality on the basis of sex, gender and sexual orientation; principles enshrined in the Bill of Rights and supported by several other clauses in the Constitution. The Convention on the Elimination of All Forms of Discrimination Against Women, of which South Africa is a signatory, exists to protect

women all over the world. South Africa is also at the forefront of the Southern African Development Community (SADC) region in terms of female representation at national, provincial and local government (Walker et al., 2004). All these positive signs, however, have not improved the situation of a large number of women who still face domestic or gender-based violence. Some men believe that they have the right to beat their wives or girlfriends if they feel that they need disciplining (Walker et al., 2004). Studies have shown that there is a strong link between gender-based violence and HIV/AIDS (Kistner, 2003). Women (especially young women) are as vulnerable to violence as they are vulnerable to HIV/AIDS. The World Health Organisation's division on Gender and Women Health (2000) has identified three areas in which women's vulnerability to violence and HIV/AIDS overlap: forced sex may directly increase the risk of HIV transmission to women through physical trauma, threats of violence may limit women's ability to negotiate safe sex, and the sharing of HIV test results with partners may increase the risk of violence.

According to Kistner (2003, p.45):

> For men, social dislocation, unemployment and poverty often mean the loss of a sense of what it means to be a man. Men who feel their position, status and identities threatened in this way, tend to re-assert their idea of masculinity and control through violent action.

Social and economic marginalisation and the erosion of 'masculinity' combine to render women subject to oppressive social structures and to gender-based violence. HIV/AIDS has compounded this context, it has exacerbated the economic and social insecurity of women and women's social and economic insecurity, in turn, makes them susceptible to infection with HIV/AIDS (Kistner, 2003). Fear of violence, stigmatisation, exclusion and destitution is prevalent among women.

South Africa has a reputation of having one of the highest rates of violent crime in the world and these questions inevitably crop up: why? why here? and why now? What is it about this society that makes for such high levels of violence? It is crucial that gender-based violence be understood because it has a direct link with the high rates of HIV. According to Kistner (2003) violent crime in post-apartheid South Africa does not come out of the blue. Researchers point out that within resistance to apartheid under the motto of 'ungovernability'

and 'people's war', violent means of resolving conflict and bringing about political change were positively sanctioned (Kistner, 2003). The beginning of the armed struggle meant that violent means found its application in other social arenas too. Kistner (2003, p.17) states: "...displaced aggression has been vented on the most physically, socially, economically and politically vulnerable, victimising and scape-goating women, children, the elderly and immigrants." High unemployment and poverty is experienced as personal rather than social failure, this fuels the crisis in masculinity and compounds displaced aggression (Walker et al., 2004). This loss of power and control may be followed by violent action through which masculinity is thought to be re-asserted (Simpson, 1993).

Sexual coercion is a by-product of gender inequity. Ajuwon, Olley, Akin-Jimoh and Akintola (2001, p. 13) define it as "....the act of forcing or attempting to force someone to engage in any sexual activity against his/her will." He goes on to mention that the term covers a continuum, ranging from unwanted touching to forced marriage to rape. It is typically perpetrated against adolescent girls and young women (Ajuwon et al., 2001). A study was carried out among 77 students in Ibadan, Nigeria, and these were some of their findings: Participants mentioned that sexual coercion of young women is a carefully planned act committed in a familiar setting usually by someone well known to the victim. Coercion was rarely depicted as an isolated event but rather a series of behaviours, including deceit, use of drugs, verbal insistence and threats and unwanted touching (Ajuwon et al., 2001). Forced sex was perceived, particularly by young men, as a man's way of punishing arrogant females who may have spurned his advances. Young women were seen as passive and trusting in sexual relationships (Ajuwon et al., 2001). Research (Hartell, 2005) has shown that young women in South Africa are at a particularly high risk of infection. Such a study from Nigeria could be of use in the South African context. In South Africa, for many young men coercion is part of sexual interaction. It is a means of asserting sexual control over women. In a study by Thorpe (2001), a young boy in Kwa Zulu Natal is quoted as saying:

> When they are going to make sex, he asked, he said 'Can we make sex?... but she said, 'no'.... The way I think , maybe he asked her again, maybe she replied and they just made sex...she didn't scream or do anything...or tell him she didn't want it...to her, no is yes (p.45).

Young men and boys appear to identify unquestioned authority and control over women as a key feature of masculinity (Walker et al., 2004). Women are seen as the property of their boyfriends. Ashforth (1999, p.55) states: "...like any other personal property, they are bought, owned, defended and controlled and men have exclusive rights to sexual intercourse with their girlfriends". However, control is not limited to sexual intercourse. In a study by Wood (2005) on sexual health and violence among township youth in the Eastern Cape, boys as young as 12 and 14 said they felt the need to demonstrate control over their girlfriends. This included telling them whom they could talk to, controlling their movements and slapping them when they were disobedient. Respondents in another study of teenage masculinity did not see that forcing a girl to have sex was rape. To them rape is an attack by a stranger (Walker et al., 2004). Walker et al. (2004) point out that: "...the study focused on the language teenagers use to talk about sex. Drama and role-plays indicated that the boys did not recognise that saying 'no' was an option for girls – they believed that girls should not have any say in the matter at all."

Studies (UNAIDS, 2005) have shown that young women are more susceptible to HIV/AIDS than young men. There are socio-economic as well as physical factors that increase women's susceptibility.

1.8.3.2) Physical factors that contribute to young women's susceptibility.

The vagina has large areas of exposed and sensitive skin, which can get cut during sexual intercourse. This allows HIV to enter the body more easily (Khomanani, 2005). The practise of tightening the vagina (prevalent among sex-workers) because of the belief that this heightens their client's or partner's sexual pleasure makes the situation worse. Walker et al. (2004) state: "dry sex involves the use of substances such as snuff, dry clothes and sponges as well as traditional herbs to tighten and dry the vagina." This leads to micro lesions and cuts during sexual intercourse which then increases the risk of HIV infection. A young woman is even more susceptible to infection because of her immature genital tract, which has less developed layers of mucous membranes than that of an older woman (Walker et al., 2004). Semen also remains for a long time in the vagina after sex, increasing the risk of transmission. The amount of HIV (viral load) in semen is particularly high in the first few months after being infected. Walker et al. (2004) state: "A man will transmit the virus to others more during this time because he is more likely to have multiple partners and because the viral load rises in seminal and not vaginal fluid." The penis has a small surface area,

which is in contact with the vaginal fluids for a shorter time. This means that a man's risk of contracting HIV is lower than that of a woman (Khomanani, 2005). STIs also make women more susceptible to HIV infection because women are less likely to seek treatment for it, for cultural and economic reasons, as well as due to the stigma attached to STIs. Post (2005) states:

> The presence of ulcerative STIs such as chancroid, syphilis and herpes usually associated with genital ulcers significantly increase susceptibility to HIV infection. Non-ulcerative STIs are far more common than ulcerative STIs and in women, are often asymptomatic and thus unrecognised (p.76).

Due to various reasons, women are predisposed to shorter incubation periods and shorter survival times. Some data show that among HIV positive women, higher-order pregnancies (fourth, fifth pregnancies and above) may trigger a full-blown attack of AIDS (Post, 2005). Post (2005) goes on to state: "If this association is confirmed, HIV positive women with higher order pregnancies could experience shorter survival times than infected males." Prolonged breastfeeding under conditions of poor nutrition is an added stress for an HIV infected woman, contributing to nutritional depletion with increased susceptibility to other infections and diseases. Post (2005) points out that: "It is suspected, though not proven, that repeated attacks by other infectious diseases lower immunity and accelerate the progress of HIV infection to full-blown disease".

1.8.3.3) Socio-economic factors that contribute to young women's susceptibility.

There are many socio-economic factors that contribute to women's (especially young women's) susceptibility to HIV/AIDS. These are mostly a result of attitudes and perceptions prevalent in society. Jewkes (2001, p.89) states: "For women, the norms that define acceptable behaviour, economic dependency and violence have been said to make them vulnerable to HIV". Social relationships are characterised by an unequal balance of power between men and women. Walker et al., point out that (2004, p.87): "...in South Africa this balance is heavily weighted in favour of men. Men are better educated, earn more than women, wield more power in society and have greater social status". This places women (especially rural young women) at a very disadvantaged and disempowered position. Women bear the brunt of poverty and have the least access to resources. They have less

access to education and earn less than their counterparts. In 1995 23% of African women aged 25 or more had no formal education, compared to 16% of African men. Women on average earn between 72% and 85% of what men with similar education earn (Walker et al., 2005). Walker et al. (2005, p.98) state: "Young African women are the poorest, most economically marginalised and least educated sector of the South African population. This places them at the bottom of the health pile and renders them particularly vulnerable to HIV/AIDS."

Poverty forces many women into transactional sex in order to survive. This could be prostitution or it could be the use of men as sources of finance. A study of transactional sex in Kwa Zulu Natal uncovered different motivations for sex. Women in dire economic circumstances have sex so as to pay for basic necessities (Walker et al., 2004). Hunter (2002) states:

> It seems that women who are unemployed and dependent on men for their economic survival tend to choose boyfriends as a way of making ends meet. A comment often made is that women *qoma* (choose a man) 'One for rent, one for food and one for clothes' (p.98).

Other women who might be better off have sex to acquire a range of commodities. Boyfriends can be a source of extras or luxuries such as designer clothing or stylish cellphones. Another kind of transactional sex that makes young women susceptible to HIV is prostitution. The size and the composition of the sex-worker population in South Africa is impossible to estimate. There are different sectors of sex-work, for example, male, female, transgendered, urban, rural, commercial, casual, indoors, outdoors (Leggett, 2001). Sex-workers come from a wide range of backgrounds. Education levels and economic positions vary (Walker et al., 2004). It can be safely assumed that a majority of sex-workers in South Africa are young women from impoverished backgrounds. Sex-workers are highly vulnerable to HIV infection. In a study of sex-workers in the Carletonville mines, a number of themes emerged to explain sex-workers' high levels of vulnerability to HIV infection. Williams, Gilgen, Campbell, Taljaard and MacPhail, (2000) state:

> The majority of women had limited education and had lost contact with family support structures. A number of them had had previous experiences of abuse and violent men. The most

> important factor, however, was the context of their working lives. Miners were resistant to using condoms and financial hardship compelled women to go along with this (p.56).

Women who are economically vulnerable rely on transactional sex as a resource often overlooking the threat of HIV/AIDS. In a study of women living in a peri-urban area on the outskirts of Durban, it was found that over 90% of participants were dependent on men financially and that meeting their immediate needs for food and shelter over-shadowed the long-term consequences of unsafe sex (Hoosen & Collins, 2001). Many older men have sex with much younger women and girls in exchange for favours, gifts or money. Khomanani (2005, p. 90) states: "Older men tend to have had more sexual partners, which increases their own risk of getting HIV and consequently passing it on to younger girls. Women for Women International (2004) state: "Formal education, training, micro credit loans and other employment opportunities can reduce the chances that women will engage in prostitution, exchange sex for material favours or be trafficked into sexually exploitative situations". Another factor that contributes to young women's susceptibility is that some young people see unprotected sex as an expression of trust. The status of the relationship is measured by the willingness of the partner to take risks and practise unsafe sex (Walker et al., 2004). Unprotected intercourse is equated with love; this renders young women susceptible to HIV/AIDS.

The fear of violence and abandonment also prevents many women from disclosing their HIV status to their partner, and from seeking help and treatment for HIV. This results in some women dying prematurely from the effects of HIV. Many women also cannot choose to abstain, use a condom or insist on other forms of safer sex, because this may result in violence or abandonment by their male partners (Khomanani, 2005).

1.9) Knowledge about HIV/AIDS

Various studies have reported findings that suggest that a majority of the youth in South Africa hold very basic information pertaining to HIV/AIDS (Hartell, 2005). On the other hand there are some young people who hold detailed knowledge about it which then translates to behavioural changes. This implies that the majority of the youth hold basic HIV/AIDS knowledge which does not translate to behavioural changes. The Health Department conducted a survey in 1998 among adolescents in South Africa called the South African Demographic and Health Survey. Part of their findings were that, even though a lot

of information pertaining to HIV/AIDS has, over the past 20 years, been disseminated by the Government and Non-Governmental Organisations (NGOs), this has not resulted in substantial behaviour change (Hartell, 2005). The results showed that 97% of the participants responded that they had a basic knowledge and a high awareness of HIV and AIDS. South African studies done by Mbananga (2002) and Harvey (1997) in their research on knowledge, attitudes and sexual behaviour related to HIV/AIDS, found that while knowledge about the disease among adolescents is generally good, many engage in high-risk sexual behaviour. The South African Demographic and Health Survey also resulted in findings that showed that there was a low awareness of detailed knowledge that would enable behaviour change (Harvey, 1997). These studies reiterate that even though there is a high awareness of basic knowledge there is also a low awareness of detailed knowledge. Young people who lack detailed HIV/AIDS knowledge will be inclined to also believe that they are not susceptible to the AIDS virus, when in fact they might be (Hartell, 2005). This is because they lack the proper knowledge about the disease. A study conducted in Tshwane among 314 students from ten secondary schools showed that although students have basic knowledge of HIV/AIDS, they do not perceive themselves susceptible to it. This demonstrates the fact that some young people do not perceive themselves susceptible to the virus because they lack detailed knowledge on the topic. Condom use is probably the most talked about subject of HIV prevention in youth information campaigns. Knowledge of condom use by the youth has been part of an aggressive campaign by health authorities, young people are encouraged to use them yet HIV prevalence rates do not reflect that this message is being heeded.

1.9.1) Condom use

Condom use is the most suggested intervention in the fight against the pandemic and health authorities strive to ensure that young people gain knowledge about it. Yet some HIV/AIDS prevention programmes in which it is utilised have failed. According to Walker et al. (2004) the reason why they have failed is that "they have focused on changing individual sexual behaviour". This they have done at the expense of looking at how society functions and then aiming at the change of sexual behaviour. Interventions have encouraged men to wear condoms and women to insist that they do but this is often impossible. Walker et al. (2004, p.45) state:

> For some men and women, the exchange of fluids during sexual intercourse is linked to strong cultural beliefs about maintaining good health. And if condom use is culturally taboo, then a programme that promotes condoms is unlikely to succeed.

For example the Botswana government's prevention campaign had very little impact. It was run under the banner 'ABC' (Abstain, Be Faithful and Condomise) and it did not take into account cultural beliefs around fluid exchange. Unequal gender relations also result in women being unable to insist on condom use. Walker et al. (2004) point out that: "the fear of violence and the threat of abandonment can stop women from insisting on condom use." Another reason for women's lack of power to insist on condom use was the threat of economic loss. In a study by Walker et al. (2004) a woman said: ".....the problem is money, that is why we listen to our men every time, even when we say I don't want to use a condom, because of money, [and because] we have children, no one will support our children."

1.9.1.1) Perceptions and attitudes towards condom use.

The practise of safe sex through the use of condoms is emphasised in all public health messages on HIV/AIDS. This message has been viewed differently by different sectors in the community. Some religious groups see this as an invitation to promiscuity (Walker et al., 2004). But condoms are viewed with suspicion for other reasons too. In some southern African countries some people actually blame the spread of HIV/AIDS on condom use. "For instance, the lubricant on condoms can be seen to cause vaginal discharges – often interpreted as a sign of ill-health" (Walker et al., 2004). Condoms, especially government issued condoms, are often seen as h easily breakable and some people once believed that they had worms in them (Parker, Nkosi, Birdsall & Hajiyiannis 2004). Walker et al. (2004) go on to state: "...also in communities where good health is seen to depend on the appropriate exchange of body fluids, condoms are seen as a barrier to maintaining health and warding off illness". An attitude that is prevalent among young people is that condoms can be a discomfort and embarrassment (Walker et al., 2004). Condoms are seen as unnatural and they get in the way of romance. The idea of 'natural sex' also accounts for young people's negative attitudes towards masturbation. In a study by Thorpe (2001) when the subject of masturbation was raised in role-plays amongst youth in the Durban area, the discussions resulted in 'awkwardness, laughter and stigma from those putting forward a view'. Another

attitude prevalent among young people is that 'youth is seen as a time of play, adventure and having fun before the responsibilities of adult life prevail' (Collins & Stadler, 2001). Thus they are unlikely to perceive themselves as being at risk of contracting a potentially fatal disease (Walker et al., 2004). Youthfulness is closely linked with experimentation and risk and it is a time when condom use is not particularly practised because it is equated with commitment and marriage. In focus group discussions, playful relationships were contrasted with 'true love' relationships in respect of responsibility and expectation (Walker et al., 2004). Youthful irresponsibility can be found across all sectors of society among the rich and poor. A study of university students found that youth get involved in casual sex relationships (Walker et al., 2004). A student mentioned the following in an interview:

> What about casual sex?...especially in our age group, I think it's the norm. I think that anyone can go into a nightclub, pick somebody up and go home and have sex. If that's what you want, if that's your aim, it's no problem...Its very easy... I know a lot of people who are doing that, it happens, it happens often... A lot of people shut up about it too, especially women who get labelled (p.55).

There are other reasons, besides youthful irresponsibility, that explain why condoms are not used. For some young people, condoms have a stigma. The use of condoms is associated with connotations of disease (Walker et al., 2004). People assume that if you want to use a condom then you have a health problem. The use of condoms can also be seen as a lack of trust between partners. Walker et al. (2004, p.98) state:

> This is a very important part of negotiating condom use. If you love and trust someone, then why should you use a condom? Partners are often asked to express their love and trust by having unprotected sex. It can also be used to maintain a relationship or to prove that a marriage is monogamous.

Another common attitude towards condom use is that some young people believe that condoms reduce the pleasure of sexual intercourse. Jokes about 'eating sweets with the wrapper on' and 'wearing a raincoat in the sun' are prevalent. One study found that both young men and women preferred 'flesh-to-flesh' (unprotected sex). Transactional sex also

presents an additional obligation on young women for them to agree to unsafe sex. Walker et al. (2004, p.56) state: "when men spend money on women there is an expectation that they can demand 'flesh-to-flesh' sex. The more they spend, the greater the expectation." Another attitude that young people have towards condoms is that condoms are about rationality whereas sexual intercourse is about passion and desire (Walker et al., 2004). The perception is that men lose control during sexual intercourse, making condom use a secondary consideration. Condoms are also seen as an awkward and unnatural interruption in the 'heat of the moment'. A study in Skinner (2001) revealed findings that reflected that some people did not want to use condoms because they interfered with the sexual act. The risk of contracting HIV was seen as less important than the immediate enjoyment of sex. There is also the belief that there is diminished responsibility at the height of sexual passion. In a study by Walker et al. (2004, p.67) a young man stated: "...there is no time to speak. There is no time for discussion, you have to act quick." Another barrier that prevents the youth from adequately using condoms is that young people are afraid of going to clinics and getting condoms. In a study by Thorpe (2001, p.98) a young person stated: "when we go to the clinic they chase us away, saying we are too young...They say we are wasting the condoms". The situation is made worse when the nurses and clinic staff are hostile. In a study by Skinner (2001) a young person when interviewed mentioned the following:

> The problem is that the nurses at the clinic are very unkind. Sometimes they even refuse to supply us with condoms... they say we are trouble-some. They think that we are not serious if we ask for condoms (p.56).

1.10) Access to healthcare

Health and healthcare during the apartheid era left a legacy of inequitable and inadequate facilities. According to Walker et al. (2004):

> Preventable diseases were allowed to spread owing to low rates of vaccination. Essential drugs were not widely available in the public health care system and very few people had access to adequate curative care. Treatment of some diseases was given priority. During the early years of apartheid, if an epidemic broke out in 'non-white' areas and there was fear that it would spread to white areas,

> strong measures were taken to prevent and eradicate the epidemic. STIs in particular, were seen as a major threat and were managed with increased official zeal (p.73).

Huge inequalities exist between the private and public health-care sectors. A large number of specialised health-care practitioners such as general practitioners, dentists and pharmacists continue to work in the private health sector. Health-care facilities in the public health sector are wholly inadequate. This demonstrates the fact that health services are most available to the people who need them the least. Those who need health-care the most have inadequate access to it (Walker et al., 2004). This is an obstacle to the fight against the pandemic because the majority of people affected or infected live in poverty. This presents an additional problem for young people whose access to healthcare is limited by the fact that a majority of them can only go to public health facilities for their medical problems. In some cases these facilities are under-resourced. Limited access to healthcare is an obstacle to lowering HIV infections and Sexually Transmitted Infections (STIs). This is due to the fact that when young people have inadequate access to healthcare this leads to them not having access to the resources which can ensure that they are informed about HIV and are therefore able to modify their sexual behaviour after accurately assessing their level of susceptibility. A majority of young people have physical limitations in their access to healthcare (Mfono, 1998). Factors such as long-distances, lack of medicines and scarce medical personnel are some of the obstacles. However, there are psychological limitations as well.

Some young people experience frustration caused by nurses when they go to some health facilities. Health service workers sometimes do not cater effectively to the needs of adolescents as Jogunosimi (2001, p. 2) states: '...many health service workers feel it is inappropriate to provide contraceptives to young people, often making it difficult or impossible for youth to obtain condoms and other forms of contraception'. Some nurses tell young people that they are too young to use contraceptives and ask them for a letter from their parents. This leads to the youth having a negative attitude towards health care and being reluctant to use health clinics. Most young people also do not like being known or seen by adults in their communities accessing sexual health information. This is because of "embarrassment about being known by adults to be sexually active" (Mfono, 1998, p. 3). This adds to the stigma some young people have to face in their communities, because of their use of health services. Some young people also experience fear and anxiety when faced with the prospect of going to a health facility. Fear of injections, medical examinations and

diagnoses hinder some people from going to clinics. These negative emotions cause young people to not access health facilities, and this prevents them from obtaining accurate medical information from them (Mfono, 1998). Such limited access causes young people to have the perceptions that they are not susceptible to diseases such as HIV/AIDS. This is because they do not have adequate access to accurate information which is given at the health centres.

1.10.1) Reproductive Health Information

Reproductive Health Information (RHI) is information that pertains to reproduction issues such as contraception, pregnancy, STIs and HIV/AIDS in particular. It is largely obtainable from health facilities. In a bid to increase young people's knowledge about HIV/AIDS, a substantial amount of RHI pertaining to HIV/AIDS has, over the past twenty years, been disseminated by the Government (through health facilities) and non governmental organisations (NGOs). This, however, has not translated to lower HIV/AIDS infection rates. These findings emerged in a 1998 South African Demographic and Health Survey among adolescents in South Africa as well as in a study by Nolwazi Mbananga (2002). This could be linked to the fact that the lack of access of young people to health facilities results in them not accessing accurate RHI. This leads them to perceive that they are not susceptible to HIV/AIDS thus leading them to engage in risky behaviour which results in high HIV/AIDS prevalence rates.

RHI is an important tool in the fight against HIV/AIDS. The government and other related stakeholders such as the loveLife organisation have implemented substantial HIV/AIDS awareness strategies, to conscientise the youth in the form of billboards, posters, pamphlets leaflets and electronic media advertisements. These, however, have not been adequately understood. Visual health information (posters and billboards) were the most poorly understood (Mbananga & Becker, 2002). Reproductive Health Information in South Africa has always focused on prevention of unwanted pregnancies, STIs and forms of contraception. With the onset of HIV/AIDS, RHI has had to shift its focus on how to educate people about HIV infection. Elkonin (1993) mentions that there are three main weapons that can stop the spread of HIV/AIDS: a cure, a vaccine and education. The first two have not been discovered yet, however, the world can use education to try and curb its spread. One way of using education would be to disseminate RHI. In South Africa this has been done quite extensively, yet (as mentioned above) there has been no significant change in prevalence rates to show for this (Mbananga, 2002). Mbananga carried out a study in order

to find out why RHI was not being understood by target communities particularly in impoverished areas and why this information was failing to transform sexual behaviour (Mbananga & Becker, 2002). Her analysis of RHI within the Social Construction of Reality (SCR) theory (Berger & Luckmann, 1967) provided three possible answers to these questions:

- RHI is void of the everyday reality of reproductive activity, concepts and knowledge of target communities.
- RHI construction focuses mainly on the nature of reproductive health problems rather than the presence of these problems.
- RHI, at development stages, does not take into consideration the norms, values and language or culture of the target community (Mbananga, 2002)

Mbananga, (2002) further states:

> The study further revealed that RHI is developed away from the target communities and those who develop it do not consider the cultural diversity of the audience. "It is developed by health professionals who are socially, physically (geographically), culturally and linguistically different from the target communities (p.5)."

It is crucially important that young people receive and understand reproductive health information. The reason for this is that this is when their attitudes and perceptions can be positively influenced by accurate information pertaining to their levels of susceptibility.

1.11) Conflicting messages about sex and HIV/AIDS.

Young people are constantly bombarded by various conflicting messages about sex and HIV/AIDS (Hartell, 2005). Being viewed as sexy and 'cool' or 'with it' is highly valued among young people and their peers. Preventative and protective measures such as abstaining from sex and using condoms are frowned at by some young people and they prefer to do what their peers tell them to do, such as having multiple partners and having unsafe sex. Messages from health authorities and parents about abstinence and condom use sometimes go unheeded because these positive messages conflict with the negative messages they obtain from their friends. While most adolescents do not want to disappoint their

parents, they also do not want to disappoint their peers, who may value sexual activity. Russell (1998, p.16) states: "many youth at this age feel the normal desire to break away from parents and begin to set their own rules. Because parents still provide the basic necessities of life, adolescents may feel that their emotional and sexual life is the area in which they can have personal control".

A study was made of adolescents' knowledge and experience of sexuality through focus groups in five provinces (Hartell, 2005). The results reflected the fact that young people do receive conflicting messages about sex and that they also lack detailed knowledge, confidence and skills to discuss sexual issues, including contraception and prevention of infection. This study also found that myths reinforce negative attitudes about safer sex and that most adolescents make decisions about sex in the absence of accurate information and access to support services. This leads to them making incorrect decisions based on inaccurate information. This fact was illustrated in a study done by the District Health Care Trust (1997). In a survey of knowledge, attitudes and behaviour among adolescents in six villages in Xhalanga, findings reflected that about 50% approved of sex before marriage and believed that sexual involvement should start between 10 and 17 years of age. Conflicting messages about sex and sexuality influence young people's perceived susceptibility in the sense that they receive incorrect information from their peers and other uninformed parties. They might get information which makes them think that they are not susceptible to the virus when in fact, they might be (Handysides, 2003). This might add to the conflictual nature of messages received by young people further misleading them to believe that they are not susceptible to the disease. This then leads to them not changing their sexual behaviour for the better thus placing them at an even larger risk of HIV infection.

1.11.1) Popular Beliefs and Perceptions towards HIV/AIDS

HIV/AIDS is understood and explained in different ways by different communities, this might cause a conflict in the way that different belief systems understand HIV/AIDS. Some explanations of HIV/AIDS are based on Christian beliefs. For instance, a bishop of St Paul's Apostolic Faith Mission of Botswana said in an interview in a study by Walker et al. (2004):

> AIDS is a punishment by God, as Sodom and Gomorrah. Today we have all kinds of unnatural things – homosexuality, Satanist cults who practice cannibalism, ritual murders, bestiality. Christ is the one who said that those who do such things are cursed already. Unless we

> discover ourselves, we are a lost people. The whole country should pray to God for deliverance (p.56).

Traditional explanations for the transmission of HIV/AIDS exist. A sangoma from Botswana put forth the argument that AIDS was a new manifestation of an old disease that has re-emerged because people (particularly young women) have rejected or abandoned their culture or traditional practices that may have regulated sexual practices. This explanation is also shared by some Swazi sangomas (Kanduza, 2004). Another explanation of AIDS is that it is a disease that was brought by white people through "the many things that they recommend to be used, such as pills, injections, condoms and the coil (contraceptives)". (Walker et al., 2004, p. 89). Some communities believe that AIDS has been around for some time but in different forms. It has made a return due to people breaking taboos such as not having sex three months after childbirth, or for a year after the death of a spouse (Walker et al., 2004). Another explanation of HIV/AIDS is that it will be said that the infected person has been bewitched by his/her enemies. Walker et al. (2004) state: "the AIDS pandemic is well suited to interpretation through the paradigm of witchcraft. It is mysterious, elusive, difficult to understand and constantly changing". The fact that in addition to it being incurable, it primarily affects the most vulnerable – the poor, the youth and the blameless – fuels suspicions of witchcraft (Walker et al., 2004). Community interpretations of HIV/AIDS are often fraught with stigma and discrimination and this conflicts with what health authorities always say about the handling of this disease in the community.

1.11.2) Stigma and discrimination

Stigma is perhaps one of the most harmful attitudes that communities have towards people living with HIV/AIDS. This is a disease which is also a sexually transmitted infection associated with death. This causes many fears and prejudices, collectively described as stigma. It is largely caused by a lack of knowledge about it. Fear, denial and stigma influences the way many respond to people living with HIV and often results in discrimination. Discrimination consists of the ways that people actively identify and act against others because they are infected or affected by HIV and AIDS (Khomanani, 2005). The HIV/AIDS pandemic, across the world, has shown itself capable of triggering responses of compassion, solidarity and support, bringing out the best in people, their families and communities. However, the disease is also associated with repression as individuals affected

(or believed to be affected) by HIV have been rejected by their families, their loved ones and their communities. The 'culture of blaming' results in society excusing itself from the responsibility of caring and looking after those living with HIV/AIDS. Some sectors of society also blame 'other' groups such as homosexuals and prostitutes thus placing themselves in a vulnerable position. Walker et al. (2004) state: "In the early 1980s the spread of HIV/AIDS was blamed on homosexual men, injecting drug users and prostitutes. In this climate of blaming, stigmatising and finger-pointing no one took responsibility – no one owned the epidemic."

People living with HIV/AIDS are often treated with indignity, their human rights often violated. This results in people being scared to be open about their status, further forcing the disease underground. This often prevents them from seeking the help they need, and it also makes it very difficult to control the spread of HIV (Khomanani, 2005). There are various powerful images that were used early in the AIDS epidemic. These reinforced and legitimised stigmatisation. Khomanani (2005) mentions the following:

Table 1

Images of HIV/AIDS

HIV/AIDS as punishment (for instance for immoral behaviour).
HIV/AIDS as a crime (for instance, in relation to innocent victims).
HIV/AIDS as war (for instance, in relation to a virus which needs to be fought).
HIV/AIDS as horror (for example, in which people are demonised and feared).
HIV/AIDS as otherness (in which the disease is an affliction of those set apart).

Adapted from the Khomanani Project.

Together with the widespread belief that HIV/AIDS is shameful, these images represent 'ready-made' but inaccurate explanations that provide a powerful basis for both stigma and discrimination. These stereotypes also enable people to deny that they are personally susceptible to be infected or affected (Freddrikkson & Kanabus, 2005). Stigma and discrimination regarding HIV/AIDS leads people, especially young people, to feel that they are not susceptible to HIV/AIDS because it mainly affects certain groups of people like promiscuous people, prostitutes or gay people. This causes them to view the disease as a

disease that affects 'them' and not 'us'. This in turn leads to young people not making the right decisions regarding their sexual behaviour therefore exacerbating the pandemic.

1.12) Conclusion

Beck, as cited in Cohen and Manion (1994, p.26), postulated that the purpose of social science is to understand social reality as different people see it and to demonstrate how these views shape the actions that they take within that reality. The analysis of the knowledge, attitudes and perceptions of young people is very important in this regard. High prevalence rates and increasing infection rates reflect that HIV/AIDS is on the increase. Perceived susceptibility to this virus is an underlying factor in the prevalence of the virus in the fight against this disease. Random surveys of knowledge, attitudes and perceptions carried out nationally may overlook some aspects of perception (such as perceived susceptibility) found amongst young people or adolescents. That is why in the continuing fight against the pandemic, it is crucial to analyse perceptions and attitudes of young people as it pertains to susceptibility to HIV/AIDS. This is because an individual's perceived susceptibility to a particular health problem may lead them to change their behaviour concerning their health (Richter, 1996). There are different factors that lead young people to have different perceptions and attitudes as it pertains to their susceptibility. The type and amount of knowledge about HIV/AIDS that young people have, the level of access they have to healthcare and the different and often conflicting messages they have about sex and sexuality are three important factors. The use of the Health Belief Model is beneficial in explaining and predicting a sample of young people's individual health behaviours by analysing their attitudes, perceptions and knowledge.

Chapter 2 - Methodology

2.1) Goals

The main goal of this study was to establish the existing perceptions, attitudes and knowledge regarding susceptibility to HIV/AIDS among Grade 11 learners. The following aspects which impact on young people's attitudes and their perceived susceptibility to HIV/AIDS were focused on: knowledge about HIV/AIDS, access to healthcare and conflicting messages about sex and HIV/AIDS.

The sub-goal was to make comparisons between female and male participants as well as sexually active and non-sexually active participants regarding knowledge, perceptions, condom usage and access to healthcare.

2.2) The questionnaire

The questionnaire (which is presented in Appendix A) comprised 51 questions to be answered by all students and a further five questions which were only to be answered by students that reported being sexually active. The final five questions were contingent upon the respondent answering 'yes' to question 51. This questionnaire was designed in order to investigate various HIV- related factors which will be outlined in the following sections. This was done in order to analyse young peoples' perceptions, attitudes and knowledge as it pertains to susceptibility to HIV/AIDS with a focus on knowledge about HIV/AIDS, access to healthcare and conflicting messages about sex and HIV/AIDS.

The questionnaire was divided into four sections. Section A determined demographical data, Section B covered aspects of knowledge regarding HIV/AIDS as well as sources of that knowledge, Section C assessed attitudes towards HIV/AIDS and People Living With HIV/AIDS (PLWHA) and section D assessed sexual behaviour, condom usage, access to healthcare and perceived susceptibility to HIV/AIDS. Based on previous surveys the questions (which will be discussed in subsequent sections) were then decided on.

The questionnaire was written in English. The reason for a single language was that the high schools that were selected use English as a medium of instruction. Even though English is used, some students needed assistance in comprehending the meaning of some of the terms. The researcher, however, was available to provide any explanation that needed to be provided. The questionnaire was handed out during class time and was completed

anonymously. It was designed in such a way that it could be completed within 45 minutes; however, no time limits were imposed. There were a few students in two of the classes who needed an extra ten minutes to complete the questionnaire, however the rest of the students were able to finish within the 45 minutes.

2.2.1) Demographical data

The questions which comprised Section A of the questionnaire concerned demographical data such as age, gender and home language.

2.2.2) Knowledge section

The Knowledge section, Section B of the questionnaire comprised 19 questions addressing the broad domains of the nature of HIV/AIDS, the transmission of HIV and the sources of knowledge that young people rely on for their HIV/AIDS knowledge. These types of questions were included so as to establish the following HIV- related factors: To determine the level of knowledge of HIV/AIDS, to determine their knowledge of where to obtain condoms, to determine with whom students have discussed HIV/AIDS and where they have acquired their knowledge of HIV/AIDS. The section followed a forced-choice style with response choices of 'yes' or 'no' for all of the questions except the last three. The last three questions provided a list of choices for the respondent to respond about the sources of HIV/AIDS Knowledge that they have.

2.2.3) Attitude Section

Section C which comprised 21 questions which were extracted from the AIDS Attitude Scale (AAS) as compiled by Shrum, Turner and Bruce (1989) was used to assess attitudes. This section used a 5-point Likert scale ranging from 'strongly agree' to 'strongly disagree'. Froman and Owen (1997) show that the data from psychometric estimates reflect that the AAS has factorial as well as construct validity. It has been used extensively in research in South Africa (Harvey, 1997) and for this reason was deemed to be suitable for the present investigation.

The AAS isolates three factors, two of which have been covered by the questions in this questionnaire. Factor 1 includes items relating to proximity to PLWHA's (statements 25, 26,

28, 29, 31, 32, 33, 34, 35, 40, 41, 42). Samples of the statements included here were 'It would not bother me to attend classes with someone living with HIV/AIDS' and 'The thought of being around someone with HIV/AIDS does not bother me'. Factor 2 includes judgemental dimensions of attitudes towards HIV/AIDS (statements 24, 27, 30, 36, 37, 38, 39, 43). These questions included statements such as 'People who receive positive results from the HIV blood test should not be allowed to get married' and 'I think that people with HIV/AIDS get what they deserve'. These types of questions were included to determine the nature of the attitudes that young people have towards People Living With HIV/AIDS. There were also a few questions included so as to establish their level of perceived prevalence of HIV/AIDS and to determine whether they are influenced by peer pressure or not.

2.2.4) Sexual behaviour section

Section D of the questionnaire contained questions that were concerned with the sexual behaviour of the students, condom usage, their access to health care and their perceived susceptibility to HIV/AIDS. There was a combination of forced-choice style questions as well as open-ended questions; the latter were included to allow the respondent to elaborate on their answer so as to provide more clarity to the researcher. This section of the questionnaire sought to establish the following HIV-related factors: To determine the frequency of condom usage, to determine whether the respondents thought they were susceptible to HIV/AIDS, to determine their willingness to engage in preventative health behaviours, to determine their level of access to healthcare, to determine whether they have had previous sexual experience, and the number of sexual partners over a fixed period.

2.3) The population and sampling

Roscoe (cited in Mouton, 1996, p.134) defined a population as a collection of objects, events and individuals having some common characteristics that the researcher is interested in studying. The population in this study was defined as Grade 11 students attending schools in Rini, which is an area in Grahamstown with historically under-resourced schools.

A multi-stage sampling technique was deemed favourable for this study and it was utilised. Firstly, a process of random sampling took place and a total of five high schools were included in the sample. A sample of 318 students was then drawn using the convenient sampling method from a total number of 599 Grade 11 students. The learners provided a

captive group as the questionnaire could be administered during class time. Participants were mainly Xhosa-speaking and they were included irrespective of their gender or socio-economic status. The primary purpose for selecting this group was because they represent one of the highest-risk groups in South Africa with regard to the possibility of contracting HIV/AIDS. Grade 11 learners (between the ages of 15 and 19) are also at a stage where they have to make decisions regarding sexual activity and they make these decisions based on their attitudes and perceptions.

2.4) Procedure

Permission was requested (letter presented in Appendix B) and obtained from the District Director of the Provincial office of the Department of Education to approach Student Governing Bodies and Principals regarding their participation in the survey. The permission was granted under the conditions that the Principals' participation would be voluntary, learners would not be forced to participate in the survey, strict confidentiality would be maintained and that feedback about the results and the recommendations of the survey would be communicated to the office of the District Director.

On entering each school, the researcher would introduce herself to the Principal, explain the purpose of the survey and inform him/her about the sort of assistance that would be required from the school. The researcher would also explain that raw data would not be provided to the school and feedback would be provided to the school in the agreed upon format. The researcher would then provide the Principal with a letter from the Provincial Office of the Department of Education. This letter (presented in Appendix C) stated that permission had been granted to the researcher to conduct the research in high schools. The researcher would then provide the Principal with a copy of the questionnaire for his/her perusal, this would be the actual questionnaire that would be administered to the participants on the agreed upon date. The researcher deemed it necessary to do this because in some instances the Principal would want to discuss the administration of the questionnaire with the School Governing Body or with a Guidance teacher prior to granting permission. The Principal would then be provided with an agreement which is presented in Appendix D. This was an agreement between the researcher and Principal, it outlined details about what the participants would be expected to do, the voluntary nature of their participation and the kind of feedback that would be provided to the school. Once permission was obtained from the Principal, the researcher would then meet with a teacher or teachers responsible for the Grade

11 learners in that particular school. The researcher would explain that strict confidentiality would be maintained, that the learners were free not to participate and that the completion of the questionnaire would take about 45 minutes.

Prior to administering the questionnaire the researcher would briefly explain the reason for the research. The students were informed that their participation was voluntary and they were free to withdraw at any time. They were encouraged to be honest and truthful in their responses and that there was no right or wrong answer. The students were also informed that strict confidentiality would be maintained; nobody would ever know who had answered which question paper. It was explained that their responses would be aggregated to obtain an overall impression and not scrutinised individually.

2.5) Validity and reliability

The questionnaire was pilot-tested on a sample group of 64 students to check for any difficulties and ambiguities which may have arisen regarding language or administration. As a result of this pilot study ambiguous and difficult terminology was recognised and a translator was on-hand to explain to the learners on subsequent questionnaire administrations.

With regard to the AAS (from which the questions were extracted) Shrum et al. (1989) write that "The AIDS Attitude Scale was demonstrated to have content validity and reliability and can therefore be used to assess attitudes towards HIV/AIDS" (p.228).

2.6) Data analysis

One of the theoretical tenets of the Health Belief Model was drawn on to inform the investigation of perceptions, attitudes and knowledge as it pertains to susceptibility to HIV/AIDS among young people. This was done because it identifies 'perceived susceptibility' as a primary concern in the investigation of how attitudes influence sexual behaviour. It further asserts that an individual's perceived susceptibility to a particular health problem may lead them to change their behaviour concerning their health (Richter, 1996)

The data was entered into a computer spreadsheet and analysed using the programme Statistica Version 7.

Descriptive statistics of the information obtained from the questionnaire were computed. Frequency counts and percentages were calculated in order to discover the frequency of individual responses to the different sections. This was done in order to obtain an overall

impression of the kinds of knowledge and attitudes that the participants had. It also provided a picture of the levels of access to healthcare that the participants had.

In addition to the generation of descriptive statistics, cross-tabulations were calculated for relevant items using one demographical variable, namely, gender. The students' self-report of being sexually active was also used. The results of the analysis will be presented in the next section.

Chapter 3 - Results

The main goal of the research project was to determine and establish the existing perceptions, attitudes and knowledge regarding susceptibility to HIV/AIDS among young people.

The response rate to the questionnaire was very good, all of the students who had been requested to complete it, completed it even though they had been informed that their participation was voluntary. A total of five schools in a historically under-resourced area were included in the study and they were relatively similar in many respects. The new political dispensation has resulted in more funds being directed to schools which previously had very little or no facilities. This has improved learning conditions but there is more that can be done.

3.1) Descriptive statistics

3.1.1) General

A total number of 318 students responded in the study. Females made up 47% (n = 150) of the sample and males made up 52% (n = 165) of the sample. Three students did not respond to this item in the questionnaire.

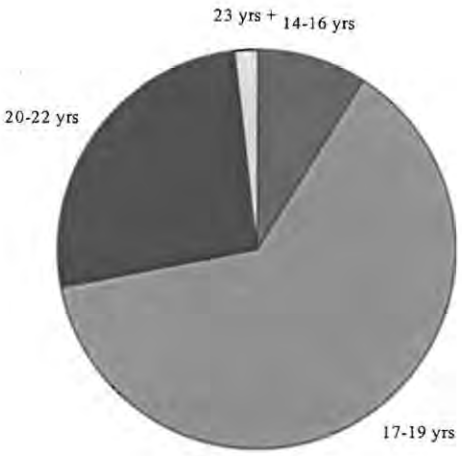

Figure 1: Participant age ranges.

The majority of the participants (63%) were between the ages of 17 and 19 years (n = 199). Eighty-two students (26%) were between the ages of 20 and 22 years, 9% of the students (n = 28) were between the ages of 14 and 16 years and 1.8% of the students (n = 6) were 23 years of age and over. Three students did not respond to this item in the questionnaire.

96% of the students (n = 304) reported that they speak IsiXhosa as a home language, 1% of the students (n = 4) reported that they speak IsiZulu as a home language and 1.6% of the students (n = 5) reported that they speak Sesotho as a home language. The rest of the participants did not respond to the item asking them about their home language. This is a representative sample because Rini is an area where isiXhosa speakers predominantly reside. It is also representative in terms of the participants' age ranges. This is because the bulk of the students are aged between 17 and 19 years. There are also a significant number of students, who are in their early 20s, this is characteristic of the current age demographics that are prevalent in a majority of under-resourced schools in South Africa.

3.1.2) Knowledge

The results of the questions relating to knowledge about HIV/AIDS are presented below. These have been divided into three sections:

- General knowledge about HIV/AIDS.
- Knowledge about the transmission of HIV/AIDS.
- Sources of HIV/AIDS knowledge.

3.1.2.1) General knowledge relating to HIV/AIDS

Table 2 presents the responses to questions which were aimed at analysing the level of general knowledge that the participants had.

Table 2

General knowledge relating to HIV/AIDS

Question	**Response ('correct' responses are given in bold type.)**		**n**
	Yes	**No**	
AIDS and HIV are the same thing.	23%	**73%**	305

Is there a cure for AIDS?	19%	**80%**	313
Most people who contract HIV/AIDS die from AIDS.	**92%**	7%	315

The table shows that 23% of the participants thought that AIDS and HIV were the same thing, this points to the fact that young people still need to distinguish between HIV and AIDS and to be knowledgeable of the fact that these two conditions are different, even though the one leads to the other.

19% of the participants stated that there is a cure for AIDS and 7% responded saying that most people who contract HIV/AIDS do not die from the disease.

3.1.2.2) Knowledge pertaining to the transmission of HIV/AIDS.

Table 3

Knowledge pertaining to the transmission of HIV/AIDS

Question HIV/AIDS can be transmitted in the following ways:	**Response ('correct' responses are given in bold type.)** **Yes**	**No**	**N**
sexual intercourse between a male and female.	**95%**	4%	317
sexual intercourse between two males.	**54%**	45%	315
from sharing cups with an HIV positive person.	4%	**95%**	317
from being bitten by insects.	21%	**75%**	307
by sharing intravenous needles for drugs.	**85%**	14%	312
from a toilet seat.	9%	**90%**	315
through hugging and caressing.	4%	**96%**	318
through kissing.	11%	**87%**	315
an HIV positive mother can pass on HIV to her baby through breastfeeding.	**73%**	23 %	304

Table 3 presents responses to questions which were aimed at determining the level of knowledge pertaining to the transmission of HIV/AIDS. It shows that a large number of the participants gave the correct response when answering the items on this section of the questionnaire. The only item in which there is evidence that there was an almost equal amount of those who said 'Yes' and those who said 'No' is the one which talks of sexual intercourse between two males. This might be due to the fact that there is not a lot of discussion that takes place around the dangers of contracting HIV among men who have

sexual intercourse with other men, thus this leads to young people not being informed about this kind of issue.

3.1.2.3) Sources of HIV/AIDS knowledge

Table 4 presents responses to questions which were asked in order to determine the sources of HIV/AIDS that the participants had.

Table 4

Sources of HIV/AIDS knowledge

Question	Friends (n = 318)		Parents (n = 318)		Nurse (n = 318)		Teacher (n = 318)		Older sibling (n = 318)	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
With whom have you discussed HIV/AIDS?	**56%**	44%	**55%**	45%	**50%**	50%	**45%**	55%	**21%**	79%
Where do you obtain information about HIV/AIDS?	**23%**	77%	**34%**	66%	**73%**	27%	**49%**	51%	**14%**	86%
From whom have you received most of your knowledge of HIV/AIDS in the past?	**25%**	75%	**36%**	64%	**47%**	53%	**40%**	60%	**10%**	90%

Table 4 shows the various sources of knowledge that participants reported. The 'yes' responses are in bold type. Most participants (56%) said that they have discussed HIV/AIDS with their friends and (79%) said that they have not discussed HIV/AIDS with older siblings. This points to the fact that the majority of young people prefer to discuss HIV/AIDS with people outside the family such as friends. However 55% of the participants reported that they have discussed HIV/AIDS with their parents as compared to 45% who reported that they had not.

An overwhelming 77% and 86% of participants said that they do not obtain information relating to HIV/AIDS from their friends or older siblings. However, a large number of participants (73%) reported that they obtain information about HIV/AIDS from nurses. A large number of participants (66%) reported that they do not obtain information about

HIV/AIDS from their parents which points to the fact that parents need to communicate more with their children regarding HIV/AIDS and issues of sexuality.

The results from the question which asked 'From where have you obtained most of your knowledge of HIV/AIDS in the past?' are more or less the same as the results for the question that was asked before that which is 'Where do you obtain information about HIV/AIDS?'. This means that the sources that the participants have relied on for knowledge about HIV/AIDS in the past are the same as the sources from which they obtain information about HIV/AIDS in the present. The results from this question are important because they provide an overall impression of the sources where the participants obtain HIV-related information. This kind of information will enable the researcher to assess whether those sources are suitable to provide this kind of information and whether the participants are able to be accurately informed so as to make the right decisions regarding their health behaviour.

3.1.3) Attitudes

This section will look at the responses that were given in response to questions that sought to examine the participants' perceptions and attitudes.

3.1.3.1) Perceived Susceptibility

The responses to the questions regarding perceived personal susceptibility are presented in the Table 4 below.

Table 5

Perceived Susceptibility to HIV infection

Question	**Response**		**n**
	Yes	**No**	
I think that young people in my community Can get HIV anytime they have sex.	54%	43%	308
I think I can contract HIV anytime (this question was posed to sexually active participants only.)	88%	11%	275

As reflected in Table 5 the majority of participants in the study felt that their peers were susceptible to HIV/AIDS regardless of whether they use condoms or not. An overwhelming

majority of students who reported that they were sexually active felt that they were personally susceptible to HIV/AIDS.

3.1.3.2) Perceived Severity

Reflected in Figure 2 are the respondents' attitudes regarding the perceived severity of HIV/AIDS. The statement that was posed to the participants was: 'There is a large number of people living with HIV/AIDS in my community.' As Figure 3 reflects, 44% of the respondents reported that they agree that there are a lot of people community who are living with HIV/AIDS; this is in addition to the 32% who strongly agree. Only 3% strongly disagreed with the statement.

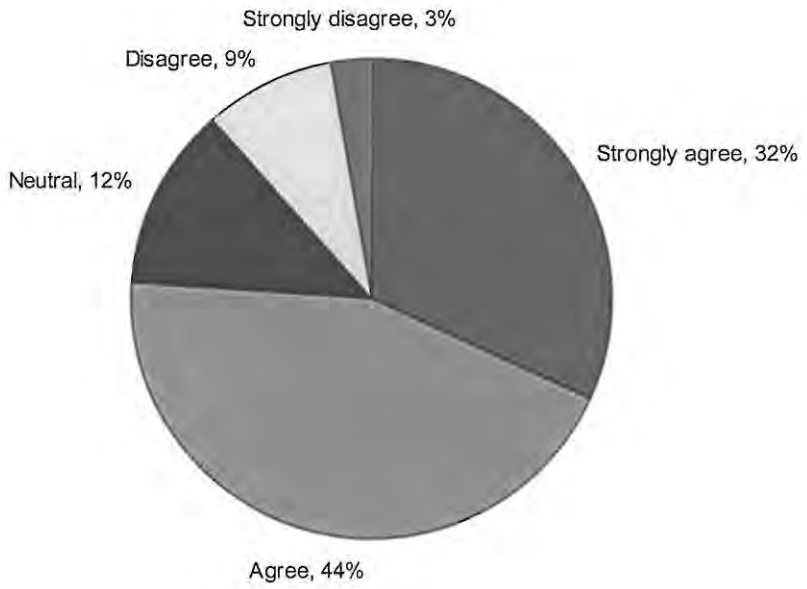

Figure 2: Perceived severity of HIV/AIDS.

3.1.3.3) Perceptions of condom usage

The responses to the questions regarding participants' perceptions towards condom use are presented in Table 5.

Table 6

Perceptions of condom use

Question	Response		n
	Yes	No	
Using a condom can lower the risk of contracting HIV/AIDS.	83%	17%	317
Do you and your partner use a condom every time when engaging in sexual intercourse?	51%	37%	277
Do you know where to get free condoms?	96%	4%	279

(The last two questions were posed to participants who had reported that they were sexually active.)

As shown in Table 6 the majority of participants agreed that the use of a condom can lower the risk of contracting HIV. A worrying trend that was revealed was that only 37% of sexually active students stated that they use a condom regularly when engaging in sexual intercourse. Ninety-six percent of sexually-active participants said that they know where to get free condoms, whilst 4% stated that they do not.

3.1.3.4) Willingness to undertake protective measures

Reflected in Table 6 below are the respondents' attitudes regarding their willingness to use protective measures when engaging in sexual intercourse. They were asked to respond to the following statement: 'There a lot of young people living with HIV/AIDS, because of this reason, do you feel the need to.....' They were then asked to choose one option from a list of three answers.

Table 7

Willingness to undertake protective measures

Question	Percentage		N
	Yes	No	
abstain from sex	20%	79%	65
be faithful to your partner	31%	69%	98
to use a condom regularly	46%	54%	147

As Table 7 reflects, a low number of participants (31%) reported that they are faithful to their partner; an even lower percentage (20%) reported that they abstain from sexual intercourse. An even worrying result is that only 46% of the respondents stated that they regularly use a condom.

3.1.3.5) Proximity to People Living With HIV/AIDS (PLWHA)

Table 8 presents results of questions that sought to analyse participants' perceptions regarding their proximity to People Living with HIV/AIDS.

Table 8

Proximity to People Living With HIV/AIDS.

Table key

SA = Strongly Agree
A = Agree
N = Neutral
D = Disagree
SD = Strongly Disagree

Question	**Response**					**n**
	SA	**A**	**N**	**D**	**SD**	
I would consider marrying someone living with HIV/AIDS.	6%	15%	14%	40%	25%	315
I would quit my job before I would work with someone living with HIV/AIDS.	4%	5%	4%	45%	41%	315
I would prefer not to be around homosexuals for fear of catching HIV.	9%	19%	16%	35%	18%	309
Being around someone with HIV/AIDS would not put my health in danger.	36%	42%	5%	12%	4%	316
People should avoid going to the dentist because they might contract HIV from dental instruments.	5%	10%	9%	46%	30%	316
The thought of being around someone living with HIV/AIDS does not bother me.	33%	42%	5%	15%	4%	316
PLWHA's should be prohibited from working in public places.	6%	8.5%	6%	47%	32%	315
I would date a person living with HIV/AIDS.	15%	40%	18%	16%	9%	316
It would not bother me to attend classes with someone living with HIV/AIDS.	42%	35%	2%	11%	8%	314
I would allow my children to play with the children of someone known to have	23%	42%	11%	14%	8%	315

HIV/AIDS.

The results presented in Table 8 reflect that a large number of participants (65%) would rather not marry someone living with HIV/AIDS. The results reflect that 86% of the participants would not quit their jobs before they would work with someone living with HIV/AIDS.

A large number (86%) of the participants acknowledged that being around someone living with HIV/AIDS would not put their health in danger. They (76%) disagreed that people should avoid going to dentists for fear of catching HIV.

The majority (76%) also stated that it would not bother them to attend classes with someone living with HIV/AIDS.

3.1.3.6) Judgemental dimensions of attitudes towards HIV/AIDS

The responses of participants regarding moral and judgemental dimensions of attitudes towards HIV/AIDS are presented in Table 8 below.

Table 9

Judgemental dimensions of attitudes towards HIV/AIDS.

Table key

SA = Strongly Agree
A = Agree
N = Neutral
D = Disagree
SD = Strongly Disagree

Question	**Response**					**n**
	SA	**A**	**N**	**D**	**SD**	
I think that People Living With HIV/AIDS get what they deserve.	5%	6%	5%	38%	44%	316
People with HIV/AIDS should not be looked down upon by others.	45%	37%	4%	8%	6%	315

The results presented in Table 9 show that a majority of participants (44%) strongly disagreed that PLWHAs get what they deserve and 38% agreed. A large majority (45%) of participants also strongly agreed that PLWHAs should not be looked down upon by others and 37% agreed.

3.1.4) Sexual Behaviour

This section concerns responses which were given in response to questions that were concerned with the students' sexual behaviour.

3.1.4.1) Sexual behaviour

As shown in Figure 3 and Table 10, 22% of the participants reported that they had never engaged in sexual intercourse before and 78% said that they had. When asked for the number of sexual partners over a fixed period, 49% reported that they had had one sexual partner and 26% reported that they had had 2-4 sexual partners.

Question: Have you ever engaged in sexual intercourse?

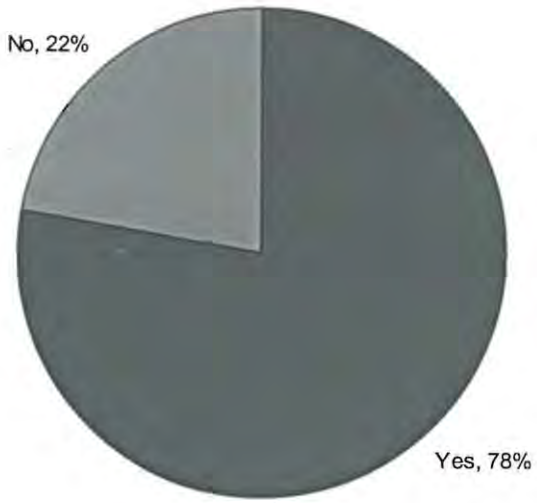

Figure 3: Sexual experience.

Table 10 :

Number of sexual partners over a fixed period.

Question	Response				n
	1	2-4	5-7	8 +	
How many sexual partners have you had in the last year?	57%	29%	4%	9%	244

3.1.5) Access to healthcare

Table 11 shows the results of the questions that sought to determine the participants' access to healthcare.

Table 11

Access to healthcare

Question	Response		n
	Agree/Yes	Disagree/No	
I get to see a nurse when I need to see one.	80%	19%	312
I have access to health information most of the time.	80%	18%	312
I feel I can talk to a nurse about any health issue.	83%	15%	313
Do you live far away from a clinic?	17%	83%	316

Table 11 reflects that the participants' access to healthcare is quite good. Eighty percent of the participants reported that they get to see a nurse when they need to see one and that they have access to health information most of the time. Eighty – three percent said that they feel that they can talk to a nuese about any health issue, whilst 17% reported that they do not live far away from a clinic.

3.2) Inferential statistics

The sub-goal was to investigate if any relationship exists between attitudes, knowledge, condom use and sexual behaviour. This section of the analysis will analyse the difference in attitudes, knowledge, condom use and sexual behaviour according to gender. It will also look at these differences according to participants who reported that they were sexually active and those who reported that they were not. Cross tabulations will be carried out towards this end.

3.2.1) Differences according to gender

3.2.1.1) Responses of male and female participants regarding knowledge about HIV/AIDS.

Table 12 shows the responses to questions which sought to analyse the participants knowledge about HIV/AIDS. The table reveals the fact that the participants knowledge about HIV/AIDS was generally good. The male participants however, scored lower than the female participants on all three questions.

Table 12

Comparisons between gender and knowledge about HIV/AIDS.

Question	**Yes/No**	**Response (Correct responses are in bold type)**	
		Female	**Male**
1) An HIV positive mother can pass on HIV/AIDS through breast milk.	Yes	**83%**	**70%**
	No	16.9%	30%
2) Most people who contract HIV die from it.	Yes	**95%**	**90%**
	No	5%	10%

3.2.1.2) Responses of male and female participants regarding condom usage.

Table 13 shows that even though the majority of participants responded saying that the use of condom can lower the risk of infection, a significant amount (16% and 18% respectively) stated that the risk of infection is not lowered.

Table 13

Comparisons between gender and Condom usage

Question	**Yes/No**	**Response (Correct responses are in bold type)**	
		Female	**Male**
1) Using a condom during sex can lower the risk of getting HIV/AIDS.	Yes	**84%**	**82%**
	No	16%	18%

3.2.1.3) Responses of male and female respondents participants regarding access to healthcare.

Table 14 shows that the male and female respondents both had quite good access to healthcare. The female participants' responses show that they had slightly better access to healthcare than the males.

Table 14

Comparisons between gender and Access to healthcare

Question	Agree/Disagree	Response	
		Female	Male
I get to see a nurse when I need to see one.	Agree	81.5%	80.4%
	Disagree	18.5%	19.6%
I have access to health information most of the time.	Agree	85.6%	78%
	Disagree	14.4%	22%
I feel that I can talk to a nurse about any health issue.	Agree	86.5%	82%
	Disagree	13.5%	17.9%
Do you live far away from a clinic?	Yes	14.8%	18.3%
	No	85.2%	81.7%

3.2.2) Responses from Sexually active and Non-sexually active participants

Table 15 shows that responses from the two groups to the first two questions regarding knowledge about HIV/AIDS were more or less the same. Their responses to the question: 'Do you feel that you know enough information about HIV/AIDS?' reflects that both groups were not confident about the sufficiency of their knowledge. Responses to the two questions about Perceived Susceptibility reflect that the participants perceive themselves to be susceptible to HIV/AIDS. Eighty-eight percent of sexually active participants responded saying that they felt personally susceptible as opposed to only 11% who responded saying that they did not feel susceptible. More than half (55% and 58% respectively) of the respondents in both groups responded saying that they felt that young people in their communities were susceptible to the HI virus.

Responses to the statement: 'Using a condom during sexual intercourse can lower the risk of contracting HIV/AIDS' reflect that the majority of respondents in both groups agreed with

it. However, close to a fifth of the participants felt that the use of condoms cannot lower the risk of contracting HIV/AIDS.

Responses to the question: 'Are you pressured to have sex by your friends?' reflect that a majority of respondents in both groups did not experience any peer pressure to engage in sexual intercourse. However, when the two groups are compared, slightly more sexually active participants did feel pressured to engage in sexual intercourse as compared to the non-sexually active participants.

A majority of participants in both groups responded saying that they get to see a nurse when they need to see one. They also responded saying that they do not live far away from the local medical centres. This could also be attributed to the fact that Rini township is a relatively small area with a dense network of taxi routes making it easier for people to be transported through to different places in it.

Table 15

Sexually active (SA) and Non-Sexually active (NSA) participants' responses.

Question	**Yes/No**	**Response**	
		SA	**NSA**
Knowledge HIV/AIDS can be transmitted through hugging and kissing.	Yes	4%	3%
	No	96%	97%
HIV/AIDS can be transmitted through insect bites.	Yes	23%	19%
	No	77%	81%
Perceived susceptibility I think I can contract HIV/AIDS anytime (this question was posed to Sexually Active participants only.)	Yes	88%	----
	No	11%	----
I think that young people in my community can get HIV anytime they have sex.	Yes	55%	58%
	No	45%	42%
Perceptions of condom usage Using a condom can lower the risk of contracting HIV/AIDS.	Yes	84%	80%
	No	16%	20%
Access to healthcare I get to see a nurse when I need to see one.	Yes	83%	76%
	No	17%	24%

Do you live far away from a clinic?	Yes	18%	14%
	No	83%	86%

Chapter 4 - Discussion

Health Belief Model theorists assume that a human being's perceptions, attitudes and knowledge will influence him/her to take a health-related action or behaviour. The nature of those perceptions is what will determine whether the person takes a positive or a negative action or behaviour. One of the determining perceptions is that of susceptibility. Perceived susceptibility to a disease or condition (in this case HIV/AIDS) can have a very strong impact on what kind of decisions a person takes regarding behaviour. It can either influence the person to take preventative steps in order to avoid infection or it can cause a person to show little concern about HIV infection and to not take preventative steps to protect him/herself from contracting it. According to one of the Health Belief Model's tenets a person who considers him/herself susceptible to HIV/AIDS will be more likely to adopt positive sexual behavioural change in order to prevent infection (Brown, 1999). For instance, a person who is sexually active, who is not involved in a mutually faithful relationship and who does not use condoms, might realise that they are at risk and are therefore susceptible to HIV infection. Upon realising that their susceptibility is high they might then decide to change their health behaviours for the better in order to avoid infection. This might, perhaps be abstaining from sexual intercourse, being in a mutually faithful relationship or using condoms regularly during sexual intercourse. However, this study has come up with findings that are contrary to what the Health Belief Model postulates. As will be shown later on in this section, young people perceive themselves to be susceptible to HIV infection, yet this has not resulted in changes in their sexual behavioural patterns.

A human being is situated in a wider macro-environment where there are numerous and varying factors which influence and impact on his/her perceptions, attitudes and knowledge. These in turn influence his/her sense of perceived susceptibility. Three of these factors have been focused on in this study and they are: knowledge about HIV/AIDS, access to healthcare and conflicting messages about sex and HIV/AIDS. These have a direct influence on a person's perceptions, especially perceived susceptibility. Each of them can either make a person feel that they are susceptible or that they are not. Knowledge about HIV/AIDS affects perceptions, attitudes and knowledge in the sense that young people who might not have adequate knowledge and facts pertaining to HIV/AIDS might feel that they are not susceptible when in fact they might be (Pinkerton et al., 2000). Lack of access to healthcare can lead a young person to believe that they are not susceptible to HIV infection, when in fact, they are. When a young person does not have access to adequate healthcare this results

in them not receiving accurate and complete HIV/AIDS information. Information pertaining to methods of transmission, symptoms of infection, protective measures etc. It is very easy for a young person to then misjudge their level of susceptibility. Conflicting messages about sex and HIV/AIDS influence young people's perceptions, attitudes and knowledge in the sense that they receive incorrect information from their peers and other uninformed parties. Such information might then lead them to erroneously think that they are not susceptible to HIV infection. A person's perceived susceptibility will then have an influence on the type of health behaviour that they decide to adopt.

The main goal of this study has been to analyse the kind of perceptions, attitudes and knowledge that young people have, with a view to finding out the role that these three constructs have on influencing a person's perceived susceptibility, and to analyse the role of the three above-mentioned factors in influencing young people's perceptions.

4.1) Knowledge about HIV/AIDS.

Results of the data analysis regarding (refer to *Sections 3.1.2.1 and 3.1.2.2)* Knowledge about HIV/AIDS' indicate that the majority of young people are generally knowledgeable about the disease. However, evidence points to the fact that a significant amount of young people still lack information on some of the most fundamental aspects of HIV/AIDS, such as the fact that HIV is technically not the same as AIDS. Richter (1996) confirmed that there are some young people who have limited knowledge regarding HIV/AIDS. Such limited knowledge leads to them holding negative attitudes and perceptions about the disease, such as perceiving themselves as less susceptible than they really are. This of course, leads to them not seeing the necessity of adopting positive protective behaviours, such as abstaining from sexual intercourse. This is corroborated by information in the Results section *(Section 3.1.3.4)* which reflects that 20% of the participants reported that they abstain from sexual intercourse, 31% reported that they are faithful to their partner and 46% reported that they use a condom regularly.

As mentioned above (refer to *Sections 3.1.2.1 and 3.1.2.2*) results of the analysis also reveal that the majority of young people generally have adequate knowledge about the disease. There have been well-funded and large-scale HIV/AIDS awareness campaigns in South Africa for the last 10 years, one of which has been credited as the largest campaign aimed at HIV prevention in the world (Berry et al., 2004). Evidence also points to the fact that young people's knowledge about the transmission of HIV/AIDS is very good. They are

knowledgeable about the various ways through which the virus cannot be transmitted. However there are some areas where their knowledge falls short, such as in the area of homosexual transmission of HIV. The majority of young people in South Africa are well-informed about the pandemic, however in spite of the high levels of awareness, prevalence rates are still high. Despite the high levels of knowledge that they have many young people still continue to be exposed to high-risk situations. This however goes against what the proponents of the Health Belief Model state, they state that a person is more likely to avoid risky behaviour if they have adequate knowledge and they perceive themselves to be susceptible based on what they know. Studies (CASE, 1995 and Visser, 1995) have also shown that even though some young people have high levels of knowledge about the disease, few perceive themselves to be susceptible or at risk. This, however, has not been part of the findings of this study; findings pertaining to perceived susceptibility will be discussed in Section 4.5 below. Cross tabulations also reveal that the male participants had less knowledge about HIV/AIDS than the females. This could be attributed to two factors: guidance counselling and clinic attendance. Guidance counselling in schools consists of information whereby girls are taught about different contraceptive methods. This is usually carried out with female students; this is also where information on STI's and HIV/AIDS is also given. Female students are also more likely to go to health clinics for contraception; this is where more information is given to them on how to protect themselves from infection. Cross tabulations also show that the sexually active students are slightly more knowledgeable about HIV/AIDS than the non-sexually active students.

4.2) Conflicting messages about sex and HIV/AIDS.

The results of the analysis (*Section 3.1.2.3*) demonstrate that quite a large majority of the participants have not discussed HIV/AIDS with their older siblings, a significant amount also reported not discussing HIV/AIDS with their parents. Half of them have, however, discussed it with their nurse, and just under half of them reporting that they have discussed it with their teacher. 73% reported that they obtain information about HIV/AIDS from nurses, however 47% reported that they have not obtained information about HIV/AIDS from nurses in the past. This points to the fact that a large number of young people do not obtain information about sex from their parents, which is where such information should be given to them first. A good sign is that nurses in the public health sector are now informing young people about HIV/AIDS whereas in the past this did not happen (refer to *Section 3.1.2.3*). Another good

sign, is that a large majority of them reported that they do not and have not obtained information from their friends, even though 56% of them reported that they do discuss HIV/AIDS with them. This is a good sign because, in as much as it is good for young people to discuss HIV/AIDS issues amongst themselves, one must be aware of the fact that they (peers and friends) cannot be relied on as a good source of information and knowledge pertaining to HIV/AIDS. Such information could be inaccurate and might be at conflict with accurate information received from health authorities and other informed parties. When young people receive conflicting messages about sex and HIV/AIDS this leads to them having the wrong perceptions about their susceptibility. This is because when they follow and believe incorrect and inaccurate information which is in most cases from their peers, this leads them to (among other things) feel that they are not at risk of infection. This is because the incorrect information they will be receiving from friends will most likely be geared towards a fun, carefree, uninhibited way of living without any cares or worries about protected sex and STI and HIV infections. The results of this study therefore reflect that young people do not receive conflicting messages about HIV/AIDS this is emphasised by the fact that the findings also reflect that young people perceive themselves to be susceptible. The findings from this study are not consistent with results that other studies (Hartell, 2004) have found. They reflect that some young people do receive conflicting messages about sex and HIV/AIDS.

4.3) Stigma and discrimination

"Stigma enables people to believe that they are not at risk for HIV. People who express stigmatising attitudes about HIV often have retained misinformation about the transmission of HIV" (AIDS Action, 2001, p.2). Stigma and discrimination can be detrimental to those who perpetrate such attitudes because it leads them to undermine their own susceptibility to the disease because it (HIV/AIDS) is attributed to 'other' people. Health behaviours such as protected sex are not adopted and this leads to an increased risk of infection. Results from the study reveal that the majority of respondents did not have attributes related to HIV/AIDS stigma. This was revealed by their responses to questions which sought to analyse their attitudes concerning proximity to People Living With HIV/AIDS as well as to questions which sought to analyse the judgemental dimensions of attitudes towards HIV/AIDS. The only exceptions were when they were asked about marrying or dating someone living with the virus. That is when more negative responses were obtained.

4.4) Access to healthcare

Limited access to healthcare is a characteristic of any developing country. A majority of South Africans who have to use public hospitals and clinics are sometimes subjected to inadequate medical centres, inadequate medical personnel, shortage of medicines and medical equipment. The situation has improved over the last ten years and more people are gaining access to healthcare. This is what can be deduced from the responses of the participants (refer to *Section 3.1.5*), an overwhelming majority of whom said that they are able to see a nurse when they need to see one, that they have access to health information most of the time, that they feel they can talk to a nurse about any health issue and that they do not live far away from a clinic. This points to the fact that they are able to obtain accurate reproductive health information that would assist them in assessing (among other things) their level of susceptibility to HIV infection and in adopting positive health behaviours to protect themselves from contracting HIV.

4.5) Perceived susceptibility

In an effort to analyse the perceived susceptibility of the participants in the study, they were first asked how severe they thought the pandemic's impact was on their community. They were given a statement and asked to respond to it. The statement was: There is a large number of people living with HIV/AIDS in my community. Thirty-two percent strongly agreed and 44% agreed with the statement (refer to *Section 3.1.3.2*). This reflects that they do acknowledge that HIV/AIDS has had a huge impact on their lives and those of others in their community. Responses from the participants also reflected that they felt that young people in their community were susceptible to contracting the HI virus. When asked about their personal susceptibility an overwhelming majority of the participants felt that they were susceptible to the HI virus. This is in contrast to studies that have been carried out before (Govender et al., 1992, Hartell, 2005 and CASE, 1995) which have come up with findings that suggest that young people in South Africa do not perceive themselves to be susceptible. Research carried out in South Africa indicates that higher perceived susceptibility is linked to greater intended or actual sexual behavioural change (Govender et al., 1992). These findings are very important because the proponents of the Health Belief Model state that positive behavioural change can be influenced by a high perception of susceptibility to HIV/AIDS.

Cross tabulations also show that there is a higher number of non-sexually active participants who believe that young people in their community are susceptible to HIV/AIDS.

4.6) Sexual behaviour

Health Belief Model theorists also state that the sexual behaviour of a human being either changes for the better or for worse after he or she has assessed their susceptibility to HIV infection. It is with this in mind that the researcher asked the participants about their sexual behaviour. Seventy-eight percent of the participants reported that they have engaged in sexual intercourse (refer to *Section 3.1.4.1*). This is a very high number, given that the majority of the participants were aged between 17 and 19 years of age. When the sexually active respondents were asked about the number of sexual partners they have had over the last year, 57% responded that there had been one, 29% reported that there had been between two and four. Of particular concern to HIV/AIDS policy makers should be the fact that 48% of sexually active participants had reported that they do not use a condom regularly when engaging in sexual intercourse. Eighty-three percent of the participants did mention, however, that the use of a condom can lower the risk of contracting HIV/AIDS and when given a choice of three protective measures (abstinence, being faithful to one partner and regular condom use) to choose from, more participants chose regular condom use. Cross tabulations show that both male and female participants felt that the use of condoms was beneficial. They also show that there is a higher number of sexually active students as compared to non-sexually active students who believe that condoms can lower the risk of contracting HIV/AIDS. Ninety-six percent of sexually active participants reported that they knew where to obtain free condoms. Results show that young people acknowledge the high value that condoms have in protecting against HIV/AIDS, young people prefer condom use when protecting themselves and they know where to obtain them for free. However, this has not translated to an increased use of condoms. Condoms are not regularly used and that is quite dangerous as this places young people at a high risk of contracting HIV/AIDS. This, is consistent with findings done by Walker et al. (2004). Their findings reflect that the level of regular condom use among young people is not high. This, added to the fact that there is a large number of young people who are involved in sexual activities at a young age, makes the situation serious and in need of urgent intervention.

Evidence shows that young people are very well informed when it comes to HIV/AIDS; however prevalence rates are still high. Young people feel that they do not receive

conflicting messages about HIV/AIDS, they receive the right information that would enable them to make the right decision concerning their sexual behaviour. They also do not have attributes which point to the fact that they stigmatise and discriminate towards People Living With HIV/AIDS. Evidence also shows that they have adequate access to healthcare; they can consult a nurse when they need to, and they do not live far away from health clinics. They do perceive themselves as susceptible to HIV/AIDS and they feel that other young people in their community are susceptible as well. However, with all these favourable conditions that would normally allow for lower HIV prevalence rates, the situation is still much the same if not even worse. A large number of young people still engage in risky sexual behaviour and there is no positive sexual behavioural change. Findings from this study reflect that there is a high level of sexual activity among young people, abstinence rates are low, a large number of young people are not faithful to their partners and that condom usage is low even though the efficiency of condoms is recognised. This is corroborated by information in the Results section *(Section 3.1.3.4)* which reflects that very low numbers of participants reported that they abstain from sex, are faithful to their partner and regularly use condoms. This points to the fact that there is little or no positive sexual behavioural change that would result in lower prevalence rates.

The Health Belief Model states that when a person has high perceived susceptibility then it is highly likely that they will change their sexual behaviour in order to ensure that they are protected from infection. However, the findings in this study do not point to the fact that young people are adopting positive sexual behaviours.

4.7) Limitations of the study

A limitation to this study is that it could have been supplemented by focus groups, conducted with the students. Information from focus groups could have provided insight into the responses that were given by the participants when responding to the questionnaire. They could have also served to alert the researcher on further areas that could be researched in the study. The informal environment provided by a focus group discussion could have enabled the participants to be more open and honest about their feelings and perceptions which would have enabled the researcher to fully understand the dynamics behind some of the perceptions and attitudes that the participants gave input on. Further insight could have been gained into the participants' shared understandings of everyday life and the ways in which they as young people are influenced by others in a group situation.

This study is a school-based study and another limitation is that it targets young people who are still in school, leaving those who might have prematurely left the schooling system, those who have completed schooling and those who have never attended school. The implication of this is that the information generated from the study can be used primarily in a school context and not necessarily in other contexts.

Another limitation of the study was that the questionnaire did not effectively tap into certain central issues that could have provided more insight into young people's perceived susceptibility. The questionnaire was designed in such a way that it could be completed within 45 minutes and it was designed in such a way that it was not long. The participants had to be able to finish it without losing their concentration, as a result some issues could not be tapped into. Issues that could have provided more insight could have been: effects of peer pressure, media and parental guidance.

4.8) Recommendations for future research

There is still a great amount of research that needs to be done on behaviour change and the perceptions and attitudes that influence and impact on a person's decision to undertake behaviour change. This study has revealed that many young people know about HIV/AIDS and its implications. It also reveals that mere knowledge does not guarantee positive behavioural change. Therefore further research needs to look at the development of behavioural change programmes aimed at young people in the schooling system. The structured environment could enable the implementation of programmes which could include assertiveness programmes, condom promotion and abstinence programmes. Assertiveness programmes could place a special emphasis on sexual assertiveness for both male and female adolescents, but especially female adolescents. Studies carried out in South Africa reflect that the level of sexual assertiveness among some young women is not sufficiently high (Walker et al., 2004), this results in them being coerced to engage in sexual intercourse, this resulting in sexually transmitted diseases and unwanted pregnancy. Such programmes could also include content that addresses the issue of gender inequality because this is one of the main reasons why females lack sexual assertiveness.

Further research could also look at the development of local capacity building programmes. These could enable the local communities to become actively involved in HIV/AIDS programmes offered by local NGOs or government parastatals which are involved in HIV youth programmes. This could enable parents to be involved in a more structured

manner in the lives of the young people in the community. Programmes involving the local community could include aspects of building strong family institutions and moral regeneration. These aspects of the programmes could encourage young people to be faithful to their partners and to abstain from sexual intercourse until they reach a mature age.

The government and other concerned stakeholders have numerous AIDS awareness campaigns which aim at educating young people on the various methods of preventing infections such as abstinence, being faithful and using condoms. However there is still a need to deliver these messages in a more effective and convincing manner. Future research could look at the development of awareness programmes which will have a main focus on young people's perceptions and attitudes, because it is the perceptions that have a major influence on the types of decisions that a young person will make concerning whether or not to engage in protected sex or to adopt a healthier lifestyle in terms of his / her sexual involvement.

4.9) Conclusion

Despite the level of knowledge that young people have about HIV/AIDS, prevalence rates have not stabilised and they are continually on the increase with infections among young people being the highest. A young person's opinion of their susceptibility is undeniably a very important factor which determines the behavioural options which they decide on. Perceptions and attitudes are a major aspect of what makes young people decide whether or not to adopt positive sexual behaviours and they are probably the reason why HIV/AIDS prevalence rates have not gone down. This study provides valuable information regarding the perceptions and attitudes related to perceived susceptibility and the role that perceived susceptibility plays in behavioural change.

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