Tavoosi *et al*., (2004) in a study among high school students found serious attitudinal problems caused by lack of education about AIDS that needed to be addressed. Similarly in the present study, the poor attitude of males due to a lack of detailed HIV/AIDS knowledge needs to be attended to. According to other studies better knowledge about how HIV is transmitted has been shown to have a positive influence on both prevention behaviours and positive attitudes towards people with HIV/AIDS (Shisana *et al*., 2002). However; this does not imply that knowledge is a sufficient condition for behavioural change and positive attitudes, but it is a necessary condition (Shisana *et al*., 2002).

5.4 BELIEFS

The belief one has concerning HIV/AIDS has a profound effect on the way one conceptualises the virus and behaves in response to it. In many instances youth have been found to have an optimistic outlook, with the belief that they are at little or no risk of contracting the virus irrespective of their behaviour (Eaton *et al*., 2003; Chng, Eke-Huber, Eaddy & Collins, 2005; Eaton *et al*., 2003). Every individual is at some risk of contracting the disease, hence acknowledging that risk enables one to take the necessary precautions to prevent it.

5.4.1 Factors influencing beliefs

There was a statistical difference between the universities with regard to their beliefs about the likelihood of contracting the virus, with the UWC students more likely to consider themselves as having 'no chance' compared to the UKZN students, who were more likely to choose 'Don't know'. This is interesting because the results from the study show that

UWC students were more likely to have sex before the age of 18 and have more sexual partners compared to students from UKZN. In view of their responses students from UWC therefore come across as being more optimistic about not contracting the disease compared to UKZN students. This is a problem as UWC students can be categorised as being the 'high risk' based on their behavioural responses. This is in keeping with findings among college students in Nigeria, where students exhibited an 'optimism bias' despite being classified as being at 'high risk' of contracting the disease (Ijadunola *et al*., 2007). A cause for concern is that this is similar to findings just under two decades ago where less than half the youth perceived themselves to be at no risk of contracting the virus (Friedland *et al*., 1991, Visser *et al*., 1995) which included students who were classified as being in the high risk category. This should not be the case today, owing largely to the high prevalence rate and the multiple HIV/AIDS awareness campaigns being currently run in South Africa.

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Another significant statistic obtained was the relationship between age and belief. The results showed that the older a person was, the more they would consider themselves at risk of contracting the disease. This is consistent with the knowledge and attitudes sections. This shows growth in the right direction as one can interpret this information as the older an individuals is, the more aware they are about the virus. This could be attributed to the individual finally taking cognisance of the virus due to a greater duration of being exposed to HIV/AIDS awareness campaigns.

5.4.2 Knowledge and beliefs

The majority of students stated they knew 'a lot' about HIV/AIDS (49.2%). Although the knowledge scores are not high, collectively most respondents deemed themselves as having 'no chance' of contracting the HIV virus (48.9%). Identical to the association between age and knowledge, there was also association between age and belief. The findings suggest that the older a respondent was, the more knowledgeable s/he was and the more likely s/he perceived themselves as being susceptible to contracting the disease.

Knowledge has been known to be associated with risk perceptions (Barden-O'Fallon, de Graft-Johnson, Bisika, Sulzbach, Benson & Tsui, 2004). The results yielded amid the universities with regard to contraction of the virus was interesting, with UWC obtaining a lower knowledge score while deeming themselves as having no chance of contracting the virus, compared to UKZN students who scored higher in the knowledge section and were more likely to choose 'don't know'. These findings thus illustrate that knowledge has an impact as to whether or not an individual will consider themselves at risk of contracting the virus. This, in turn, will impact on the behavioural decisions of an individual as unrealistically low beliefs of contacting the disease have been associated in some groups with high rates of sexual activity and low condom use (Eaton *et al*., 2003) which is actually consistent with the UWC results in this study. Research done in Zimbabwe has shown that women who have higher levels of knowledge, perception of risk and have a relative or friend infected with HIV were associated with behavioural change (Gregson, Zhuwau, Anderson & Chandiwana, 1998). This is important, as it leads to an individual taking the

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necessary precautions and making the correct decisions if they consider themselves at risk of contracting the virus; and will, for example, use of a condom during sexual intercourse.

On the other hand, age was also associated with an increase in sexual activity. Thus the older and more knowledgeable a student was, and the more s/he perceived themselves at risk of contracting the virus, the more sexually active s/he was. This was similar to research by Akwara, Madise & Hinde (2003) where the researcher found high levels of risk-taking was associated with high levels of perceived risk. Conversely, the increase in sexual activity with age could be reason for students' increased knowledge about the disease and the increase in perceived risk. However, this could have also been attributed to older students being married or in long-term relationships which, should hopefully, lead to safer sexual practices, a monogamous relationship hence prevention of new infections.

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5.5 SOURCES OF HIV/AIDS INFORMATION AMONG UNIVERSITY STUDENTS

Television and billboards were regarded as the main sources of HIV/AIDS information among the students. When compared to other articles, the findings are consistent among youth nationally and internationally (Lonn *et al*., 2007, Pharaoh *et al*., 2007, Opt *et al*., 2004, Ichharam *et al*., 2002). This shows that media is an efficient was to disseminate important information, however the information that is transmitted may be limited to certain aspects of HIV/AIDS only, such as condom use, abstinence and knowing your HIV status, thereby restricting knowledge of an individual. Media also leaves room for misinterpretation which is why it should be supplemented with more formal education.

Only 71.9% of the students stated having received HIV/AIDS information from campus. The results are higher than those for international students' (29.9%), (Opt *et al*., 2004), however considering the high prevalence of the disease among the youth in South Africa it is disappointing. It is unacceptable that HIV/AIDS information received from campuses is so low considering a full-time student averages between six-to-eight hours a day on campus. Interestingly enough, research done by Friedland *et al*., (1991) showed that campus health was the preferred source of HIV/AIDS information. Could the campus health services not be as involved due to the mass campaigning on and off campus? Irrespective, there should be some follow through on their part as most students would find it easier to go to the campus clinic as it is both cheap and accessible.

Another worrying statistic is that less than half the students are receiving HIV/AIDS information from friends and family. HIV is a topic that should be openly discussed amongst peers and family members in order to prevent infection, provided they receive the correct information. Once again the path points to formal education. It is within the control of higher education to offer courses that provide the students with the correct information rather than have them guess or receive false information, thereby placing them at risk.

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5.6 RELIGIOUS BELIEFS OF UNIVERSITY STUDENTS

A vast majority of the respondents were Christian (n = 402, 61%). Although more than half the respondents stated they attend a place of worship at least once a week (n = 361, 55%). Many of the students (n =233, 35%) stated that they attend their place of worship

infrequently or not al all (n = 69, 10%). This is important as literature suggests that religious attitudes are associated with conservative sexual attitudes and perceived vulnerability to HIV (Lefkowitz, Gillen, Shearer & Boone, 2004). Religion and behaviour are closely linked because religion has the potential to influence decisions regarding sex-related issues such as birth control, abstinence and abortion (Lefkowitz *et al*, 2004). By not attending a place of worship, it leaves the individual open to formulate their own moral decisions and ideas concerning sex prior to marriage and condom use. Considering that many of the students are in their early twenties, making the correct decision with the influence of peer and cultural pressure is difficult. Religious teachings have also been found to have a prominent place in people's understanding of HIV/AIDS in Africa (Caldwell, 2000). Attending a place of worship would therefore give that student the tools, support and correct moral standing enabling them to make an informed choice.

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5.7 IMPLICATIONS FOR PHYSIOTHERAPY

Physiotherapy is described as a branch of medicine that incorporates physical means such as manual therapy, respiratory therapy and exercise therapy to rehabilitate an individual to their highest functional level. Physiotherapists also use health promotion as a tool to prevent disease and injury from occurring. This is achieved by providing advice and health education to patients, carers, support workers and other health care professionals. Thus physiotherapy not only involves treating, but also teaching patients. In treating HIV infected patients a physiotherapist would provide symptomatic and prophylactic treatment to help patients have a healthier and better quality life. This involves respiratory physiotherapy for chest infections, exercise therapy to prevent and/or improve muscle

atrophy and general rehabilitation to improve the functional capabilities of these patients. Health promotion is an essential tool that should not be neglected. Health care professionals have always practiced their professions in a threefold objective: curing, caring and preventing (Kemm & Close, 1995). The pattern usually followed is curing and if this is limited, then caring with minimal emphasis on prevention is followed (Kemm *et al*., 1995). Patient education is important in every profession, as prophylaxis is better than cure. It is thus imperative for physiotherapists to be involved in health promotion campaigns targeting the youth. This will require physiotherapists to broaden their role and work in partnership with those engaged in health promotion, such as community health workers (Porter, 2008). These campaigns should incorporate education on the pathogenesis of the HIV virus, modes of HIV transmission and the progressively debilitating effect the virus has on an individual's functional capacity. Through education and delivering relevant information on how the virus will affect the independence and skill of an individual over a period of time, we can empower the youth and guide them to make an informed decision.

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The statistics of the study prove that a greater effort is required to reduce the prevalence of HIV. The study revealed that ignorance among younger students was greater than that of older students. Young adults are thus embarking on a detrimental path of ill-health which can be avoided. These young adults need to be made aware of the social implications of ignorance towards HIV and the possible repercussions of the attitude that "it won't happen to me". Empowerment of our youth cannot be achieved through physiotherapy alone. This requires a multi-disciplinary team approach involving all health care professionals. We

need to strategise and implement community outreach programmes, as well as structured courses at schools and universities and occupational health education workshops.

The tools to prevent the spread of HIV globally begin with making informed decisions. Morals, values and self-confidence are an integral part of shaping the children of tomorrow into bright successful leaders. Better planning is far less costly than better reacting. Therefore, why not prevent infection before it is allowed to consume our society? We cannot wipe out the mistakes of yesterday, however we can learn from them. But, in order for society to build a brighter and better future, the seeds of empowerment need to be planted today.

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5.8 SUMMARY

This chapter discussed the findings of the study in relation to the knowledge, attitudes, beliefs, behaviours and sources of information among students at two tertiary institutions in South Africa. The results obtained from the two universities were also compared.

Although students had a good knowledge of HIV/AIDS, they are still lacking detailed knowledge on the modes of HIV transmission which is vital to the prevention of infection. Students from both universities displayed a positive attitude towards people living with HIV/AIDS. UWC students were considered to engage in riskier behaviour compared to UKZN students in terms of initial age of first sexual experience and number of sexual partners. There was a relationship noted between gender and age in terms of knowledge, attitudes and behaviour. With regard to belief, only age was significantly associated. There was a statistical difference between the universities in terms of knowledge, beliefs and some aspects of their behaviour.

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The findings were contrary to what one would expect to find. How is it that the HIV prevalence remains so low in despite students engaging in such risky behaviours in the Western Cape compared to KwaZulu-Natal? Theoretically, the results should have been reversed. One poor decision is all that is required to contract the disease. UKZN has the lower frequency of engaging in risky behaviour. However, when risky behaviour is engaged, all inhibitions could be lost due to the feeling of freedom. Alternatively, UKZN students could be making a concerted effort to change and protect themselves. UWC

students are assuming that they will not contract the disease or are not as fearful of contracting it possibly due to less exposure compared to their UKZN counterparts.

The importance of the universities and health care professionals to step in and provide a more integrated formal education on HIV/AIDS for university students is apparent. The next chapter presents the summary conclusion and recommendations.

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CHAPTER 6

SUMMARY, CONCLUSION AND RECOMMEDATIONS

6.1 INTRODUCTION

This chapter focuses on the summary of the study. The conclusion of the study, the limitations and recommendations are also discussed.

6.2 SUMMARY

The study explored the knowledge, attitudes, beliefs, behaviours and sources of HIV/AIDS information among students at two tertiary institutions in South Africa. The study also identified the difference between the two universities as they are situated in different provinces; namely KwaZulu-Natal and Western Cape.

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The questionnaire used in the study was an amalgamation from those developed by Shrum *et a*l., (1989), Brown *et al*., (1991), Carey *et al*., (1997), The National College Students Health Risk Behavior survey and the AIDS Attitudes survey from the Centers of Disease Control and Prevention. The questionnaires were then adapted to suit South African students.

The study yielded surprising results in terms of the differences between the two campuses. The results demonstrated that the student participants in the study had a sound basic knowledge of HIV/AIDS but lacked in-depth information on the transmission of the virus –

information needed to avoid infection. Students from UKZN scored higher overall than students from UWC with regards to the knowledge questionnaire. Students in general showed a positive attitude towards people living with HIV/AIDS on both campuses. UWC students were more optimistic than UKZN students, which was relevant and vital point considering UWC students participated in riskier behaviours than UKZN students. However, due to the high incidence of HIV/AIDS in KwaZulu-Natal, students are more likely to be aware of the virus than students in the Western Cape. There was also a statistical difference noted between the gender and age, with males scoring lower than females and older students obtaining higher scores in terms of knowledge and attitudes. Males were also likely to have more sexual partners and consume alcohol on a regular basis than their female counterparts.

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Media, more specifically television and billboards, contributed the most to the students' knowledge of HIV/AIDS. Only 71.9% of students noted that they received information form the campus health centre. That means that 447 students did not receive information from the campuses, which was a worrying statistic considering the number of hours a full-time student spends on campus. The lack of knowledge and students not accessing information on campuses could possibly fuel risky behaviours. This increases the risk of the transmission of HIV in South African youth attending tertiary institutions.

6.3 CONCLUSION

This study highlights a significant lack of awareness by students at tertiary institutions as to how HIV is transmitted. It also draws attention to areas that should be addressed to reduce the spread of HIV.

HIV/AIDS does not only affect the person infected by the virus, but has a ripple effect that goes beyond the affected family and has implications for health care and the economy of South Africa. A person infected with HIV/AIDS will probably have to take time off work as a result of the infection. This can affect their take-home pay once their sick leave allocation has been sued up, and will also affect productivity and morale at the work place. As the disease progresses it could result in the person no longer being able to work. This results in a loss of income for the family; not only as a result of the person infected having to stop work, but also because other family members will have to take time off work or subsistence farming (people often return to their rural homesteads when very ill) in order to care for the sick, having a double impact on income for the family concerned. Businesses also suffer as a result of having to recruit and train a new employee to fill the position. The health care system has also come under strain as a result of HIV/AIDS such as the cost of care, number to care for and fatigue by care giver.

We can see that students at UKZN are now making a concerted effort to protect themselves and UWC students could be taking the situation for granted because as stated by Barnes (2000) they have been sheltered by the virus due to the low prevalence in the Western Cape. Empowering youth with the ability to make informed decisions around sex and HIV

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is one effective way to protect them from contracting the virus. One of the methods for the youth to protect themselves is if they make an informed decision, and this can only be achieved through education. This study supports this as UKZN students, having a higher knowledge score, engaged in less risky behaviours compared to UWC students. Ongoing and more importantly in-depth information, with a focus on viral transmission modes should be provided to the students in order to help them select safer sexual practice and incorporate these practices into their lives.

The study has met its objectives and confirmed that although students have a sound basic knowledge on HIV/AIDS, they lack more in-depth knowledge needed to prevent infection. Students still participated in risky behaviour despite having a basic knowledge of HIV, males more than females. The study also highlighted that that alcohol is more of a problem on campuses than substance abuse. The implications of the partaking of alcohol in relation to HIV/AIDS are often overlooked and needs to be addressed along with the disease.

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6.4 LIMITATIONS OF THE STUDY

There were several limitations in this study namely:

1. A self administered questionnaire was given to the respondent; this relied on the ability of the respondent to recall information. The participants might not have been able to recall all the information received on HIV/AIDS.

2. The questionnaire was done close to exam time therefore some of the students selection with regard to behaviours may have been dissimilar had it been answered after exams.

3. The respondent could have chosen answers that he/she deemed to be socially and morally acceptable.

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4. Caution should be taken in generalising the results of the study to young people in general in KwaZulu-Natal and the Western Cape.

6.5 RECOMMENDATIONS

The following recommendations are made based on the results of the study:

1. Campus health care centres need to be more actively involved in the distribution of relevant preventative information concerning HIV to the students.

2. Alcohol and substance abuse is a topic that needs to be addressed as binge drinking is a problem on campuses, especially among males.

3. A full curriculum should be held in the student's first year and smaller tutorials thereafter to remind, reinforce and update the student about the disease. This should focus on information regarding the transmission of the disease.

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4. Many of the students categorised as having a 'high risk' of contracting the disease, believed themselves not to be at risk of contracting the disease. This is serious and needs to be addressed. Educational courses should therefore incorporate what type of lifestyle classifies an individual as high risk and help by providing a means of reducing the risk.

5. Female students need to be empowered in areas of self development such as self esteem and self worth.

6. Ongoing evaluation of courses are required to improve and structure the content to make it more appropriate to students.

7. Further research is required in this area to determine why UWC students are engaging in risky behaviours and if the changes in the UKZN students are consistent.

8. Future research should include more universities in these two provinces, which would provide more representative information of university students' knowledge, attitudes, beliefs, behaviours and sources of HIV/AIDS information in KwaZulu-Natal and the Western Cape.

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APPENDIX 1

Ethical Clearance

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH
DEVELOPMENT

Private Bag X17, Bellville 7535
South Africa
Telegraph: UNIBELL
Telephone: +27 21 959-2948/2949
Fax: +27 21 959-3170
Website: www.uwc.ac.za

25 June 2008

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and the ethics of the following research project by Ms. P Reddy (Dept. of Physiotherapy)

Research Project: The knowledge, attitudes, beliefs, behaviour and sources of HIV/AIDS information among university students at two tertiary institutions in South Africa

Registration no. 08/5/9

Peter Syster
Research Development
University of the Western Cape

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RESPICE PROSPICE

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APPENDIX 2

Permission letter to Head of Department

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959, Fax: 27 21-959
E-mail: 2114049@uwc.ac.za

To: The Head of Department

Re: Administration of Questionnaires to students for Research in HIV/AIDS

Dear: Sir/Madam

I am a postgraduate student doing a Master of Science degree in the department of physiotherapy at the University of the Western Cape. Due to the nature of my course, I am conducting a study where I intend to gather information about the knowledge, attitudes, beliefs, behaviours and sources of HIV/AIDS information among university among students at two tertiary institutions in South Africa. The two provinces I have chosen to conduct the study in are; KwaZulu-Natal and the Western Cape. The reason these two provinces were chosen is because KwaZulu-Natal has the highest prevalence of HIV/AIDS in South Africa and the Western Cape has the lowest. I have chosen via convenience selection to conduct the study at, the University of Kwa-Zulu Natal (UKZN), the Westville Campus and the University of the Western Cape (UWC).

As part of my study, I have to administer questionnaires to students. I would like to request permission to include students from your department as part of the study. Ethical Clearance for the research project has been obtained from the University of the Western Cape. The registration number is 08/5/9 (please see attached letter).

This research project is an excellent opportunity to determine why the prevalence of HIV/AIDS in the country has not significantly reduced despite the numerous prevention campaigns. The outcomes of the study will provide valuable information regarding the knowledge, attitudes, behavior, beliefs and sources of HIV/AIDS information among university students. The results of this study will also add to the current literature on risks for HIV/AIDS among university students and may be used to review current polices and programmes addressing HIV/AIDS.

I look forward to hearing from you. Should you require any further information concerning the research please feel free to contact me.

Thanking you

Yours Sincerely

UNIVERSITY of the
WESTERN CAPE

_____

Miss Preshani Reddy
(BSc) Physiotherapy
(C) 083 799 7409
2114049@uwc.ac.za

APPENDIX 3

Letter of information to Participant

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959, Fax: 27 21-959
E-mail: 2114049@uwc.ac.za

Dear Potential Participant

I am a postgraduate student doing a Master of Science degree in the department of physiotherapy at the University of the Western Cape. Due to the nature of my course, I am conducting a study where I intend to gather information about the knowledge, attitudes, beliefs, behaviours and sources of HIV/AIDS information among university among students at two tertiary institutions in South Africa.

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The information you provide may help with future efforts towards slowing the spread of sexually transmitted diseases including HIV/AIDS. The results of this study will also add to the current literature on risks for HIV/AIDS among university students and may be used to review current polices and programmes addressing HIV/AIDS. I hope that, in the future, other people might benefit from this study through improved understanding of HIV/AIDS and how to be more effective in the prevention of the disease in terms of information distribution and campaigning

The survey is voluntary and it has been designed to be as brief and convenient as possible. The survey should take 30 minutes to complete. No names or ID numbers should be put on the survey. A consent form will have to be signed prior to commencement of the survey. The signed consent form should be detached from the questionnaire prior to hand and placed in a separate box from the questionnaire, therefore guaranteeing anonymity. The signed consent form and questionnaire will be kept in a locked filing cabinet which only

the researcher will have access to. None of the information you provide will be shared with anyone: including lecturers or colleagues at the university. If you feel you don't want to participate further in this study at this point, you have the liberty to withdraw. For those that do want to continue, we will move on and ask for your voluntary permission to continue.

Should you have and questions or concerns before or after the study, feel free to contact me telephonically or via e-mail.

Preshani Reddy
Cell: 0837997409
E-mail: 2114049@uwc.ac.za

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APPENDIX 4

Consent form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

E-mail: 2114049@uwc.ac.za

Title of Research Project:

The knowledge, attitudes, beliefs, behaviours and sources of HIV/AIDS information among university students at two tertiary institutions in South Africa.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

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Participant's name……

Participant's signature…….

Date……

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Student: Miss Preshani Reddy

Cell: 0837997409

Email: 2114049@uwc.ac.za

Study Coordinator: Professor Jose' Franz

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021)959-3647

APPENDIX 5

Questionnaire

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HIV/AIDS Knowledge, Attitudes, Beliefs and Behaviors and Sources of HIV prevention Information Study

INSTRUCTIONS: From question 2 (Q2), please circle your response.

Q1. How old are you? (Age last birthday) …… (Years)

Q2. What is your gender?

1. Female
2. Male

Q3. In which area did you grow up?

1. Urban (city) area
2. Rural area

Q4. If rural, when did you move to an urban area?

1. 1 – 3 years ago
2. 3 – 5 years ago
3. 5 – 10 years ago
4. More than 10 years
5. I am only here to study and plan on returning

Q5. What is your academic discipline?

1. Arts/Humanities/Social Sciences
2. Physical Sciences
3. Medical/Health Sciences
4. Education
5. Commerce
6. Public/Business Administration
7. Engineering/Technology

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Q6. What is your current year at University?

1. 1st year
2. 2nd year
3. 3rd year
4. 4th year
5. 5th year
6. 6th year
7. Graduate/Postgraduate Student

Q7. Are you a full-time student?

1. Yes
2. No

Q8. To which race group do you belong?

1. White
2. African
3. Coloured (mixed ancestry)
4. Indian
5. Asian
6. Other

Q9. What is your marital status?

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1. Never been married
2. Married
3. Separated
4. Divorced
5. Widowed
6. Co-habiting/Living with someone as married

Q10. Where do you currently live?

1. University residence
2. Other university housing
3. Off-campus house or apartment
4. Parent/guardian's home
5. Other

Q11. Are you a member of a social club or society eg. University choir/ athletic team?

1. Yes
2. No

Q12. How old were you when you had your first drink of alcohol?

1. I have never drank alcohol
2. I have never had a drink of alcohol other than a few sips
3. 12 years old or younger
4. 13 or 14 years old
5. 15 or 16 years old
6. 17 or 18 years old
7. 19 or 20 years old
8. 21 to 24 years old
9. 25 years old or older

Q13. During the past 30 days, on how many days did you have at least one drink of alcohol?

1. 0 days
2. 1 or 2 days
3. 3 to 5 days
4. 6 to 9 days
5. 10 to 19 days
6. 20 to 29 days
7. All 30 days

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Q14. During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours?

1. 0 days
2. 1 day
3. 2 days
4. 3 to 5 days
5. 6 to 9 days
6. 10 to 19 days
7. 20 or more days

Q15. During your life, how many times have you used marijuana (dagga)?

1. 0 times
2. 1 or 2 times
3. 3 to 9 times
4. 10 to 19 times
5. 20 to 39 times
6. 40 to 99 times
7. 100 or more times

Q16. How old were you when you tried marijuana (dagga) for the first time?

1. I have never tried marijuana
2. 12 years old or younger
3. 13 or 14 years old
4. 15 or 16 years old
5. 17 or 18 years old
6. 19 or 20 years old
7. 21 to 24 years old
8. 25 years old or older

Q17. During the past 30 days, how many times have you used any form of cocaine, including powder, crack, or freebase?

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1. 0 times
2. 1 or 2 times
3. 3 to 9 times
4. 10 to 19 times
5. 20 to 39 times
6. 40 or more times

Q18. During your life, how many times have you used any form of cocaine, including powder, crack, or freebase?

1. 0 times
2. 1 or 2 times
3. 3 to 9 times
4. 10 to 19 times
5. 20 to 39 times
6. 40 to 99 times
7. 100 or more times

Q19. How old were you when you tried any form of cocaine, including powder, crack, or freebase, for the first time?

1. I have never tried cocaine
2. 12 years old or younger
3. 13 or 14 years old
4. 15 or 16 years old
5. 17 or 18 years old
6. 19 or 20 years old
7. 21 to 24 years old
8. 25 years old or older

Q20. During your life, how many times have you sniffed glue, or breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high?

1. 0 times
2. 1 or 2 times
3. 3 to 9 times
4. 10 to 19 times
5. 20 to 39 times
6. 40 to 99 times
7. 100 or more times

Q21. During your life, how many times have you taken steroid pills or shots without a doctor's prescription?

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1. 0 times
2. 1 or 2 times
3. 3 to 9 times
4. 10 to 19 times
5. 20 to 39 times
6. 40 to 99 times
7. 100 or more times

Q22. During your life, how many times have you used any other type of illegal drug, such as LSD, PCP (Angel dust), ecstasy, magic mushrooms, speed, ice, tic or heroin?

1. 0 times
2. 1 or 2 times
3. 3 to 9 times
4. 10 to 19 times
5. 20 to 39 times
6. 40 to 99 times
7. 100 or more times

Q23. During the past 30 days, how many times have you used any other type of illegal drug, such as LSD, PCP (Angel dust), ecstasy, magic mushrooms, speed, ice, tic or heroin?

1. 0 times
2. 1 or 2 times
3. 3 to 9 times
4. 10 to 19 times
5. 20 to 39 times
6. 40 or more times

Q24. During the past 30 days, how many times have you used any illegal drug in combination with drinking alcohol?

1. 0 times
2. 1 or 2 times
3. 3 to 9 times
4. 10 to 19 times
5. 20 to 39 times
6. 40 or more times

Q25. During your life, how many times have you used a needle to inject any illegal drug into your body?

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1. 0 times
2. 1 time
3. 2 or more times

Q26. How old were you when you had sexual intercourse for the first time?

1. I have never had sexual intercourse
2. 12 years old or younger
3. 13 or 14 years old
4. 15 or 16 years old
5. 17 or 18 years old
6. 19 or 20 years old
7. 21 to 24 years old
8. 25 years old or older

Q27. During your life, with how many females have you had sexual intercourse?

1. I have never had sexual intercourse with a female
2. 1 female
3. 2 females
4. 3 females
5. 4 females
6. 5 females
7. 6 or more females

Q28. During the past 3 months, with how many females have you had sexual intercourse?

1. I have never had sexual intercourse with a female
2. I have had sexual intercourse with a female, but not during the past 3 months
3. 1 female
4. 2 females
5. 3 females
6. 4 females
7. 5 females
8. 6 or more females

Q29. During your life, with how many males have you had sexual intercourse?

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1. I have never had sexual intercourse with a male
2. 1 male
3. 2 males
4. 3 males
5. 4 males
6. 5 males
7. 6 or more males

Q30. During the past 3 months, with how many males have you had sexual intercourse?

1. I have never had sexual intercourse with a male
2. I have had sexual intercourse with a male, but not during the past 3 months
3. 1 male
4. 2 males
5. 3 males
6. 4 males
7. 5 males
8. 6 or more males

Q31. During the past 30 days, how many times did you have sexual intercourse?

1. 0 times
2. 1 time
3. 2 or 3 times
4. 4 to 9 times
5. 10 to 19 times
6. 20 or more times

Q32. During the past 30 days, how often did you or your partner use a condom?

1. I have not had sexual intercourse during the past 30 days
2. Never used a condom
3. Rarely used a condom
4. Sometimes used a condom
5. Most of the time used a condom
6. Always used a condom

Q33. The last time you had sexual intercourse; did you or your partner use a condom?

1. I have never had sexual intercourse
2. Yes
3. No

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Q34. Did you drink alcohol or use drugs before you had sexual intercourse the last time?

1. I have never had sexual intercourse
2. Yes
3. No

Q35. Does any relative, friend or colleague of yours have or had HIV/AIDS?

1. Yes
2. No
3. Not sure

Q36. What are the chances that you might catch HIV?

1. No chance
2. Moderate chance
3. Good chance
4. Don't know *(Skip to* Q38*)*
5. Already infected *(Skip to*Q38*)*

Q37. What is the main reason why you would not contract HIV/AIDS?
(Circle only one answer)

1. Abstinence from sex/no sex
2. Have/had only one partner
3. Always use a condom
4. Use contraceptives
5. Use traditional medicine
6. Had sex with a virgin
7. Partner is faithful
8. No needle sharing
9. No blood contact
10. There is no such thing as AIDS
11. It can't happen to me
12. Have/had multiple sexual partners
13. Partner is infected
14. Have unprotected sex
15. Drug use
16. Accidents
17. Contact sports
18. Rape
19. Other (specify)----------

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INSTRUCTIONS: For each statement, please circle true (T), false (F), or I don't know, please do not guess; instead circle don't know (DK).

	(1)	(2)	(3)
	True	**False**	**Don't Know**
Q38. HIV and AIDS are the same thing.	T	F	DK
Q39. There is a cure for AIDS.	T	F	DK
Q40. A person can get HIV from a toilet seat.	T	F	DK
Q41. Coughing and sneezing DO NOT spread HIV.	T	F	DK
Q42. HIV can be spread by mosquitoes.	T	F	DK
Q43. AIDS is the cause of HIV.	T	F	DK
Q44. A person can get HIV by sharing a glass of water with someone who has HIV.	T	F	DK
Q45. HIV is killed by bleach.	T	F	DK
Q46. It is possible to get HIV when a person gets a tattoo.	T	F	DK
Q47. A pregnant woman with HIV can give the virus to her unborn baby.	T	F	DK
Q48. Pulling out the penis before a man climaxes or ejaculates keeps a woman from getting HIV during sex.	T	F	DK
Q49. A woman can get HIV if she has anal sex with a man.	T	F	DK
Q50. Showering, or washing one's genitals or private parts after sex keeps a person from getting HIV .	T	F	DK
Q51. Eating healthy foods can keep a person from getting HIV.	T	F	DK

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	True	False	Don't Know
Q52. All pregnant women infected with HIV will have babies born with AID	T	F	DK
Q53. Using a latex condom or rubber can lower a person's chance of getting HIV.	T	F	DK
Q54. A person with HIV can look and feel healthy.	T	F	DK
Q55. People who have been infected with HIV, quickly show serious signs of being infected.	T	F	DK
Q56. A person can be infected with HIV for 5 years or more without getting AIDS.	T	F	DK
Q57. There is a vaccine that can stop adults from getting HIV	T	F	DK
Q58. Some drugs have been made for the treatment of AIDS.	T	F	DK
Q59. Women are always tested for HIV during their pap smears (An internal vaginal exam in which cells from the cervix and vagina are examined for abnormalities.)	T	F	DK
Q60. A person can not get HIV by having oral sex (mouth to penis) with a man who has HIV.	T	F	DK
Q61. A person can get HIV even if she or he has sex with a person one time.	T	F	DK
Q62. Using a lambskin condom or rubber is the best protection against HIV.	T	F	DK
Q63. People are likely to get HIV by deep kissing, putting their tongue into their partner's mouth, if their partner has HIV.	T	F	DK
Q64. A person can get HIV by giving blood.	T	F	DK
Q65. A woman can not get HIV if she has sex during her period/menstruation.	T	F	DK

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	True	False	Don't Know
Q66. You can usually tell if someone has HIV by looking at them.	T	F	DK
Q67. There is a female condom that can help decrease a woman's chance of getting HIV.	T	F	DK
Q68. A natural skin condom works better against HIV than a latex condom.	T	F	DK
Q69. A person will not get HIV if she or he is taking antibiotics.	T	F	DK
Q70. Having sex with more than one partner can increase a person's chance of being infected with HIV.	T	F	DK
Q71. Taking a test for HIV one week after having sex will tell a person if she or he has HIV.	T	F	DK
Q72. A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV.	T	F	DK
Q73. A person can get HIV through contact with saliva, tears, sweat, or urine.	T	F	DK
Q74. A person can get HIV from the wetness from a woman's vagina.	T	F	DK
Q75. A person can get HIV if having oral sex, (mouth on vagina), with a woman.	T	F	DK
Q76. If a person tests positive for HIV, then the test site (clinic) will have to tell all of his or her partners.	T	F	DK
Q77. Using vaseline or baby oil with condoms lowers the chance of getting HIV.	T	F	DK
Q78. Washing equipment used to inject drugs with cold water kills HIV.	T	F	DK
Q79. A woman can get HIV if she has vaginal sex with a man who has HIV.	T	F	DK

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	True	False	Don't Know
Q80. Athletes who share needles when using steroids can get HIV from the needles.	T	F	DK
Q81. Douching (introducing a stream of water into the vagina) after sex will keep a woman from getting HIV.	T	F	DK
Q82. Taking vitamins keeps a person from getting HIV.	T	F	DK

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INSTRUCTIONS: For each of the following statements, please note whether you agree or disagree with the statement by circling the number that corresponds with your answer. There are no correct answers, only your opinions. Use the following scale:

1=SA: Strongly agree with the statement
2=A: Agree with the statement
3=N: Neither agree nor disagree with the statement
4=D: Disagree with the statement
5=SD: Strongly disagree with the statement

	SA	A	N	D	SD
Q83. Limiting the spread of AIDS is more important than trying to protect the rights of people with AIDS.	1	2	3	4	5
Q84. Support groups for people with HIV would be very helpful to them.	1	2	3	4	5
Q85. I would consider marrying someone with HIV infection.	1	2	3	4	5
Q86. I would quit my job before I would work with someone who has AIDS.	1	2	3	4	5
Q87. People should not be afraid of catching HIV from casual contact, like hugging or shaking hands.	1	2	3	4	5
Q88. I would like to feel at ease around people with AIDS.	1	2	3	4	5
Q89. People who receive positive results from the HIV blood test should not be allowed to get married.	1	2	3	4	5
Q90. I would prefer not to be around homosexuals for fear of catching AIDS.	1	2	3	4	5
Q91. Being around someone with AIDS would not put my health in danger.	1	2	3	4	5
Q92. I would consider asking a person who has been to prison to get an HIV test before dating them.	1	2	3	4	5
Q93. People with AIDS should not avoid being around other people.	1	2	3	4	5
Q94. People should avoid going to the dentist because they might catch HIV from dental instruments.	1	2	3	4	5

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	SA	A	N	D	SD
Q95. A person who has been to jail or prison has a greater chance of being infected with HIV.	1	2	3	4	5
Q96. The thought of being around someone with AIDS does not bother me.	1	2	3	4	5
Q97. People with HIV infection should not be prohibited from working in public places.	1	2	3	4	5
Q98. I would not want to be in the same room with someone who I knew had AIDS.	1	2	3	4	5
Q99. People who give HIV to others should face criminal charges.	1	2	3	4	5
Q100. People should not be afraid to donate blood because of AIDS.	1	2	3	4	5
Q101. A list of people who have HIV infection should be available to anyone.	1	2	3	4	5
Q102. I would date a person with AIDS.	1	2	3	4	5
Q103. No one deserves to have a disease like HIV infection.	1	2	3	4	5
Q104. It would not bother me to attend class with someone who has AIDS.	1	2	3	4	5
Q105. An employer should have the right to fire an employee with HIV infection regardless of the type of work s/he does.	1	2	3	4	5
Q106. I would allow my children to play with the children of someone known to have AIDS.	1	2	3	4	5
Q107. People get AIDS by performing unnatural sex acts.	1	2	3	4	5
Q108. People with HIV should not be looked down upon by others.	1	2	3	4	5
Q109. I could tell by looking at someone if s/he has AIDS.	1	2	3	4	5

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	SA	A	N	D	SD
Q110. Health care workers should not refuse to care for people with HIV infection regardless of their personal feelings about the disease.	1	2	3	4	5
Q111. Children who have AIDS should not be prohibited from going to schools or day care centers.	1	2	3	4	5
Q112. HIV blood test results should be confidential to avoid discrimination against people with positive results.	1	2	3	4	5
Q113. HIV infection is a punishment of immoral behavior.	1	2	3	4	5
Q114. I would not be afraid to take care of a family member with AIDS.	1	2	3	4	5
Q115. If I discovered that my roommate had AIDS, I would move out.	1	2	3	4	5
Q116. Churches should take a strong stand against drug abuse and homosexuality to prevent the spread of AIDS.	1	2	3	4	5
Q117. I could comfortably discuss AIDS with others.	1	2	3	4	5
Q118. People with AIDS are not worth getting to know.	1	2	3	4	5
Q119. Parents who transmit HIV to their children should be prosecuted as child abusers.	1	2	3	4	5
Q120. People would not be so afraid of AIDS if they knew more about the disease.	1	2	3	4	5
Q121. I would not avoid a friend if s/he had AIDS.	1	2	3	4	5

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INSTRUCTIONS: For this set of questions, please circle your response.

Q122. How much do you know about AIDS?

1. A lot
2. Some
3. A little
4. Nothing

In the past month have you:

Q123. Seen public service announcements about AIDS on television?

1. Yes
2. No

Q124. Seen public service announcements about AIDS on bus/taxi/train displays?

1. Yes
2. No

Q125. Seen public service announcements about AIDS on airport public service posters?

1. Yes
2. No

Q126. Seen public service announcements about AIDS on street signs/billboards?

1. Yes
2. No

Q127. Heard public service announcements about AIDS on radio?

1. Yes
2. No

Q128. Received information about AIDS from university/campus programmes?

1. Yes
2. No

Q129. Received information about AIDS from church or religious organizations?

1. Yes
2. No

Q130. Received information about AIDS from your workplace?

1. Yes
2. No
3. Not currently working
4. Self-employed

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Q131. Received information about AIDS from a health department?

1. Yes
2. No

Q132. Received information about AIDS from a community organization?

1. Yes
2. No

Q133. Received information about AIDS from a family member?

1. Yes
2. No

Q134. Received information about AIDS from a friend or acquaintance?

1. Yes
2. No

Q135. Received information about AIDS from an AIDS hotline?

1. Yes
2. No

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Q136. Have you received information about AIDS from magazine articles?

1. Yes
2. No

Q137. Have you received information about AIDS from newspaper articles?

1. Yes
2. No

Q138. Have you received information about AIDS from store displays/store distributed brochures?

1. Yes
2. No

Q139. How would you describe your religious affiliation?

1. Christianity
2. Muslim
3. Hindu
4. Atheist
5. Other

Q140. How frequently do you attend your place of worship?

1. Three or more times per week
2. Two times per week
3. Once per week
4. Infrequently
5. No attendance

Thank you for your participation, it is greatly appreciated!!

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