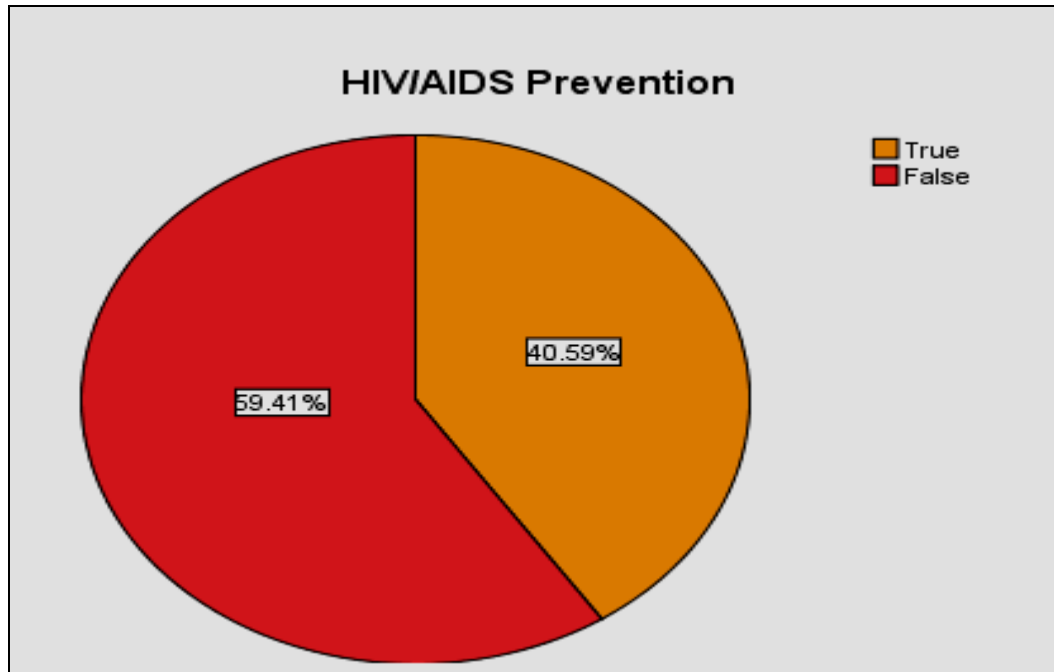
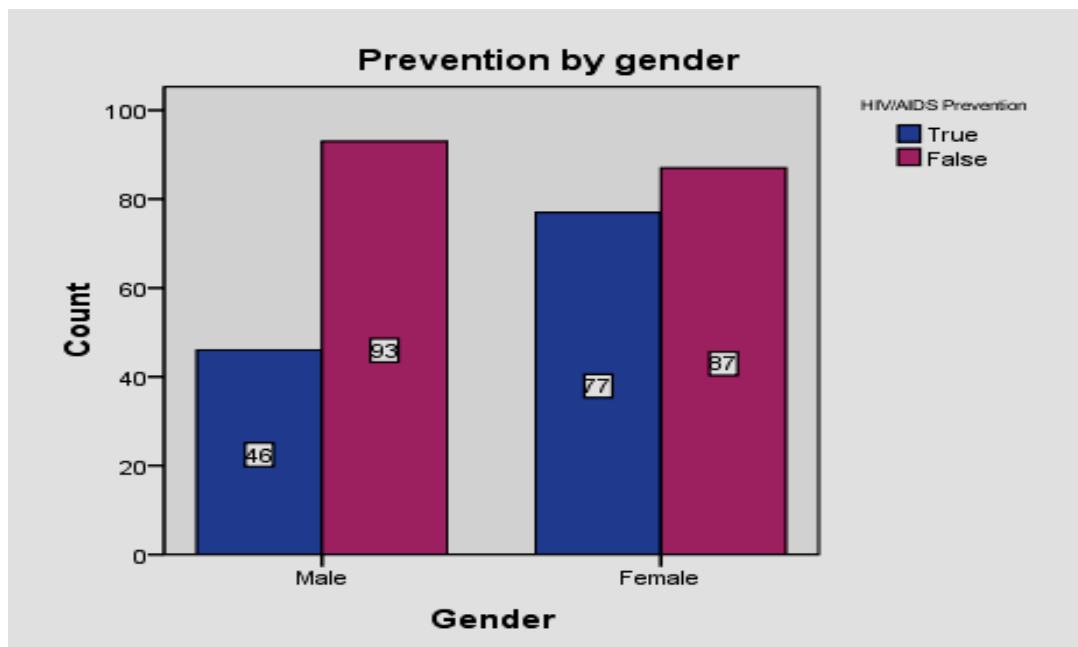


Figure 14: HIV/AIDS Prevention



From the analysis, it became clear that 123 (41%) of respondents had good knowledge of prevention as compared to 180 (59%) respondents who had poor knowledge of prevention (figure 14).

Figure 15: Knowledge of Prevention and Gender



An analysis of respondents' knowledge of prevention by gender gave the following results (figure 15 above):

From the total of 41% among respondents regarded as having good knowledge of prevention, 15.2% were male respondents and 25.4% were females. This could mean that more females than males have good knowledge of how HIV/AIDS can be prevented.

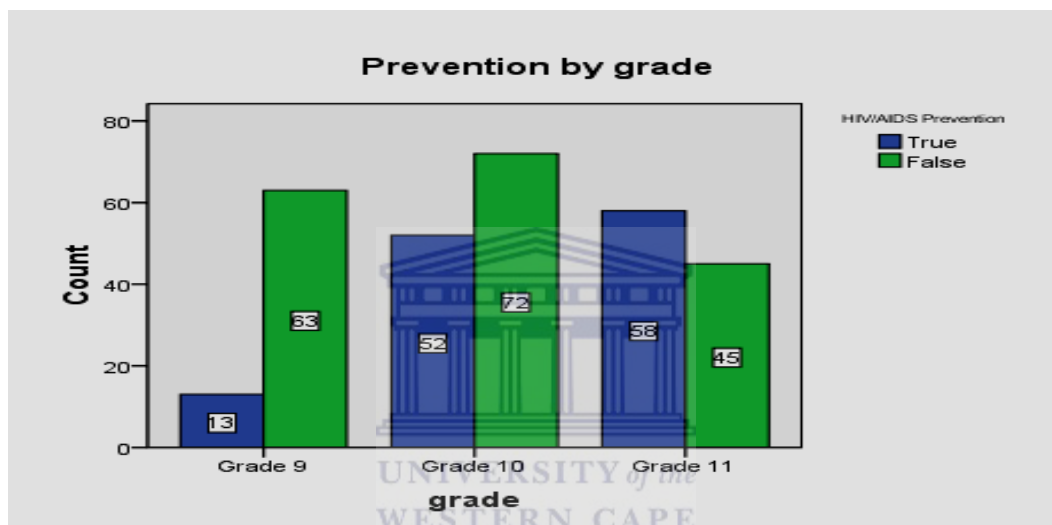
Among the 59% of those having poor knowledge of prevention of the pandemic, 30.7% were male respondents and 28.7% were female respondents. The poor knowledge percentages are higher than those with good knowledge of prevention. It could therefore be deduced that both male and female respondents generally have poor rather than good knowledge of prevention. Although there is a minor percentage difference between the male and female poor knowledge group, it is important to note that male respondents rank higher than females in terms of having poor knowledge of how the disease can be prevented. Therefore, taking into consideration that the percentage of male respondents was lower than that of females with regards to good knowledge, it could be concluded that respondents in general had poor knowledge of prevention, but the percentage of male respondents with that poor knowledge, are higher than that of females.

Table 5: Age and HIV/AIDS Prevention Cross-tabulation

Age		HIV/AIDS Prevention		
		True	False	Total
15	Count	12	26	38
	% within age	31.6%	68.4%	100.0%
	% of Total	4.0%	8.6%	12.5%
16	Count	28	34	62
	% within age	45.2%	54.8%	100.0%
	% of Total	9.2%	11.2%	20.5%
17	Count	32	46	78
	% within age	41.0%	59.0%	100.0%
	% of Total	10.6%	15.2%	25.7%
18	Count	35	50	85
	% within age	41.2%	58.8%	100.0%
	% of Total	11.6%	16.5%	28.1%
Other	Count	16	24	40
	% within age	40.0%	60.0%	100.0%
	% of Total	5.3%	7.9%	13.2%
Total	Count	123	180	303
	% within age	40.6%	59.4%	100.0%
	% of Total	40.6%	59.4%	100.0%

An age analysis with regard to knowledge of prevention shows that all age groups have a poor knowledge rather than a good knowledge; both on proportion and percentage, i.e., 59% as opposed to 41% respectively (see Table 5). The reported poor knowledge group lies mostly among the 18 year olds (17%), followed by 17 year olds 46 (15%), the 16 year olds 34 (11%) and the 15 year olds by 26 (9%). Other age groups contribute 7% towards the poor knowledge.

Figure 16: Knowledge of Prevention and School Grade



With regards to school grade, figure 16 illustrates that good knowledge levels for prevention (19.1%) are found only among the grade 11's where the percentages are higher than those with poor knowledge (14.9%). Both the grade 9 and 10 respondents had higher percentages of poor knowledge of prevention (20.8% and 23.8% respectively) than those with good knowledge of prevention (4.3% and 17.2% respectively). It can be concluded that even although the percentage of respondents with a poor knowledge of prevention (59%) is higher than those with a good knowledge of prevention (41%), the grade 11 respondents had a better knowledge as compared to other grades

6.3.4 Communication

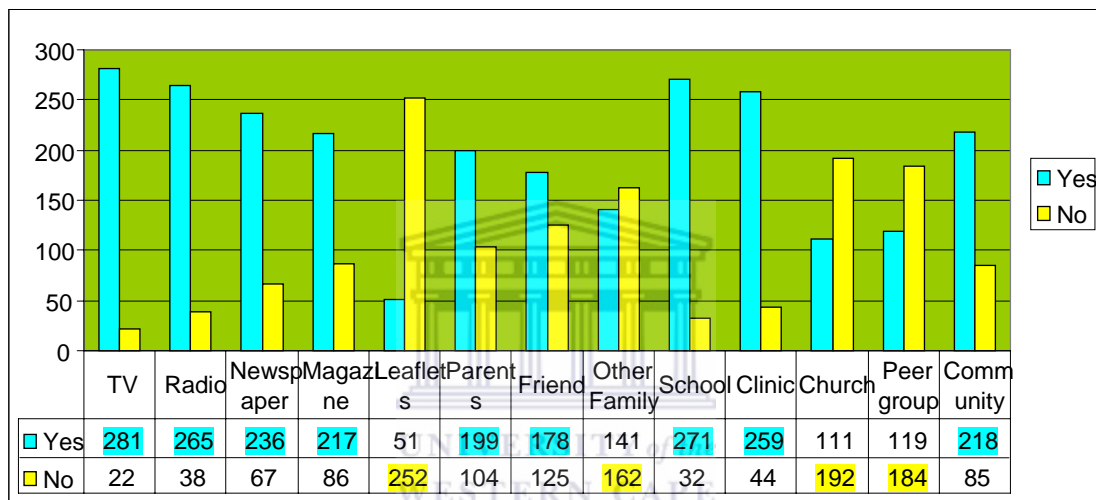
Questions 7, 8 and 10 were used to determine the manner in which learners communicate about HIV/AIDS. Question 7 examines various sources of

getting information on HIV/AIDS and question 8 explored whether or not getting information about HIV/AIDS is easy. Question 10 was meant to explore the degree of communication between respondents and their partners.

6.3.4.1 Sources of Information about HIV/AIDS

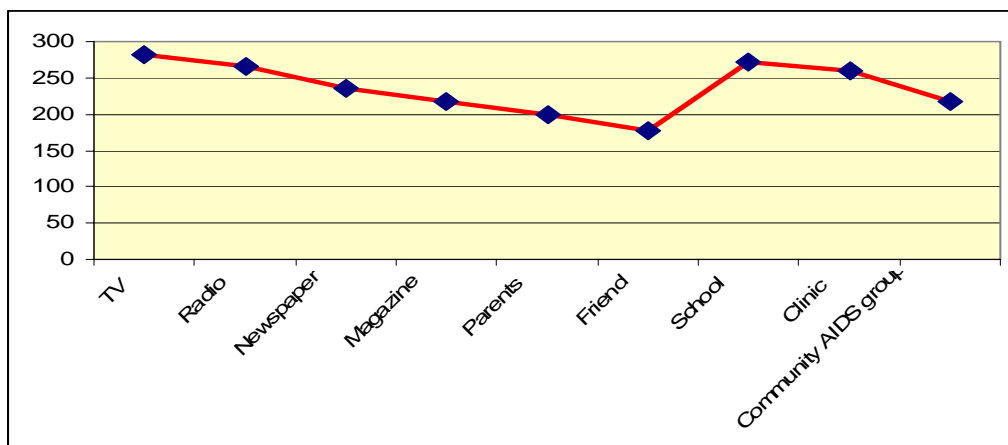
Figure 17 reports on the various sources indicated by respondents where information about HIV/AIDS is readily available.

Figure 17: Sources of obtaining information about HIV/AIDS



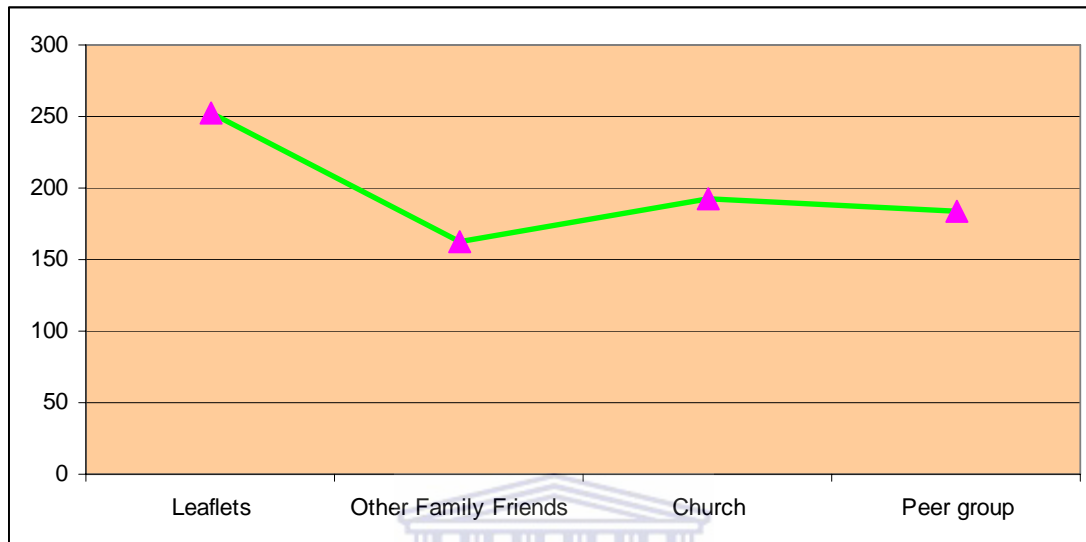
Television ranks high among the sources that provided information as indicated by respondents, followed by the school, radio, clinic, newspaper, the community AIDS group, magazine, parents and friends (figure 18).

Figure 18: Sources of information by rank of providing information



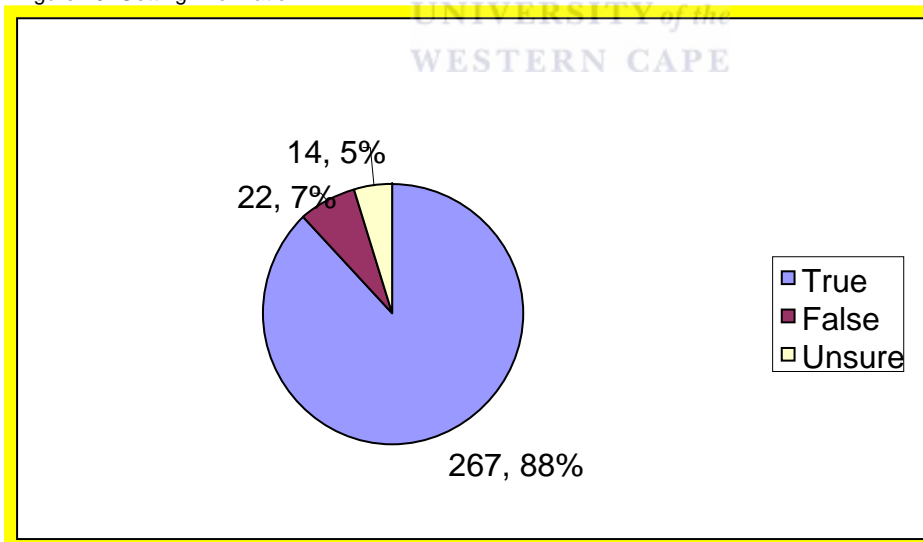
Among the sources chosen to have provided less information on HIV/AIDS are leaflets, church, peer group, other family members, friends and parents (figure 19).

Figure 19: Sources that provide less information by rank



6.3.4.2 Getting Information is Easy

Figure 20: Getting Information



The majority of respondents 267 (88%) indicated that getting information about HIV/AIDS is easy. Only 22 (7%) of the respondents felt that it is not easy to obtain information and 14 (5%) was unsure. A comment can be made at this point that as the majority of respondents indicated that getting information about HIV/AIDS is easy, it is an indication that obtaining

information relies more on the role played by available sources of information than on the difficulty to obtain it.

6.3.4.3 Talking about HIV/AIDS with Partners

This part is aimed at exploring whether communication about HIV/AIDS takes place among respondents and their partners. The majority of respondents 195 (65%) indicated that they do talk about HIV/AIDS with their partners as compared to 105 (35%) that indicated that they don't talk about HIV/AIDS with their partners.

From the 65% of those who do talk about HIV/AIDS with their partners, analysis indicated the following:

- 93 (31%) are male participants and 102 (34%) are female respondents.
- 82 (27%) are found among the grade 10's, followed by 77 (26%) of grade 11's and 36 (12%) of grade 9's.
- It is among the 18 year olds (62 or 21%) that talking about HIV/AIDS with partners happens most frequently, followed by the 17 year olds (46 or 15%), and the 16 year olds by (39 or 13%). Talking about HIV/AIDS is less frequent among other age groups (27 or 9%) and the 15 year olds (21 or 7%).

Of the 35% who do not talk about HIV/AIDS with their partners, the following results emerged:

- 46 (15%) are males and 59 (20%) are females;
- Both the grade 9 and 10 are indicated by 13% and the grade 11's by 9%;
- 11% is the highest percentage indicated by the 17 year olds and the rest of age groups are below 8%.

To summarise, there is an overall indication that knowledge of HIV/AIDS in terms of the general basic knowledge, transmission and prevention categories defined for analysis, is lacking among respondents. The poor knowledge could be interpreted as having limited knowledge about the pandemic and varies considerably by genders, ages and school grade groups. Research in terms of the how information is acquired indicates that information is available

through different sources and that it is easily available. The question remains whether respondents were serious about absorbing and using this information correctly.

6.4 Attitudes in Relation to HIV/AIDS

The attitudes section was aimed at determining the attitudes of learners towards HIV/AIDS infection. Questions 9 and 11 explored respondents' knowledge of their own statuses and that of their partners and question 12 focused on determining whether or not respondents thought their partners were having other relationships. Question 13, 14, 15, 16 and 17 explored learners' attitudes towards other people currently known and whether they have revealed their HIV/AIDS status; their attitudes (current treatment) towards those people; and their attitudes (future treatment) should they meet someone who has HIV/AIDS; and respondents' attitudes towards being infected by HIV themselves and whether they thought their family members could be affected by HIV/AIDS respectively. Questions 31 and 32 looked at the attitudes of respondents with regards to making decisions about sex.

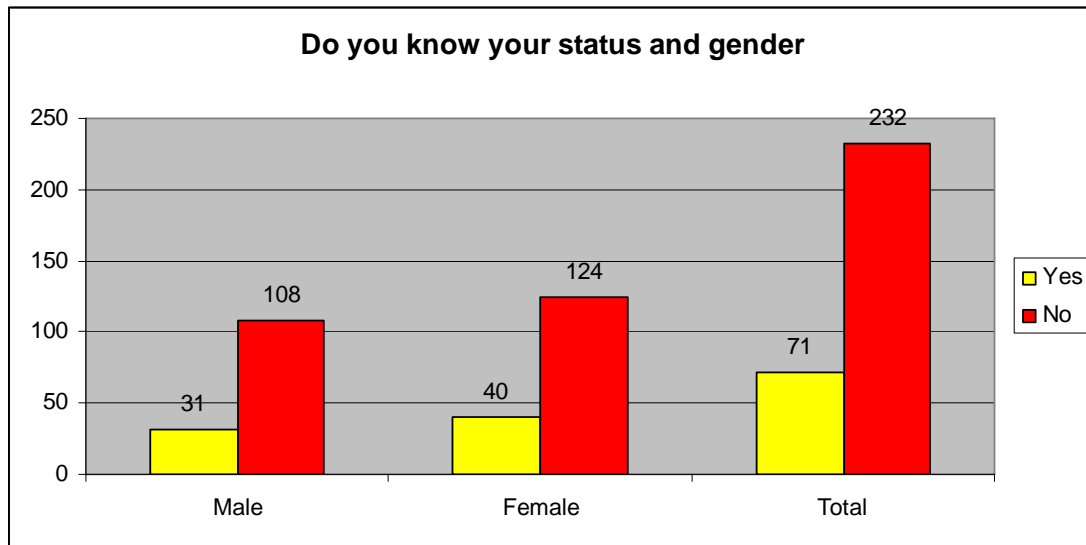
6.4.1 Status Knowledge and Other Relationships of Partners

Respondents' knowledge of their own statuses and that of their partners, as well as whether they thought their were having other relationships, could serve as important indicators for attitudes as it could help determine the level of perceived risk of infection.

6.4.1.1 Status Knowledge of Self

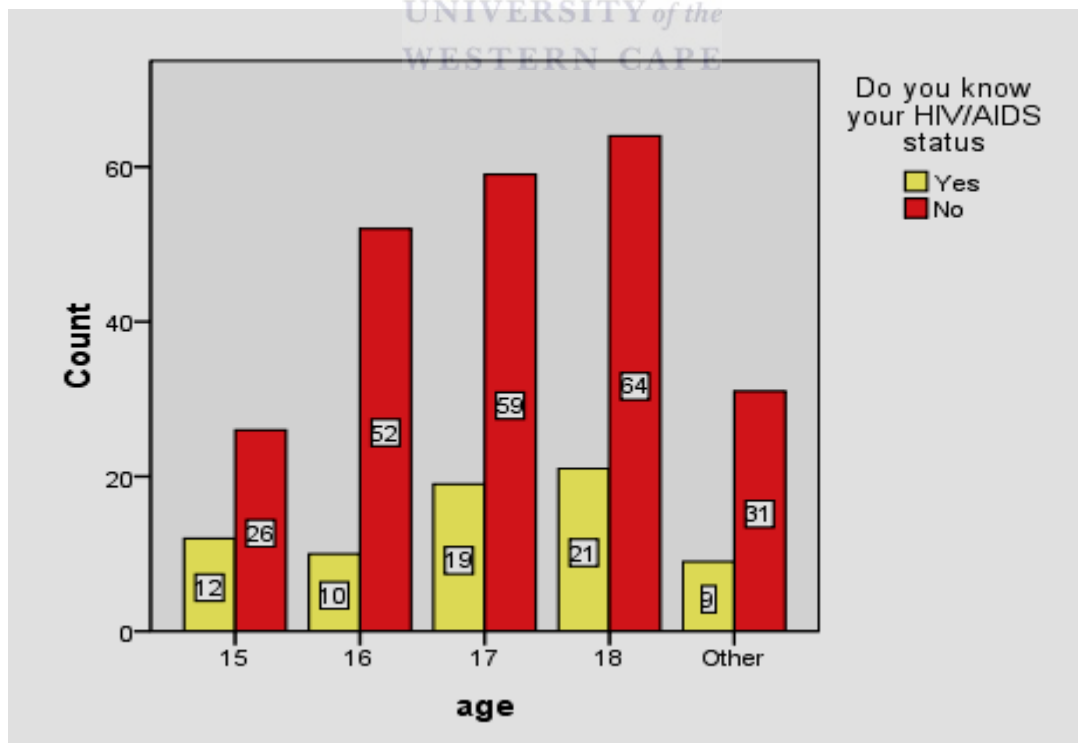
Figure 21 displays the results that emerged from the question of whether respondents knew their HIV/AIDS statuses and comparisons are made between gender, age and grades. A total count of 71 (23%) of respondents indicated that they knew their HIV/AIDS statuses compared to 232 (77%) of respondents who indicated that they do not know their HIV/AIDS statuses. This means that the majority of respondents disregard of gender, age and school grade did not know their HIV/AIDS statuses.

Figure 21: Knowledge of Status by Gender



Comparisons by gender and “do you know your HIV/AIDS status” revealed that of the 23% of respondents that knew their statuses, 13% were females while 10% were males. Of the 77% that did not know their statuses, 36% were males and 41% were females, indicating that more females than males did not know their statuses.

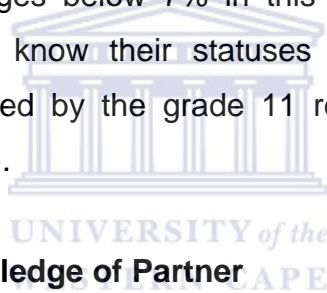
Figure 22: Knowledge of Status and Age



When looking at the age of respondents and knowledge of their statuses (figure 22), the following can be highlighted:

- Of the 23% that knew their statuses, the highest number is among the 18 year olds, namely 21 (7%), followed by the 17 year olds with a number of 19 (6%);
- Of the 77% that did not know their statuses, 18 year and 17 year olds ranked the highest by 64 (21%) and 59 (20%) respectively, followed by the 16 year olds 52 (17%). Other and the 15 year olds ranked the lowest by 31 (10%) and 26 (9%) respectively.

With regards to respondents' knowledge of their own statuses and school grades, results indicated that 11% was the highest percentage of all reported amongst the grade 10 respondents that knew their statuses. Both grades 9 and 11 reported percentages below 7% in this category. The majority of respondents that did not know their statuses are among the grade 10 respondents (30%), followed by the grade 11 respondents (27%) and the grade 9 respondents (20%).



6.4.1.2 Status Knowledge of Partner

Respondents were asked whether they knew the HIV/AIDS statuses of their partners. From the total of all respondents, the majority of 250 (84%) indicated that they did not know their partner statuses and both male and female respondents were largely implicated (41% and 43% respectively). This finding was opposed to only a few respondents 48 (16%) that did say they knew their partner statuses. Of these respondents, 5% were males and 11% were females.

High percentages were present among the 18 and 17 year olds, both attaining 23% each, followed by the 16 year olds with 19% and other age groups with 11%. The 15 year olds reported the lowest findings of 8% with regards to not knowing their partner's status.

In terms of school grades, it was among the grade 10's that the highest percentages were observed, namely 99 (33%), followed by the grade 11's 84 (28%) and the grade 9's 67 (23%).

Comparisons between respondents' knowledge of their own statuses and that of their partner's, presented results not far different from both proportionally and by percentage. No conclusions can be made at this point as we do not know whether there are sexual engagements of any kind taking place between respondents and their partners.

6.4.1.3 Partner Relationships

Respondents were asked whether they think their partners are having other relationships or not. Results indicated high percentages of respondents who did not think that their partners were having other relationships 219 (74%) as opposed to 76 (26%) who thought their partners were having other relationships.

6.4.2 Perceived Risk of Infection

In terms of being infected, only 137 (45%) of respondents thought that they could be infected with HIV/AIDS as compared to 163 (54%) who didn't think that they could be infected. Just a small number of respondents 3 (1%) did not respond to the question.

When enquired about whether their family members could be affected by HIV/AIDS, a total of 193 (64%) of respondents thought that their family members could be affected by HIV/AIDS and 110 (36%) thought that their family members could not be affected by HIV/AIDS.

6.4.3 Knowledge of People who revealed their Status

On the question of knowledge of people who revealed their statuses, 150 (49%) of respondents indicated that they did know such people as compared to 153 (51%) who didn't know such people. Subsequent to knowledge of people who revealed their statuses, was a question of how they would treat them if they currently knew them and how they would treat them in future in

cases where they didn't know them currently. Of those who currently knew someone who revealed an HIV/AIDS status, the following was found:

- 31 (10%) indicated that they avoid such people as they do not know how to treat them and
- 116 (38%) indicated that they accept such people the same as other people in the community.
- A small number, below 2%, reported that they avoid these people because did not want to be associated with them or because of being afraid to be in contact with HIV/AIDS infected people.

Among those who currently did not know people who revealed their statuses and what their treatment would be should they know them in future, it was found that:

- 23 (8%) said they would avoid such people because they wouldn't know how to treat them and
- 112 (37%) said they would accept such people just like anybody else in the community.
- Only a total of 5 (2%) indicated that they would avoid such people because of not wanting to be associated with HIV/AIDS infected people.
- A total of 11 (4%) indicated that they would avoid people infected with HIV/AIDS should they know them in future due to being afraid of infected people.

In general, it can be reported that respondents had a positive attitude towards people currently known to be infected and those that may be infected in future. This is based on the high response rate that indicated respondents' current and future willingness of acceptance of infected people. It is, however, important to note those percentages below 4 in general that indicated current and future avoidance because of not wanting to be associated with infected people or being afraid of infected people.

6.4.4 Decision Making about Sex in Relationships

Question 31 and 32 (see addendum iii) explored what respondents thought in terms of male and female's decisions about sex.

In relation to the question whether it is okay for women to say no to sex, 232 (77%) indicated yes as opposed to 71 (23%) that said no. Of those who said yes, 95 (31%) were males and 137 (45%) were females.

With regards to the question whether it is okay for men to say no to sex, 217 (72%) said yes as opposed to 86 (28%) that indicated no. Within the percentage that indicated yes, 89 (30%) were males and 128 (42%) were females.

It can be reported that although there is a general consensus that both male and females can say no to sex, females voted higher for both males and females than males on saying yes to both questions.

6.5 Sexual Behaviour

6.5.1 Learners' levels of engagements in sexual activities

This section focused on respondents' engagement in sexual activities. Questions 18, 19, 20, 21, 22, 23, 24 and 25 were used to explore respondents' engagements in sexual activities and the risks patterns. In particular, question 18 explored whether respondents ever had sex. From question 19, questioning focused on respondents that indicated they had sex and excluded all those that said they have not had sex yet. These questions explored age at first sex, sex of partner, whether they continue having sex, frequency of having sex, with how many partners they have sex, when was the last time to have sex and whether partner was known at last time of having sex.

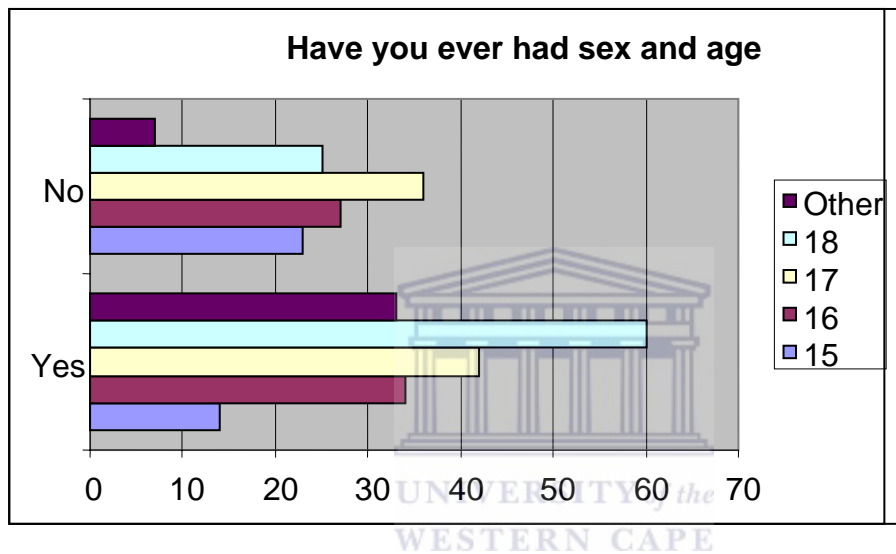
6.5.1.1 Sexual Experience

Respondents were asked a question on whether they ever had sex. In total, most respondents 182 (60%) reported that they had sex whilst 121 (40%) had not. Comparisons in terms of gender, age and school grade of respondents

were made in relation to this question. In terms of gender, the following results were found:

- A total of 103 (74%) of males had sex as opposed to 36 (26%) who did not;
- A total of 80 (49%) of females had sex as opposed to 84 (51%) who did not;
- More males 103 (56%) had sex than females 80 (44%).

Figure 23: Ever had Sex and Age



Comparisons amongst the age groups (figure 23 above) revealed that the highest number of those that indicated they had sex was among the 18 years old 60 (33%), followed by the 17 years old 42 (23%) and the 16 years old 34 (19%). The other age group is indicated by 33 (18%) and it covered the ages below 15 and over 18 years. Among the age group of 15, only 13 (7%) of respondents indicated that they had sex. These results are based on the total number of 182 respondents that indicated they had sex.

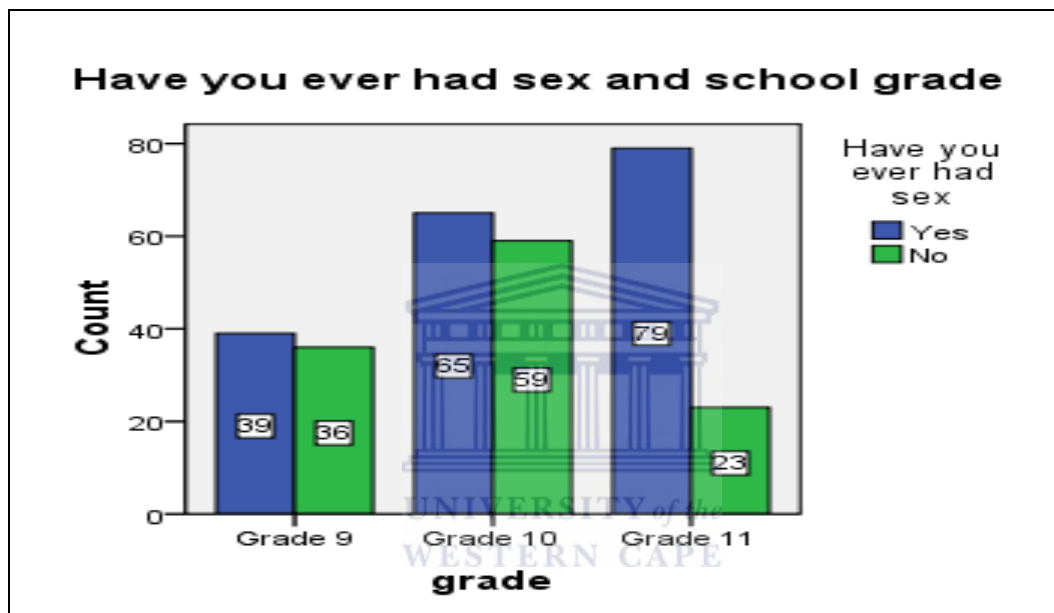
Of those who had not had sex, the highest numbers are among the 17 years old 36 (30%), followed by the 16 year olds 28 (23%), the 18 years old 25 (21%) and the 15 years old 25 (21%).

It is important to note that there was a 12% gap among the 15 years old that indicated they had sex and those that have not. This could mean that sexual

activities among the 15 years old are currently not rife as compared to other age groups, especially the 18 year olds.

In terms of the school grades, the comparison between those who had sex and those who had not, revealed that the lowest counts 23 (20%) was observed amongst the grade 11's; followed by the grade 9's with 36 (30%) and the grade 10's with 59 (50%).

Figure 24: Ever had Sex and School Grade



Statistical count increases within the grades were observed amongst those who had sex (Figure 24). The greatest count increase was among the grade 11's who had the highest count of 79 (43%), followed by the grade 10's with 65 (36%) and lastly the grade 9's with 39 (21%). One can infer that as the learners progress with grades, they become much more sexually active than whilst in lower grades.

6.5.1.2 Age at First Sex and Sex of Partner

Figure 25: Age at First Sex and Gender

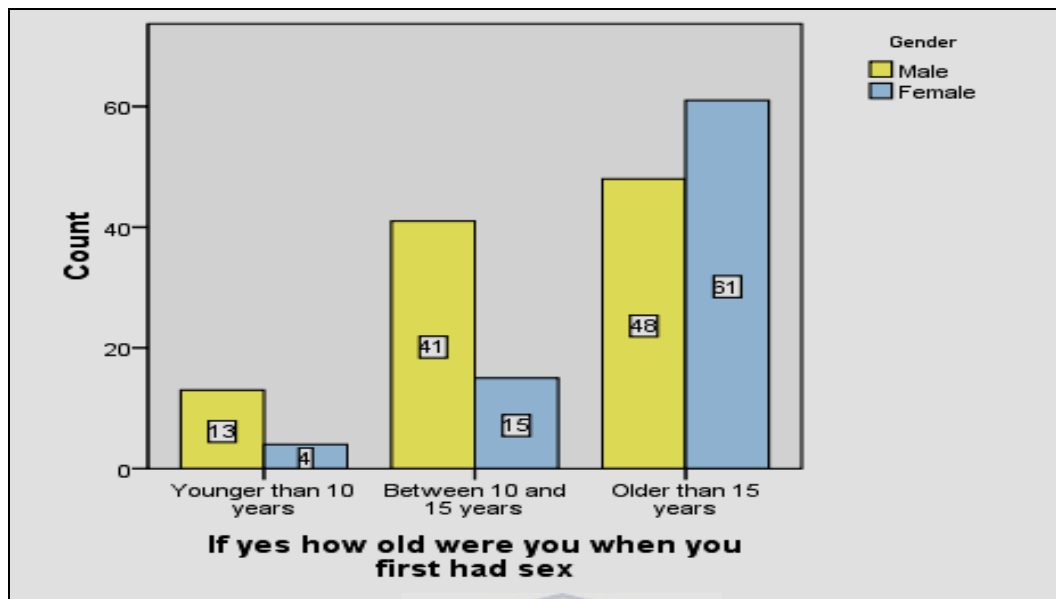


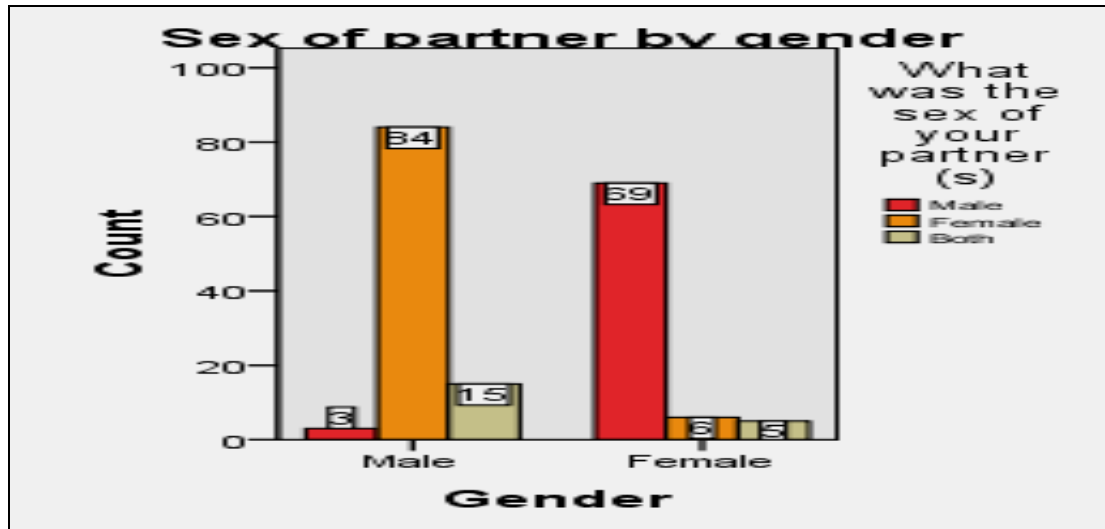
Figure 25 displays the age at first sex among those who indicated that they had sex. Males generally initiated sex at younger ages than females and the pattern is constant for between 10 and 15 years and younger than 10 years. Most females indicated that their age at first sex was when they were older than 15 years. The average age at first sex for all respondents was 15 years.

Within the male category, a small number of respondents had sex when they were younger than 10. There was a greater increase observed as the age increased and minor count differences were observed within the ages between 10 and 15 and older than 15.

Although increase with age was observed amongst the female respondents, the number for those that had sex whilst younger than 10 years was three times lower than that of males.

It is clear from the above discussion that male initiation of sex was much more vigorous at an early age and by the time they became older than 15, they have had sex 5 times more than females.

Figure 26: Sex of Partner by Gender



On exploring sex of the partner at first sex, most sexual practices among males and females (an average of 84%) were reported to be heterosexual.

Among males,

- 84 (82%) indicated having had sex with females;
- 3 (3%) had sex with other males;
- 15 (15%) had sex with both sexes.

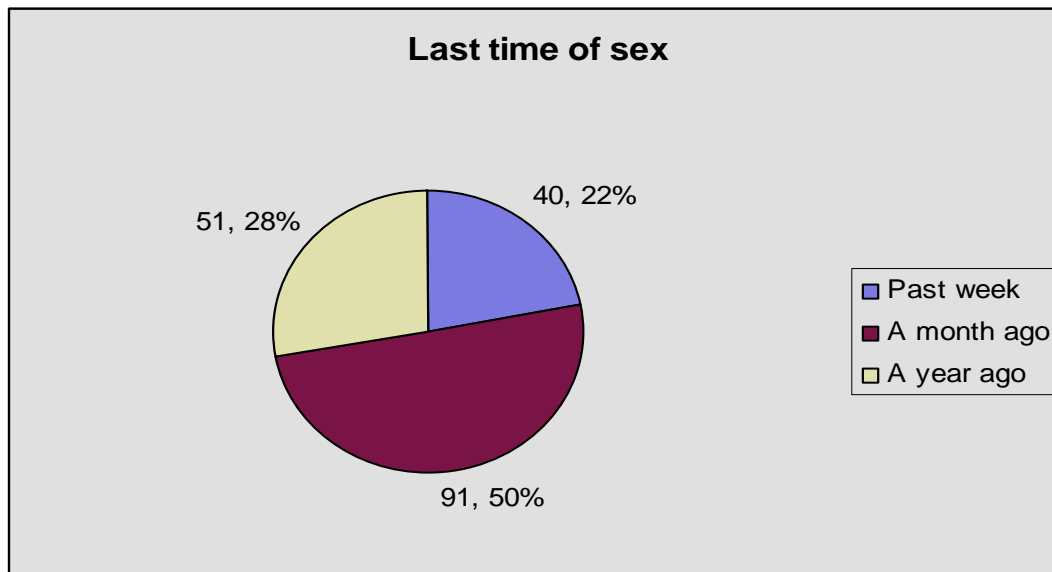
Among females,

- 69 (86%) indicated having had sex with males;
- 6 (8%) had sex with other females;
- 5 (6%) had sex with both sexes.

6.5.1.3 Last Time of Sex

Respondents were asked to indicate in question 24, how long ago they last had sex. The indication to this question required respondents to indicate whether it was in the past week, a month ago or a year ago.

Figure 27: How long ago did you last have sex?



Results showed that half of the respondents 91 (50%) had sex a month ago, followed by 51 (28%) that had sex a year ago and 40 (22%) that had sex in the past week (figure 27). The results could be an indication that sex was more regular on a monthly basis.

Of those who had sex in a month ago, 30% were males and 20% were females. With the other periods of last time of sex, male percentages were more than those of females by 2%.

The results of sex in a month ago indicated regularity amongst the 18 year olds who accounted for 15% and all others for percentages below 11%. Sex in a month ago amongst the grades was more regular amongst the grade 10 and 11 respondents with 20% each while the grade 9's accounted for 10%.

6.5.2 Risk Patterns of Sexual Engagement

The pattern of risk in terms of sexual engagement was determined by whether respondents continued to have sex, the frequency with which sex was done, the number of sexual partners and the use of condoms.

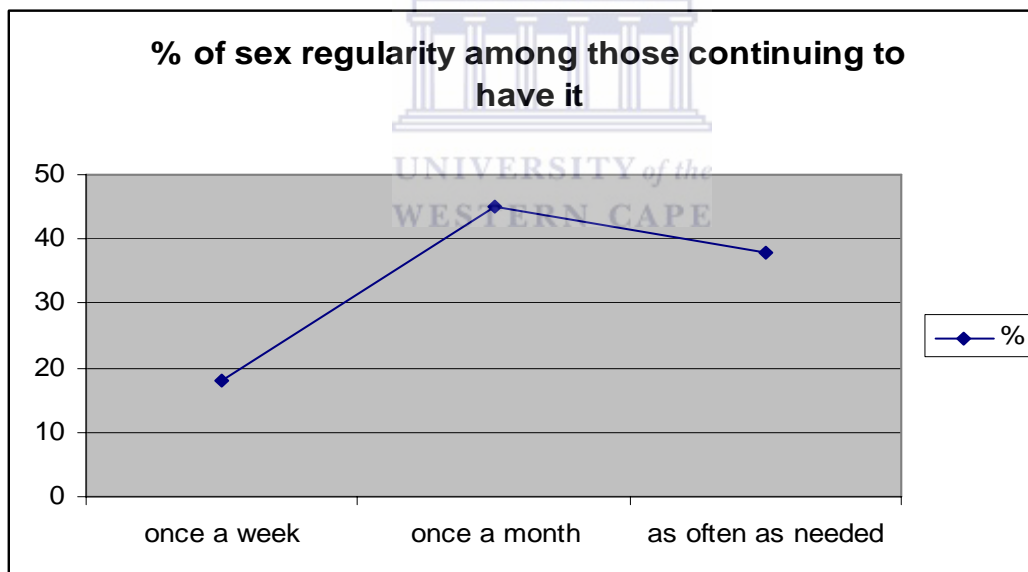
6.5.2.1 Continuation of Having Sex

With regards to the question of whether respondents continued having sex since the first time they had it, it emerged that the majority (67%) of respondents continued to have sex as opposed to 33% who no longer engaged in it.

When comparing between the age at first sex and whether they continued having sex, those who started having sex at the age of 15 continued having it more than other groups by 54%, followed by those who started it when they were between 10 and 15 years (34%) and those who started it when they were younger than 10 years (12%). This could mean that the older the age of respondents at first sex, the more likely they would continue having sex.

6.5.2.2 Frequency of Sex

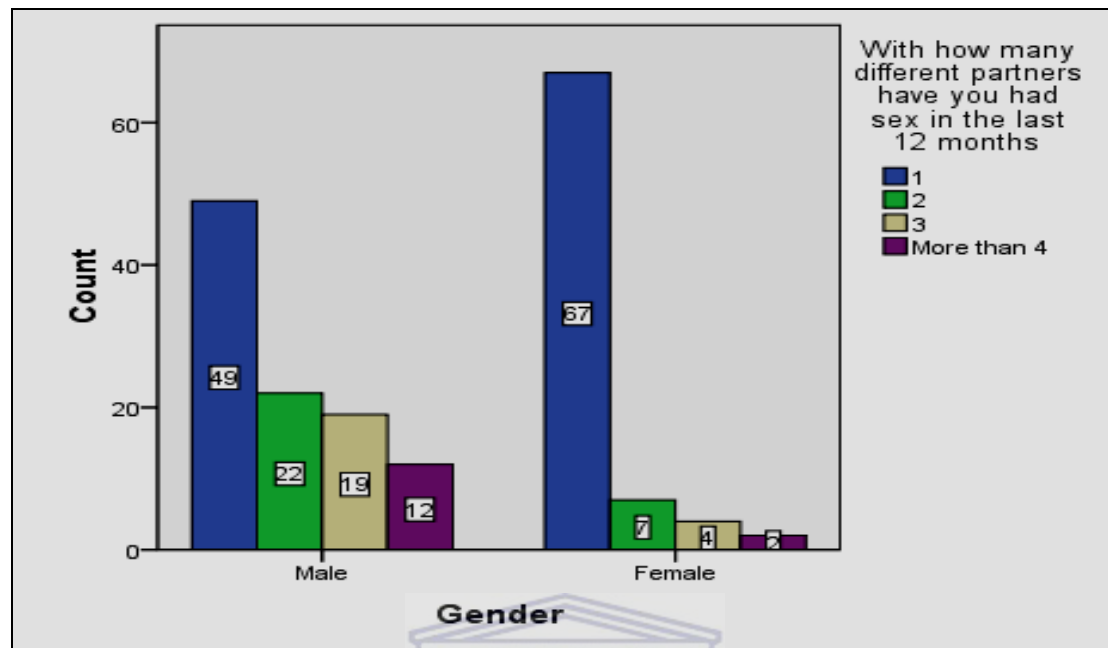
Figure 28: The regularity of sex among respondents continuing to have sex



Amongst those that continued to have sex, it was often done once per month (45%) or as often as needed (38%). It was indicated in lower percentages that sex was often done once a week (18%) figure 28. However, the regularity of once a week could be regarded as the minimum for the analysis considering that 38% had it as often as needed.

6.5.2.3 Number of Partners

Figure 29: Number of Partners by Gender



With regards to the number of partners (figure 29), the following results were reported:

- The majority of both male and females indicated that they had 1 partner 116 (64%);
- 29 (16%) reported having 2 partners and 12% of them were males and 2% were females;
- 23 (12%) reported having 3 partners and 10% of them were males and 2% were females;
- 14 (8%) reported having more than 4 partners and 7% of them were males and 1% were females.

From the results indicated above, it can be reported that a pattern of having more than one partner was seen more frequently amongst males than females.

6.5.2.4 Knowledge of Partner at Last Sex and Use of Prevention.

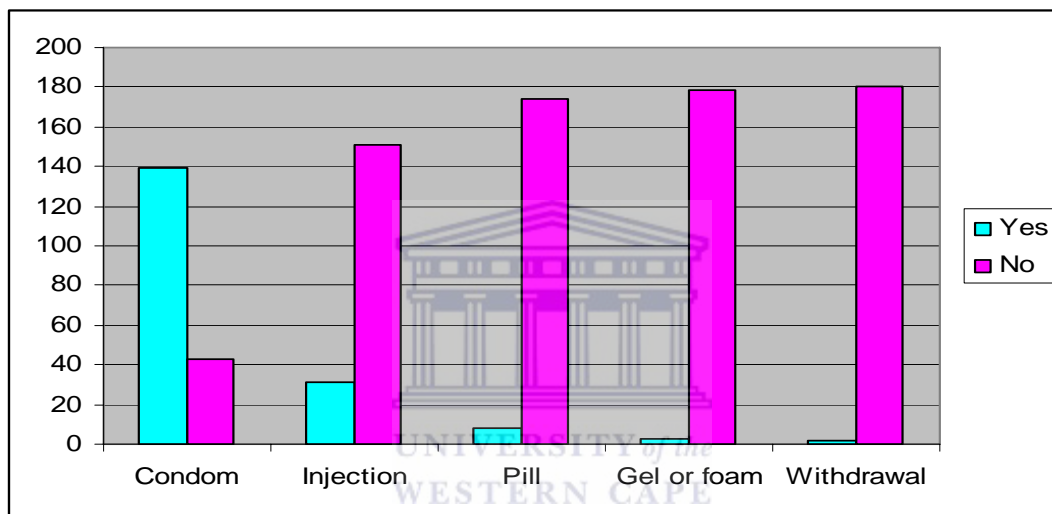
Cross-tabulations were performed from a total of 182 respondents who had sex to establish whether they knew their partners at last sex and whether they

used any form of protection for pregnancy or infections. Responses drawn from this total were divided between those who knew their partner and those who did not.

Among those that knew their partner, 109 (60%) of them used some form of protection as compared to 28 (15%) who did not use protection. Among those who did not know their partner, 38 (21%) used some form of protection as compared to 7 (4%) who did not.

6.5.2.5 Preferred Method of Prevention

Figure 30: Various Methods of Prevention as chosen by respondents



Results on whether a form of protection was used at last sex indicated that 81% of participants did use some form of protection whereas 19% did not. Figure 30 is an indication of the most preferred method of prevention at last sex. It should be noted that comparisons amongst these methods were only based on the total number of respondents' preferences of a prevention method and not on comparing methods of prevention against each other. The use of condoms emerged as a favourable method of prevention among respondents, followed by the use of injection. Within the use of condoms, analysis indicated that a total of 139 (76%) of both male and female respondents preferred the use of condoms.

Table 6: Gender * If yes what did you or your partner use: Condom Cross-tabulation

	If yes what did you or your partner use: Condom
--	---

		Yes	No	Total
Male	Count	75	27	102
	% within Gender	73.5%	26.5%	100.0%
Female	Count	64	16	80
	% within Gender	80.0%	20.0%	100.0%
Total	Count	139	43	182
	% within Gender	76.4%	23.6%	100.0%

6.5.2.6 Reasons for having sex by Age and Gender

Figure 31: Respondents' Reasons for Having Sex

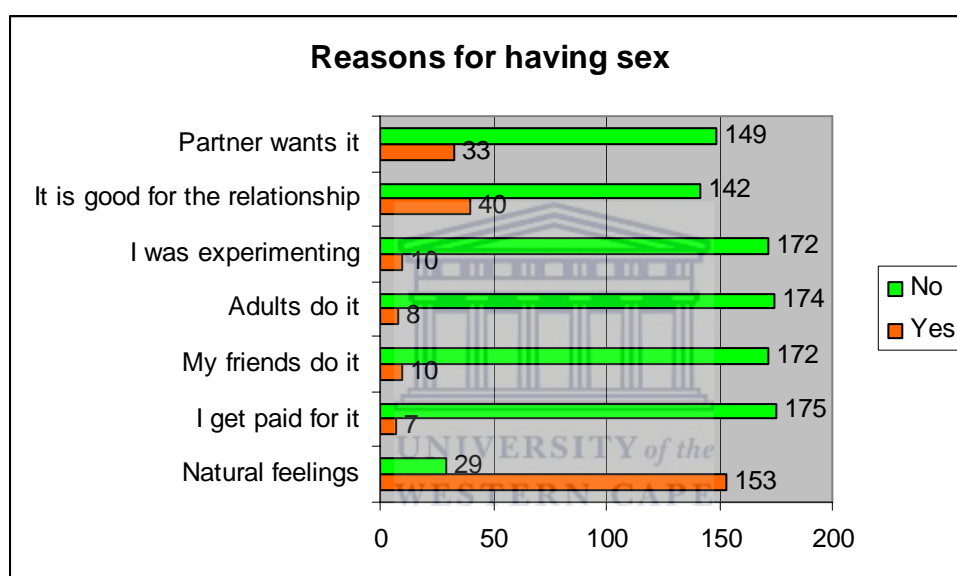


Figure 31 is an indication of respondents' reasons for having sex. The indication is only for respondents who had sex. The most compelling reason for having sex was because of natural feelings, followed by an indication that sex was good for the relationship and that the partner wanted it.

6.6 Knowledge and Sexual Behaviour

6.6.1 General basic knowledge of HIV/AIDS and ever had sex

Table 7: Chi-Square Tests General basic knowledge and ever had sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.124 ^a	1	.725
Likelihood Ratio	.124	1	.725

Linear-by-Linear Association	.124	1	.725
N of Valid Cases	303		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 59.50.

Cross-tabulations on general basic knowledge and whether respondents ever had sex produced a chi-square statistic of 0.124 with 1 degree of freedom (table 7). The observed probability value is 0.725 and is well above the 0.05 or 5%, meaning that there is a 72.5% chance that there is no association between general basic knowledge and respondents having had sex. Therefore, the null hypothesis is accepted. This chi-square statistic is reliable as no cells had expected frequencies of less than 5.

6.6.2 Knowledge of HIV/AIDS transmission and ever had sex

Table 8: Chi-Square Tests Knowledge of HIV/AIDS transmission and have you ever had sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.214 ^a	1	.644
Likelihood Ratio	.215	1	.643
Linear-by-Linear Association	.213	1	.644
N of Valid Cases	303		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 23.56.

Looking at the association between knowledge of HIV/AIDS transmission and ever had sex (table 8), a chi-square value of 0.214 with 1 degree of freedom. The given probability value is 0.644, a result indicating that there is 64.4% chance of null hypothesis being true. It can therefore be reported that there is no association between knowledge of HIV/AIDS prevention and respondents ever having sex. The analysis is also likely to be a reliable one as neither of the expected frequency criteria was violated.

6.6.3 Knowledge of HIV/AIDS prevention and ever had sex

Table 9: Chi-Square Tests of Knowledge of HIV/AIDS prevention and ever had sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.044 ^a	1	.833
Likelihood Ratio	.044	1	.833

Linear-by-Linear Association	.044	1	.834
N of Valid Cases	303		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 49.12.

Table 9 provides results looking at the association between knowledge of HIV/AIDS prevention and respondents ever having sex. Results produced a chi-square value of 0.44 with 1 degree of freedom and observed probability value of 0.833. This indicates that there is an 83.3% chance of the null hypothesis being true and no evidence to reject it. We are therefore stating that it is likely that's there is no association between respondents' knowledge of HIV/AIDS prevention and the report on ever having had sex.

6.6.4 General basic knowledge of HIV/AIDS and continuing having sex

Table 10: Chi-Square Tests General Basic Knowledge and do you continue having sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.398 ^a	1	.528
Likelihood Ratio	.398	1	.528
Linear-by-Linear Association	.396	1	.529
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 30.00.

Analysis was performed to determine whether there is an association between respondents' general basic knowledge of HIV/AIDS and their continuation to have sex (table 10). Chi-square statistic of 0.398 with 1 degree of freedom was produced. The observed probability value is 0.528, meaning that there is a 52.8% chance of the null hypothesis being true. It can be reported that there is no association between respondents' general basic knowledge of HIV/AIDS and their continuation to have sex. No cells have expected frequencies of less than 5, meaning that the chi-square is a reliable one.

6.6.5 Knowledge of HIV/AIDS transmission and continuing having sex

Table 11: Chi-Square Tests HIV/AIDS transmission and do you continue having sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.570 ^a	1	.210

Likelihood Ratio	1.634	1	.201
Linear-by-Linear Association	1.561	1	.211
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.20.

Chi-square statistic of 1.57 for knowledge of HIV/AIDS transmission and continuation to have sex was produced with 1 degree of freedom. Probability value is observed at 0.21, indicating that there is a 21% chance of the null hypothesis being true. Thus, it can be reported that there is no association between respondents' knowledge of transmission and their continuity to have sex. The analysis is also reliable as no less than 5 frequencies were expected.

6.6.6 Knowledge of HIV/AIDS prevention and continue having sex

Table 12: Chi-Square Tests Knowledge of HIV/AIDS prevention and do you continue having sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.808 ^a	1	.051
Likelihood Ratio	3.888	1	.049
Linear-by-Linear Association	3.788	1	.052
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 24.07.

Analysis was also conducted to determine the association between knowledge of prevention and continuity to have sex. The value of chi-square is 3.808 with 1 degree of freedom and an observed probability value of 0.051. This means that there is a 5% significant chance of the null hypothesis being true. However, because 5% was chosen as the significant level, the null hypothesis is rejected even though it is accepted that there is 5% chance of it being true. Thus, an alternative hypothesis is accepted meaning that there is an association between participants' knowledge of prevention and their continuation to have sex.

6.6.7 General basic knowledge and age at first sex

Table 13: Chi-Square Tests General basic knowledge and age at first sex

	Value	df	Asymp. Sig. (2-sided)

Pearson Chi-Square	.139 ^a	2	.933
Likelihood Ratio	.139	2	.933
Linear-by-Linear Association	.000	1	1.000
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.50.

An analysis concerned with determining respondents' general basic knowledge and age at first sex, was conducted. Chi-square statistic of 0.139 was produced with 2 degrees of freedom and an observed probability of 0.933. The result is an indication that there is a 93.3% chance of the null hypothesis being true. The null hypothesis is therefore accepted, meaning that there is no association between general basic knowledge and age at first sex.

6.6.8 Knowledge of HIV/AIDS transmission and age at first sex

Table 14: Chi-Square Tests Knowledge of HIV/AIDS transmission and age at first sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.082 ^a	2	.353
Likelihood Ratio	2.009	2	.366
Linear-by-Linear Association	.564	1	.452
N of Valid Cases	182		

a. 1 cell (16.7%) expected count less than 5. The minimum expected count is 3.46.

Table 14 illustrates results from analysing an association between knowledge of HIV/AIDS transmission and age at first sex. Chi-square statistic of 2.082 was produced with 2 degrees of freedom and a probability value of 0.353. This means that there is a 35.3% chance of the null hypothesis being true and it can be reported that there is no association between knowledge of HIV/AIDS transmission and respondents' age at first sex. The analysis is considered to be reliable and therefore accepted.

6.6.9 Knowledge of HIV/AIDS prevention and age at first sex

Table 15: Chi-Square Tests Knowledge of HIV/AIDS prevention and age at first sex

	Value	df	Asymp. Sig. (2-sided)

Pearson Chi-Square	.189 ^a	2	.910
Likelihood Ratio	.191	2	.909
Linear-by-Linear Association	.063	1	.802
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.82.

Results in table 15 produced a chi-square statistic of 0.189 with 2 degrees of freedom and observed a probability value of 0.910. The null hypothesis is accepted as there is a 91.0% chance of it being true. No cells expected a less than 5 count and the analysis is reliable.

6.6.10 General basic knowledge of HIV/AIDS and number of partners

Table 16: Chi-Square Tests General basic knowledge and number of partners

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.278 ^a	3	.351
Likelihood Ratio	3.318	3	.345
Linear-by-Linear Association	.052	1	.819
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.00.

No significant association was observed between general basic knowledge of HIV/AIDS and number of partners. The chance of the null hypothesis being true is 35.1% with 3 degrees of freedom and it is therefore accepted. The analysis is therefore reliable.

6.6.11 Knowledge of HIV/AIDS transmission and number of partners

Table 17: Chi-Square Tests HIV/AIDS transmission and number of partners

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.050 ^a	3	.384
Likelihood Ratio	3.341	3	.342
Linear-by-Linear Association	.022	1	.882
N of Valid Cases	182		

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 2.85.

Results indicate no significant association existing between knowledge of HIV/AIDS transmission and number of partners. There is a 38.4% chance of the null hypothesis being true and can therefore not be rejected.

6.6.12 Knowledge of HIV/AIDS prevention and number of partners

Table 18: Chi-Square Tests HIV/AIDS prevention and number of partners

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.647 ^a	3	.649
Likelihood Ratio	1.618	3	.655
Linear-by-Linear Association	.227	1	.633
N of Valid Cases	182		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.62.

There is no significant association observed within the knowledge of prevention and number of partners. There is a 64.9% chance of the null hypothesis being true.

6.6.13 Respondents' knowledge of their HIV/AIDS status and ever having sex

Table 19: Chi-Square Tests Knowledge of HIV/AIDS status of self and ever had sex

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.862 ^a	1	.353
Likelihood Ratio	.871	1	.351
Linear-by-Linear Association	.859	1	.354
N of Valid Cases	303		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 28.35.

Results indicate no significant association between respondents' knowledge of their HIV/AIDS status and ever having sex. There is a 35.3% chance of the null hypothesis being true.

6.7 Attitudes and Sexual Behaviour

An analysis comparing attitudes of respondents towards people infected with HIV/AIDS, their perceived risk of infection and sexual behaviour was conducted. The following results were obtained:

6.7.1 Respondents' knowledge of people who revealed their HIV/AIDS statuses and sexual behaviour:

- There is no significant association between knowledge of people who revealed their statuses and respondents' ever having sex. The null hypothesis has a 36.0% chance of being true;
- No significant association exists between knowledge of people who revealed their HIV/AIDS statuses and number of partners. The null hypothesis has a 31.9% chance of being true;
- No significant association exists between respondents' knowledge of people who revealed their HIV/AIDS statuses and the frequency of having sex. There is a 23.5% chance of the null hypothesis being true.

6.7.2 Respondents' perceived risk of infection and sexual behaviour:

- There is a significant association between respondents' perceived risk of infection and the frequency of having sex. Observed probability is 0.005 and the alternative hypothesis is therefore accepted;
- There is no association between respondents' perceived risk of infection and number of partners. The null hypothesis has a 12.5% chance of being true;
- There is no association between respondents' perceived risk of infection and ever having sex. The null hypothesis has a 10.8% chance of not being rejected

6.8 Qualitative Findings

Qualitative data were collected within the questionnaire using open-ended questions and section 4 of the questionnaire was dedicated for this purpose. Questions 34 to 37 focused on exploring problems experienced by participants when seeking help and/or information in various social settings in the community. Questions particularly explored problems experienced from parents, clinics (nurses), schools (teachers) and peer groups (other teenagers). Questions 38 to 41 explored participants' suggestions on what role can be played by each of those people from whom problems are experienced towards the prevention of risky sexual behaviours among teenagers. In the discussion that follows I first summarize the findings into

themes and sub-themes (where relevant) with examples of quotes of participants that best summarizes their experiences. This is followed by a brief explanatory discussion.

6.8.1 Problems Experienced by Teenagers when seeking Information or Help Related to HIV/AIDS and Sex

6.8.1.1 Problems experienced at clinics

Table 20: Thematic breakdown of problems at clinic

Theme	Sub-theme and/or d Quotes that summarises experiences.	# of responses out of 303
Moralising behaviour –of nurses based on own beliefs/opinion of sex	“they tell us we are too young to know about sex” “nurses say sex is for adults”	250
Attitude/Behaviour of nurses	Verbal abuse “Nurses shout at us”, “nurses are cheeky and I am scared they will shout at me”	233
	Unapproachable attitude “Nurses are not approachable, the people that work at clinics are not friendly and are not open for us to talk to them”, nurses don’t care”	169
	Discrimination “sometimes they think we have HIV/AIDS, nurses already think we do sex”	104
	Belittling attitude “nurses laugh at our questions, you see nurses laughing and calling others to come hear you and nurses laugh at our questions”	157
Unfriendly environment	Waiting in long queues “they don’t help us in time so you get bored waiting for long and people watching you, I wait for a long time in the clinic and I don’t like standing in line”	175
	Clinics do not protect confidentiality “sometimes we go to the clinic then we meet with our parents there, then we end up not getting what we wanted, you get afraid to make tests at the clinic” “Sometimes you are seen by a neighbour or relative and the next thing your parents know you were at the clinic”	123
	Lack of assistance and attention “nurses are not willing to help teenagers” and they say they are busy and have time for other patients”	291
	Bad treatment “nurses give you injection, pill or condom when you just need information”	98

A thematic breakdown of problems experienced at clinics (table 20) indicated nurses' beliefs and opinions, attitudes and behaviour and unfriendly environment as leading problems experienced by teenagers when wanting information or help at clinics. They thus feel scared and shy to approach the nurses or clinics for information.

a) Moralizing behaviour based on believes and opinions of nurses.

A very strong theme that emerged in relation to the question on experiences of community clinics was the moralizing behaviour of nurses. Learners perceptions were that this behaviour was based on own believes and opinions of nurses and it scared them off to approach the clinics for information on sex. Extracts such as “they tell us we are too young for sex”, “nurses say sex is for adults” were indicated.

b) Attitudes and behaviour

With regards to attitudes and behaviour theme, verbal abuse mainly in a form of shouting was indicated as the commonly experienced problem by the majority (233) of teenagers. Phrases such as “nurses shout at us” and “nurses are cheeky and I am scared they will shout at me” emerged mostly as responses among participants. A significant number of participants (169) indicated that nurses are not accessible “not approachable and are also not open for us to talk to them” and therefore teenagers become afraid and shy to ask for help. Other sub-themes under the attitudes and behaviour of nurses were the discrimination and belittling attitudes of nurses towards teenagers at clinics. Participants expressed that “nurses already think you have sex and “you see nurses laughing and calling others to come hear you, and laugh at your questions” as some of their mostly experienced forms of discrimination and belittling.

c) Unfriendly environment

The theme of unfriendly environment characterised with sub-themes of waiting in long queues, unprotected confidentiality, lack of assistance and bad treatment from nurses formed part of the experienced problems. It was expressed by teenagers that they wait in long queues without being helped

and this lead to being seen by other people including parents and or family members. Phrases such as “they don’t help us in time so you get bored waiting for long and people watching you; the next thing your parents know that you were at the clinic” emerged. Moreover, teenagers are also afraid to take tests and also experience the unwillingness of nurses to help them. Exact responses included “nurses passes you”, and “nurses are not interested in teenagers and will tell you they have patients to attend”. On the contrary, participants reported that they would **be given injections or pills without any information**. Such experiences may leave information seeking teenagers feeling afraid, exposed, unprotected, dismissed and as a result give up on gaining important information of a life-time.

Similar findings by Wood, Maepa and Jewkes (undated) in the Northern Province in South Africa confirm that one of the most important concerns of adolescents when visiting a public health clinic for contraceptives was the attitudes of nursing staff. Teenagers reported “verbal harassment by nurses scolding”, asking “funny” questions and being rude, short tempered and arrogant. Nurses perceived that moral guidance is part of their roles. The study also supports the finding that adolescents regard the clinic setting as problematic especially when sharing a waiting area with elders.

8.1.2 Problems experienced from parents

Table 21: Thematic breakdown of problems from parents

Theme	Sub-theme and Quote that summarises experiences.	# of responses out of 303
Communication and relationship with parents	Lack of attention, time and willingness to listen “parents don’t listen, they say it is not the right time, my mother was busy drinking alcohol”	300
	Lack of confidence to speak about sex “our parents say they have no time for such things, parents swear they will never speak to us about sex”	107
Parents attitudes and behaviour	Verbal abuse “parents shout and want to beat you” ” Some parents are strict so you get scared to ask, parents get angry and make you feel guilty, parents say teenagers hold no respect for them	264
	Physical and Emotional abuse “teens don’t feel free as parents harass and beat you, some parents are moody, so	169

	we are afraid”	
Parents’ lack of information	Misinformed “parents don’t tell right answers”	157
	Need information “parents need information about sex themselves, parents don’t have such information, some parents don’t know much and cannot help”	270
Assumptions and fears about sex	Fear of unknown “parents always think pregnancy and don’t want to talk about sex, Parents think you will go and have sex, parents think you already have sex”	298

With regards to problems experienced from parents, the themes of communication and relationship with parents, parents’ attitudes and behaviour, parents’ lack of information and assumptions about sex were identified (table 21).

a) Communication and relationship with parents

Communication and relationship with parents have been indicated as a major barrier or problem between parents and teenagers in this study. A strong sub-theme that emerged in this regard is lack of attention, time and willingness to listen to children’s needs. 300 responses fit into this theme. Also parents do not encourage communication and information sharing about sex, as one participant summarizes “they will never speak to us about sex”.

b) Parents’ attitudes and behaviour

Sub-themes of verbal, physical and emotional abuse were identified as problems linked to the attitudes and behaviour of parents. The attitudes and behaviour of parents seemed to be a very serious issue for teenagers, making it difficult for them to seek help within their families. 264 responses fit to this sub-theme. Responses such as “parents shout and want to beat you”, and that “some parents fight teenagers” summarize the overall perceptions. These behaviours by parents around topics of sex and HIV/AIDS were viewed as rather harsh and leave teenagers feeling afraid to open up discussions on the topic.

c) Parents lack information

According to participants, it is not just that parents do not want to talk, but they might lack information (270) and skills to talk about sex. Learners also thought that parents are misinformed (157) on HIV/AIDS themselves.

d) Fears and Assumptions about sex information to adolescents

Participants experienced that parents have assumptions about sex which are imposed and therefore forming barriers to giving and getting information. Parents “always think pregnancy” the moment they ask them questions or assume that “we already have sex” or “think you will go have sex”. Therefore parents are reluctant to share sex information.

Beliefs about the role of the family versus health professional and the state have been addressed in several studies (Nathanson 1991, Kreinen and Smith 1999, Senderowitz 1999). A study by Mturi (2001) in Lesotho highlights the problem of communications about sex between parents and adolescents. The study supports the experiences of participants in my study that parents are either shy to discuss sex related matter or they think the discussion will encourage sexual activities. Some parents blame tradition that these issues are not supposed to be discussed. Rio (2006) acknowledges that cultural practices have strong influences that maintain talking about sex or contraceptives as taboo in many African countries. Khan (2006) also addressed controversies and fears of parents with regards to the provision of proper information on issues of sexuality. A study by Wodi (2005) note the cultural constraints associated with the prevention of HIV/AIDS. In his study, youth respondents had never discussed HIV/AIDS with their parents or guardians.

6.8.1.3 Problems experienced with teachers regarding sex and HIV education.

Table 22: Thematic breakdown of problems with teachers

Theme	Sub-theme and Quote that summarises experiences.	# of responses out of 303
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Attitudes and misbehaviour by teachers	<p>Judgemental attitude by teachers</p> <p>“Some teachers say that we know nothing about school work but jump to adult things”</p> <p>Sex with learners</p> <p>“Other teachers take advantage and have sex with teenagers; teenagers are seduced by educators in many ways”.</p> <p>“Teachers end up sleeping with them, teachers propose to them”</p>	16 98
Time constraints	<p>Lack of time “Teachers lack time to talk about HIV/AIDS”</p> <p>Laisser-faire “Some teachers say they don’t teach LO, you should go to LO teacher, they tell us we must find information from our parents, teachers tell us to go to clinic”</p>	79 101

Among the problems experienced from teachers, two themes, i.e. the attitudes and behaviour of teachers and the time constraints were identified. It needs to be noted that despite the identified themes, a significant number of **participants (112) felt and expressed that teachers are the reachable sources of information and phrases such as:**

“No problem, teachers are supportive, they just answer you because they know that teens get into these things and need help, and teachers are most helpful” were some of the responses given.

a) Attitudes and misbehaviour by teachers

With regards to the problems experienced from teachers under this theme, sub-themes of sexual misbehaviour, judgement and teachers taking opportunity were identified. Participants indicated that when seeking information from teachers, other “teachers take advantage and end up sleeping with learners”. Thus, when teenagers seek information, it is viewed by other teachers as an opportunity to have sex with learners. Other learners felt that they are being judged by teachers and therefore making it difficult for them to seek information. Learners expressed that they are being told that “they know nothing about their school work and jump to adult things” or that the treatment from teachers start being different towards a learner that sought information.

b) Time constraints

Participants are of the opinion that even though teachers may be willing to help them when seeking information, they normally do not have time within their schedules to accommodate questions from learners. Other teachers who, are perceived to have time, opt to be not involved with the subject and refer learners to Life Orientation (LO) or are referred to their parents or clinics for information”.

Studies indicate that teachers and other professionals are reluctant to provide unmarried or childless young people, especially girls, with sexual knowledge and/or contraceptives (Murray, Stewart & Rosen, 2000). McCall & McKay (2004) indicate that even in a developed country like Canada the sexual health education to the youth in schools are inadequate. Schools do not provide adequate instructional time and teachers shy away from several key issues. The need for a coordinated system between schools and health systems is strongly recommended in these studies.

6.8.1.4 Problems experienced from peers

Table 23: Thematic breakdown of problems from teenagers

Theme	Sub-theme and Quote that summarises experiences.	# of responses out of 303
Lack of confidentiality respect and trust	Inability to keep secret “they tell everyone about your secret and expose your privacy, they never keep your problem to them and your information is not safe”.	184
	Disrespect and name calling “they laugh at you and they say you are a stupid virgin” “others gossip about you”	156
Lack of information and Misleading information	Misinformed “they give you wrong information, they don’t have a clue, they lie to you”	102
	Promoting teen sex: “other teens advise you to try it as it is fun, they tell you to go have it and you’ll feel good, they tell you that you are going to get sick if you don’t have it, they give bad ideas and pretend to have information and they make you have sex	298
Engaged in own issues.	“they tell you what happened to them instead”	118

Problems from other teenagers were expressed as mainly being around themes of lack of confidentiality, lack of information and misleading and engagement in own issues. It may seem that learners lack trust and are reluctant to obtain information from other teenagers due to the following reasons.

a) Lack of confidentiality, respect and trust

With regards to this theme, participants felt that once they seek information or share their problems with other teenagers, they become exposed and their information known to everyone, they are not respected and that they lack trust towards others. The problem with other teenagers was that they “do not keep secret, they tell everyone about your problem and your information is not safe”. The other problem experienced within this theme is that of not being respected and being called names by other teenagers. Of particular, participants said other teenagers say “you are a stupid virgin or they laugh at you”.

b) Lack of information and misleading information

Participants indicated that other adolescents are not good resources of information because they lack information or “give you wrong information”. Quotes like: “they lie to you...” and “they have no clue...” were given. Moreover, participants stated that other teenagers promote sexual behaviour by telling them to “try sex, that sex is fun, you’ll feel good after having it and that you will get sick if you don’t have it”.

c) Judgement

A significant number of participants (118) reported that other teenagers would talk about themselves when others seek information or help. This is done through telling what happened to them instead and as a result identified as a form of judgement.

The providing of misleading information among teenagers is also reported by Ajuwon et al. (2006) who indicate that adolescents harbour misconceptions around issues of sexual engagements. In terms of leading others into having

sex, Varga (1999) note the role of same sex peer pressure in creating pressure to initiate sex. In this study, young people indicated having sex because their friends do it.

6.8.2 Suggestions on roles towards preventing risky sexual behaviours

6.8.2.1 Suggestions on roles of parents

Table 24: Thematic breakdown of parents' roles

Theme	Sub-theme and Quotes that summarises roles	# of responses out of 303
Communication and accessibility	Verbal communication "talk to us about sex, be open and love them enough to talk about sex, encourage their children to have one partner, parents have to sit down with their children and talk about these issues"	300
	Be friendly "parents should talk to their children and stop being rude, they should at least try to talk to their children about the risks of sexual behaviour and talk nicely without shouting, parents should not be strict and talk to their children so that they become open to them"	297
	Transparency "talk openly and answer questions openly, parents have to be fair and honest to tell us about sex"	245
Responsibility	Give advise "parents should advise teenagers about sexual behaviour and its consequences, every parent must protect his child because we have high rate of teenage pregnancy in the country"	280
	Teach "teach and show kids how to protect themselves and what problems they will face"	291
	Guide "parents must be free to talk to us about HIV/AIDS and be good examples"	187
	Intervene "stop teenagers from going to clubs, stop their children from going around at night, they have to stop children from drinking alcohol, selling their bodies and working at night"	166

On enquiring about what can be done by parents to prevent risky sexual behaviour among teenagers, communication and accessibility and responsibility emerged as themes from the suggested roles. Participants gave the following responses within themes.

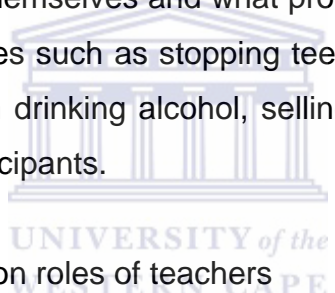
a) Communication

Within the theme of communication and accessibility, participants felt that parents need to engage in verbal communication with their children. Phrases such as “talk to us about sex” were strongly indicated by many participants.

Participants also indicated that parents should be more accessible to their children through being friendly and transparent. As indicated in their responses, there were indications that parents should “stop being rude, talk nicely and be open” to teenagers.

b) Responsibility

Within the theme of responsibility, roles such as giving advice, teaching, guiding and intervening were allocated to parents by participants. More specifically, participants felt that parents should advise teenagers, teach and show kids how to protect themselves and what problems they will face and be good examples. Other roles such as stopping teenagers from going to clubs and stopping children from drinking alcohol, selling their bodies and working at night were given by participants.



6.8.2.2 Suggestions on roles of teachers

Table 25: Thematic breakdown of teachers' roles

Theme	Sub-theme and Quotes that summarises roles	# of responses out of 303
Give information about HIV/AIDS and sexuality	Teach “teach the learners about the consequences of doing sex, teach teens about HIV/AIDS and give them knowledge, teach about this problem and stop taking advantage”	287
	Discuss “they should talk about sex and encourage teenagers to practice safe sex or abstain, have periods where life is discussed, have periods where teachers teach about sexual behaviour”	284
Reach out	Give advise “advise and help teenagers about unprotected sex and pregnancy”, they should all be involved in talking to us”	179
	Listen “give children a chance to reveal what they know or think”	168

Take action	Implement ways of distributing information "open groups of people who can motivate teenagers, guide learners about risky sexual behaviours, give more lesson or HIV workshops, do some activities and programmes at school like Lovelife so that many teenagers may be aware, give special class for sex and develop HIV/AIDS debating groups at school"	294
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The roles to be played by teachers were divided into themes of giving information about HIV/AIDS and sexuality, reaching out and taking action.

a) Give information about HIV/AIDS and sexuality

The role of giving information was highlighted by a lot of participants. It was indicated that teachers should actively teach learners and give them knowledge about the consequences of doing sex, that teachers should hold discussions to talk about sex and encourage teenagers to practice safe sex.

b) Reach out

This theme was identified as roles of teachers that could be exercised through giving advice and listening. Participants felt that teachers should advise teenagers on issues of unprotected sex and pregnancy. It was also indicated that the role of listening should be enforced through giving teenagers a chance to also share what they know about the topic under discussion.

c) Take action

Participants felt that teachers need to take action as a role towards prevention of risky sexual behaviour among teenagers. Within this theme, ways of distributing information were identified as an active role that can be played. Phrases indicating that teachers should open focus/debating groups, guide learners, give more lessons and workshops were identified as ways in which teachers can be involved.

6.8.2.3 Suggestions on roles of nurses

Table 26: Thematic breakdown of nurses' roles

Theme	Sub-theme and Quotes that summarises roles	# of responses out of 303
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Be accessible	Good treatment “give nice services and advise that condoms are not 100% safe, “respect teenagers, be friendly and treat them with respect, allow teenagers to speak to them and stop being cheeky, stop shouting at us”	299
	Be supportive “encourage teens to use condoms if they think they are old enough to have sex, get more closer to teenagers and talk to them, always have time for teenagers when they are at the clinic”	281
Strategies	Plan “increase clinics in the community because one clinic is not enough, which is why nurses don’t have time for us, get a chance to visit schools and tell learners about this information, counsel during weekends and teach more”	204
	Make time and give privacy “allocate special time for teenagers at the clinic, open a section at the clinic and make extra hour for teenagers”	274
	Network “nurses must go to schools and advise teenagers and have workshops at schools”	276
Give information	Communicate “provide condoms and pamphlets about HIV/AIDS, tell stories of sex in the clinic”	256
	Advise “tell teenagers how important it is to use condoms or abstain, make teenagers aware of the dangers of risky sexual behaviour, advise teenagers on how to be safe from getting HIV/AIDS and unwanted pregnancy”	197

Among the roles allocated to nurses, the themes of be accessible, strategies and give information emerged and are discussed below.

a) Be accessible

Participants felt that nurses should give teenagers good treatment and become supportive as their role towards preventing risky sexual behaviours among teenagers. The phrases in terms of good treatment “give nice services...., respect teenagers, allow teenagers to speak and stop shouting at us” were indicated. It was also felt by participants that nurses should be supportive towards learners through encouraging the use of condoms, by getting more closer to teenagers and having time for teenagers at the clinic.

b) Strategies

Within the theme of strategising, participants indicated that the role that can be played by nurses would be through planning around issues of teenagers, making time and giving privacy and networking. With regards to planning,

participants were of view that clinics should be increased, that nurses should visit schools and counsel during weekends. Participants also indicated that nurses should allocate special time for teenagers at the clinic and that they should go to school and hold workshops.

c) Give information

Sub-themes of communicating and advising were identified within the theme of giving information. Provision of condoms and pamphlets about HIV/AIDS was one phrase that indicated participants' suggestions on how information could be distributed. It was also indicated by participants that nurses should play a role of telling teens about the importance of using condoms or abstaining, making teens aware of the dangers of risky sexual behaviours and also give advice on safety from getting HIV/AIDS and unwanted pregnancies.

6.8.2.4 Suggestions on roles of teenagers

Table 27: Thematic breakdown of teenagers' roles

Theme	Sub-theme and Quotes that summarises roles	# of responses out of 303
Take responsibility	Protection and taking a stance "teenagers should abstain or have protected sex, we teenagers must take care of ourselves, use condoms and not sleep around, teenagers must protect themselves against HIV/AIDS, don't listen to friends and know when to say NO, stop having many sexual partners, have safe sex and go to clinic to know their status, stay away from alcohol because after drinking, they sleep around"	289
Communicate	Verbal communication "always talk about it, always advise each other and talk about the dangers of having unprotected sex" Listen and respect "trust each other and listen, talk to each other about their problems, teenagers need to respect each other and the choices they make"	205 198
Get involved	Offer help "give each others the right advise, we should work together as teenagers and encourage each other about positive things in life" Take initiatives "have teenager groups and talks about sexual behaviour and encourage each other, open youth group where they will get and give information, try to keep themselves busy so that they don't think about sex, open a free club like youth alive at school, get involved in support groups and express themselves to overcome peer pressure"	216 293

In response to the question of what role can be played by other teenagers towards preventing risky sexual behaviours among teenagers, the following themes and sub-themes emerged.

a) Take responsibility

Participants indicated that teenagers should take responsibility of their lives through protecting themselves and taking a stance. Phrases such as “teenagers should abstain or have protected sex, use condoms and not sleep around, don’t listen to friends and know when to say no” were suggested strongly as ways of protection and taking a stance. Participants also suggested that teenagers should also protect themselves by not having many sexual partners and staying away from alcohol.

b) Communicate

The theme of communication was identified and went with sub-themes of verbal communication, listening and respect. It was suggested that teenagers should play a role of verbal communication through always talking about HIV/AIDS and the dangers of unprotected sex with other teenagers. As a way of communication, it was felt that teenagers should trust each other and respect one another and the choices each other make.

c) Get involved

Getting involved was identified as a theme and under it were sub-themes of offering help and taking initiatives as roles that can be played by teenagers towards preventing risky sexual behaviours among teenagers. Participants indicated that teenagers should give each other right advices and have positive influence in each other’s lives by encouraging positive things. It was also strongly suggested that teenagers should also take initiatives by getting involved or having among other things, teenage support or youth groups where they could help each other and get support to overcome peer pressure.

6.8.3 Summary

Participants generally had poor knowledge levels based on general basic knowledge, transmission and prevention subcategories. The poor knowledge levels are above 90%, indicating limited knowledge on factual information about what HIV/AIDS is, how it is contracted and how it can be prevented. The poor knowledge varied considerably by gender, age and school grade and it is important to note those variations.

Information on the pandemic was easily obtained via various sources including talking with partners about it, which was an indication that the poor knowledge problem could be attributed to individual interpretation and how well the information was received and the correct understanding of it.

The majority of participants neither knew their statuses (77%) or that of their partners (84%) and fewer participants thought their partners were having other relationships. Over half of participants (54%) did not think they could be infected with HIV/AIDS but did think that their family members could be affected by the pandemic. There was a generally positive attitude towards people currently known to be infected and those who may be infected in future. This was indicated by participants' indication that they accepted and would in the future accept those who may be known to have HIV/AIDS. Most participants indicated that they had sex, and those continuing to have it after the first time had it with more than 1 partner. The average sex debut for participants was 15 years and the use of condoms at first sex and continuation thereof was popular amongst the participants. Participants indicated natural feelings as the most compelling reason for having sex.

Numerous indications on the problems experienced from parents, teachers, nurses and other teenagers were presented together with roles that can be played by these individuals towards reducing risky sexual behaviours among teenagers.

CHAPTER 7: DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

The goal of this study was to quantitatively explore the knowledge, attitudes and sexual practices of high school learners in the era of HIV/AIDS in a rural Free State town, and as well as to qualitatively explore challenges experienced by learners when seeking information and their suggestions on intervention strategies.

The objectives of the survey were:

- To explore the knowledge levels, attitudes and sexual practices of high school learners at a selected rural town;
- To establish whether there is a difference in knowledge levels and sexual behaviour pattern of learners according to age at first sex;
- To establish whether there is an association between knowledge levels and sexual behaviours;
- To explore participants' perceptions about the information resources and what their suggestions are on prevention strategies.

The Null Hypotheses were:

- *There is no association between knowledge levels of learners and their sexual behaviours in terms of ever having sex and continuing to have sex;*
- *There is no association between knowledge and age at first sex;*
- *There is no association between perceived risk of infection and number of partners;*
- *There is no association between perceived risk of infection and frequency of sex.*

This chapter focuses on discussing the findings of the study based on the study objectives and literature. Discussion of the quantitative findings is structured according to the research objectives related to knowledge, attitudes

and sexual behaviour of learners. The qualitative findings of the open questions are presented according to the identified themes. Conclusions on the findings are also presented followed by the recommendations.

7.2 Summary of findings and literature relevance

7.2.1 Levels of knowledge, sexual practices and attitudes towards HIV positive people

An overall 64% of poor **knowledge** level of HIV/AIDS was found. The poor knowledge was based on general basic knowledge of HIV/AIDS (51%), transmission (81%) and prevention (59%) of the pandemic.

The poor knowledge varies by gender, age and grade but the variations are worth noting:

- Females generally had poorer basic knowledge of HIV/AIDS and transmission than males;
- More males than females had poor knowledge of prevention;
- It is important to note that with regards to age, even though respondents' knowledge was poor, the 18 year olds seemed to have more basic knowledge of HIV/AIDS and transmission than other age groups;
- However, the 18 year olds scored the lowest amongst other age groups in terms of good knowledge of prevention;
- Grade 11 learners were more knowledgeable on prevention of HIV/AIDS than other grades.

The findings differ significantly with those of the Free State youth survey (www.yry.ac.za) in which participants were found to be generally well informed with regards to knowledge of HIV/AIDS. The population in the Youth Survey were youth from selected towns (both rural and urban) of Free State. Thus, this could mean that conflicting results emanated from this study. The study of Pharaoh (2004) also contradicted my study as it found that participants were knowledgeable about transmission and lacked sufficient

knowledge about prevention, whereas this study found HIV/AIDS related knowledge to be poor on both transmission and prevention.

There was generally a positive **attitude** among the respondents towards people known to be infected and those who may be known in the future. They indicated that they accepted or would accept such people. Current and future avoidance of such people was mainly attributed to not knowing how to treat or being afraid of HIV/AIDS infected people. Only a few (2% on average) indicated that they avoid or would avoid people known to be infected because of not wanting to be associated with them. Jaiswal et al. (2005) observed a significant change in attitudes, where high school student reported that they would allow HIV positive people inside their house.

Respondents thought that HIV/AIDS could affect other people but they did not associate themselves with the risk of infection. This was proven by the finding that most respondents did not think they can be infected with HIV/AIDS but did think that their family members can be affected by it. The Reproductive Health Research Unit (2003) found that 62% of HIV infected and 73% of HIV negative South African youth who participated in a national survey thought that they were at little or no risk of contracting HIV. This study raised a concern about the underestimation of risk observed amongst the youth.

About 81% of respondents did not know their HIV status and the statuses of their partners. Inferences on this fact cannot be made and would need further exploration on how important this issue is to them. However, it is worth noting that Ntozi and Kirunga (1997) found in their study that 12% of respondents did not want to know their statuses because knowing will worry them more since the disease is not curable.

In terms of **sexual behaviour**, more respondents (60%) have had sex and continued to have it in higher percentages. The continuation of having sex was especially observed to be more likely among those whose sexual debut was at the age of 15. Males were more likely to have had sex at a younger age and continued having it more frequently with more than one partner than

females. Peltzer et al. (2005) and Pettifor et al. (2004) also observed similar results where initiation of sex was at an early age especially among male participants.

The majority of respondents seem to engage in safe sex in terms of the following indicators:

- Majority of those that continued having sex (64%) had one partner although special cognisance should be given to 16% of males who had at least two partners;
- Most respondents (76%) preferred the use of condoms as a form of protection when having sex and it was also used by most respondents at first sex. The results also indicated that 81% also used condoms at last sex. A study of Peltzer et al. (2005) indicates that condom use at first sex was indicated in high percentages by respondents, although 56% lower use of condoms at last sex was also reported;
- In most cases, the partners were known by those that continued to have sex.



7.2.2 Associations between Variables

Hypothesis: There is no association between knowledge levels of learner and their sexual behaviours in terms of ever having sex and continuing to have sex.

With regards to association between knowledge levels and respondents' sexual behaviour, the null hypothesis has been confirmed at the 95% confidence level. Findings indicated that respondents' knowledge levels of HIV/AIDS have no association with their decisions of having sex and continuing to have it. This could mean that what and how much they know do not affect or have an influence on their sexual behaviour.

Generally, this study found that knowledge with regards to HIV/AIDS among learners is poor, change in sexual behaviour is weak and the continuation of

engaging in sexual activities is rife. Thus, it is a poor knowledge versus weak change in behaviour pattern.

Other studies found that knowledge levels of young people were higher or sufficient but change in risky sexual behaviours was weak (Maswanya et al. (1999), James et al. (2004). These studies reported high levels of knowledge but weak correlation with behaviour change.

Hypothesis: There is no association between knowledge and age at first sex

With regard to the association between knowledge and age at first sex, the study found that male respondents initiated sex earlier than females. The null hypothesis has been confirmed at the 95% confidence level. No association was found between knowledge of HIV/AIDS and age at first sex

Hypothesis: There is no association between perceived risk of infection and the number of partners.

Perceived risk of infection was found to be not associated with the number of partners and the decision to have unprotected sex and the hypothesis has been confirmed at a 95% confidence level. This could imply that participants (especially male participants) thought that the number of partners one has, could not place them at risk of getting infected. Tefera (2004) found that over half of respondents (56.3%) who practiced unsafe sex did not perceive themselves to be at risk of HIV infection. Wodi (2005) also found that over half of youth in his study felt little threat from HIV/AIDS.

Hypothesis: There is no association between perceived risk of infection and frequency of sex

The hypothesis has been rejected at the 95% confidence level.

The analysis indicated that the frequency of having sex was associated with perceived risk of infection among the respondents. This could again mean

that respondents perceived that the possible danger of infection could result from how frequently sex is performed.

7.2.3 Participants experiences when seeking information or help and their suggestions on prevention of risky sexual behaviours

Qualitative data collection was aimed to carry out the objective of exploring problems experienced by participants and their suggestions towards preventing risky sexual behaviour among teenagers. Data were collected through the use of open-ended questions within the questionnaire. The problems were explored by enquiring what is experienced by participants when seeking information from parents, nurses, teachers and other teenagers. Subsequently, exploration of suggestions was based on enquiring what roles can be played by such people from whom problems are experienced towards the preventing sexual behaviour among teenagers. The themes that transpired from the analysis enable the following discussion on experiences of learners and their suggestions.

7.2.3.1 Problems experienced by teenagers when seeking information

The following themes emerged regarding the problems experienced by learners when seeking information or help around issues of HIV/AIDS and sex.

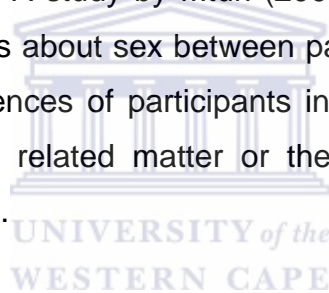
Problems with nurses

Problems experienced at clinics were mostly related to the behaviour of nurses. These include moralising behaviour, belittling and unapproachable attitudes of nurses as well as the experience of verbal abuse and discrimination. Clinics were viewed as unfriendly environments with no protection of confidentiality, bad treatment and lack of assistance. Similar findings by Wood et al. (undated) in the Northern Province in South Africa confirms that one of the most important concerns of adolescents when visiting a public health clinic for contraceptives was the attitudes of nursing staff.

Problems with parents

Communication, attitudes and accessibility of parents regarding the discussion of sex and HIV/AIDS were major problems experienced by teenagers. Participants experienced lack of attention, time and willingness of parents to listen to them. Participants also indicated that parents are not comfortable with discussing such topics and thus choose not to entertain them. According to participants, parents are strict and get angry towards their children in this regard. Verbal, physical and emotional abuse seemed to be more prominent among parents towards their children. There was also lack of confidence and fears among parents to speak about sex and HIV/AIDS.

Several studies support findings of my study regarding the role of parents in providing information to teenagers. (Nathanson 1991, Kreinen and Smith 1999, Senderowitz 1999). A study by Mturi (2001) in Lesotho highlights the problem of communications about sex between parents and adolescents. The study supports the experiences of participants in my study that parents are either shy to discuss sex related matter or they think the discussion will encourage sexual activities.



Problems with teachers

The attitudes and misbehaviours of teachers and time constraints were indicated as major problems experienced by teenagers. Participants complained about a judgemental attitude among teachers. There were also indications from learners that teachers take advantage of teenagers who seek information by having sex with them and/or proposing sex to them. They questioned whether teachers who will be willing to help have time for them.

Studies indicate that teachers and other professionals are reluctant to provide unmarried or childless young people, especially girls, with sexual knowledge and/or contraceptives (Murray et al., 2000). McCall & McKay (2004) indicate that even in a developed country like Canada the sexual health education to the youth in schools are inadequate

Problems with other teenagers

Among the problems experienced from other teenagers were lack of confidentiality, lack of information and being given misleading information. Participants indicated that other teenagers are unable to keep secrets which leads to lack of trust among them. Other teenagers are also accused of misinforming others and promoting sexual engagements amongst teenagers.

The provision of misleading information among teenagers was also observed by Ajuwon et al. (2006) who indicate that adolescents harbour misconceptions around issues of sexual engagements

7.2.3.2 Suggestions on prevention of risky sexual behaviours

Participants made valuable suggestions on what can be done to prevent sexual risky behaviours among participants. The roles of parents were suggested more around issues of communication. Participants indicated that parents should talk more with their children and take the responsibility of teaching, guiding and intervening in the lives of their children.

Suggestions also encourage teachers to give more information through teaching and giving advices and reaching out to learners.

As far as clinics are concerned, it was suggested that nurses should be more involved through giving good treatment and support, planning and implementing strategies of addressing issues of sexuality among young people and also communicating.

The role of teenagers was identified to be more of taking responsibility of their own lives, communicating with others and getting involved in issues that concern young people.

7.3 Conclusions

This study focused on knowledge, attitudes and sexual practices of high school learners in the era of HIV/AIDS in rural Free State town. The study was largely quantitative and used questionnaire to collect data. Qualitative information was also collected through incorporating open-ended questions

within the questionnaire. Both methods provided valuable information that lead to significant findings as presented above. The objectives of the study and hypothesis are believed to have been addressed adequately and answered. However, it is believed that a comprehensive mix method study could have enhanced the depth of the study. Limitations of the study were outlined in chapter 1.

7.4 Recommendations

The following recommendations are presented based on the findings of this study. The researcher is however aware of the fact that the findings can only be generalized to the population of this study:

- There should be serious concerns about the low knowledge levels of respondents regarding HIV/AIDS. The low levels of knowledge could be an indication that much more work in terms of fact focused education need to be done focusing on what HIV/AIDS is, how it gets transmitted and how it can be prevented. Knowledge base need to be boosted through the provision of proper and adequate information about sex and HIV/AIDS to learners in the school setting, home and other relevant institutions
- Continuous peer education training and involvement of young people in plans to address HIV/AIDS is highly recommended.

Education of adolescents has been acknowledged as a more proper way of targeting HIV/AIDS if we are to win the battle of fighting it. A study by Jaiswal et al. (2005) found that high school students had significant improvements in the knowledge and attitudes after an education programme was offered.

- This study also calls upon intergenerational communication and information sharing forums. It is recommended that services be linked through involving schools, clinics, churches, parents and teenagers as social support systems to youth. Programmes that facilitate

engagements of these stake holders should be aimed towards building self-esteem of young people and assisting in determining goals for the future. Such programmes could incorporate discussion forums in which the views of participants will be valued and exposure to more information is obtained.

- Young people continue to engage in sexual activities despite the risks associated with it. Youth friendly condom distributing zones should be established as this could further enhance the use of condoms among teenagers
- It is strongly recommended that parents and schools should listen to the voices of children regarding their experiences at clinics. The protection of teenagers' privacy and confidentiality is vital if they are expected to use health care facilities
- School authorities and health care practitioners like community nurses, should meet and discuss ways of helping learners in a respectful way and decide on user friendly way of promoting sexual health.
- School principals and/or life skills teachers should organize meetings to share the outcome of this research with parents in a non-threatening way. Parents should be supported and empowered with information on HIV/AIDS and encouraged to communicate with children about this issue.
- Parents, teachers and nurses should be encouraged to be more accessible and lenient towards young people as their positive attitude could curtail engagements in risky sexual activities. Thus, the study calls for robust engagement of community leaders and elders working together with teenagers in programmes designed to enhance education.

- Education programmes should endeavour to address peer pressure and instil positive role modelling in young people towards their peers. Positive peer pressure has been noted as playing an important role in influencing behaviour change amongst adolescents by theorists who believe that knowledge but environment and social context influence behaviour (Swart et al. 2005).
- In-depth and comprehensive studies using both qualitative and quantitative methods among young people in rural areas are highly recommended.

7.5 Concluding remarks

This study explored knowledge, attitudes and sexual practices of high school learners in the era of HIV/AIDS using a questionnaire. The study also explored participants' views on the experiences of teenagers when seeking information and their suggestions on prevention of risky sexual behaviours among teenagers (open-ended questions included in the questionnaire). It is fully acknowledged that the study is not a proper quantitative-qualitative combined study; however, the open-ended questions provided valuable and rich data from which important themes were established. Proper use of both designs would be advantageous in future.

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FACULTY OF COMMUNITY AND HEALTH SCIENCES

ADDENDUMS

DEPARTMENT OF SOCIAL WORK

Addendum i

GUIDELINES FOR THE PARTICIPANT INFORMATION SHEET (PIS).

Date:

Ref: (supervisor's name) and tel
Student researchers:

Dear...

You **are invited to participate** in a research study titled:

The following written information is given to assist you to make a decision whether to participate or not. Please feel to ask the researchers to clarify anything in this letter is not clear to you..

The **goal this** research is and we hope that the findings of this study will contribute to.....

If you agree to participate you will be **required** to make yourself available (for a one-to-one interview / participate in a group discussion/complete a questionnaire) which will take about.... your time. This will be done at a venue.....

The **potential risk(s)** for participating is/are (that you find some of the questions of a very personal nature (OR INDICATE THAT NO POTENTIAL RISKS ARE FORESEEN.)You are encouraged to discuss with the researcher or assistant any feelings of discomfort that you may experience during or after the interview. We will also make available an independent consultant for this purpose should this be your choice.

Participation in this research is **voluntary**.

You are also free to withdraw from the research should you at any time feel uncomfortable to continue.

There are no financial **costs or direct benefits** for you for by participating the project.. However your participating is highly valued for the potential.....

Every attempt will be made to keep information **confidential/anonymous** in the sense that you will not be named in the writing up of the research. (not applicable in focus groups, alert the participant that partaking in a focus group means that you share information with other in the group and al though the group may agreed to the norm of confidentiality, the researcher cannot guarantee this) The findings of the research will be reported and may be published but no participant's **identity** will be revealed.

If you agree to participate, kindly complete the following and sign.

CONSENT FORM.

Title of research:

I have read the information about this research / it has been read to me. I had the opportunity to ask question an my questions have been answered to my satisfaction.

I..... confirm that I understand the goal, and risks/benefits of participating in this research project.

I was informed that the findings will be reported **anonymously** and that the researcher will at all times adhere to professional ethical behaviour in this project.

(In the case of focus groups, add that group member realise that the researcher cannot guarantee respect for confidentiality by other participants.

I am participating voluntarily and am aware that I can withdraw at any time should I wish to do so.

Signed (participant) name and signature

Date:.....

Researcher name and signature

Date:.....



UNIVERSITY OF
WESTERN CAPE

FACULTY OF COMMUNITY AND HEALTH SCIENCES

Addendum ii

DEPARTMENT OF SOCIAL WORK

TSEBISO YA BA NKAKAROLO

Mohla: April 2007

Ref: Supervisor: Professor S. Terblanche Tel: (021) 959 2277
Student researcher: Gladys Klaas-Makolomakwe Tel: 073 137 4618
Student No.: 2615552

Motswadi ya ratehang

Ngwana wa hao o memelwa ho nka karolo patlisisong ya thuto sehlohong se latelang: Tsebo, mokgwa le boitshwaro ba baithuti ba dikolo tsa sekondari mabapi le lefu la HIV/AIDS motse-toropong Foreisitata.

Tlhahiso leseding e latelang e etseditswe ho ka o thusa bakeng sa ho nka qeto hore ngwana wa hao a ka nka karolo kapa thjee. Ka kopo, phutulloha ho ka botsa dipotso ho motsamaisi wa dipatlisiso ha o hloka tlhalosetso efe kappa efe ya lengolo lena.

Dintlhakgolo tsa patlisiso ena ke ho toboketsa tsebo ya ngwana wa hao ka lefu la HIV/AIDS mme re tshepa hore sepheto se tla fumanwa se tla bapala karolo ntshetsopeleng le twantshong ya lefu lena.

Ha o dumela hore ngwana a ka nka karolo, ngwana o tla lebellwa ho nka karolo puisanong ya sehlopha e tla nka hora le ho tlatsa pampiri ya dipotso e tla nka metsotso e mashome a mararo. Tsena tsohle di tla etsetswa sekolong ka mora dihora tsa thuto.

Bothata bo ka hlahang ho nkeng karolo ke hore ngwana a ka fumana tse ding tsa dipotso di le mabapi le bophelo ba hae. Ngwana o kgothalletswa ho bua le motsamaisi wa patlisiso ena kapa bathusi ba hae haeba a na le ho se ikutlwe hantle ka morao kapa lekgatheng la patlisiso. Hape, ngwana o lokolohile ho ka ikgula patlisisong nako efe kapa efe ha a se o sa batle ho tswella. Motho ya ikgethileng ho ka buisana le batho o tla ba teng bakeng sa taba ena ha eba ngwana a ka batla ho bua le motho e mong ya sa nkeng karolo patlisisong.

Ho nka karolo mona ke ka boithaupi feela, ho nka karolo ha ngwana wa hao ho amohelehile haholo bakeng sa patlisiso tabeng ena e re amang le ho ntshetsa pele mekga ya twantsho ya ho thibela lefu lena. Ha ho moputso o hlophisitsweng bakeng sa hae ha a nka karolo projekeng ena.

Teko tsohle di tla etswa hore sepheto se dule se le lekunutu mme a sa tsebahale ka hore a se hlahiswe ha ho ngolwa raporoto ya patlisiso ena. Ho nka karolo puisanong ya sehlopha ho bolela hore o tla arolelana tsebo le ba bang sehlopheng mme le ha eba ho ka dumellanwa ka lekunutu la sehlopha, motsamaisi wa patlisiso a ka se kgone ho ka tiisa sena. Sepheto sa patlisiso ena se tla repotwa mme se ka phatlalatswa entle le ho hlahisa bankakarolo.

Haeba o dumela hore ngwana a ka nka karolo, ka kopo tlatsa foromo e latelang mme o e saene:

FOROMO YA TUMELLO.

Sehloho sa patlisiso: Tsebo, mokgwa le boitshwaro ba baithuti ba dikolo tsa sekondari mabapi le lefu la HIV/AIDS motes-toropong wa Foreisitata.

Nna ke badile tlhahisoleseding ka patlisiso ena/ kapa ke e balletswe. Ke bile le monyetla wa ho botsa dipotso mme tsa arajwa ka ba ka kgotsofala.

Nna..... Ke tiisa hore ke utlwisisa dintlhakgolo le bothata/tefo ha ngwana a nka karolo projekeng ena ya patlisiso.

Ke ile ka tsebiswa hore sepheto se tla phatlalatswa ntle le ho bolela mabitso mme mmatlisisi o tla ikamahanya le bonkgonthe ba setho projekeng ena. Bakeng sa puisano ya sehlopha, ke ellellwa hore mmatlisisi ha a na hona ho ka tiisa hlomphe ya lekunutu la sehlopha ke ba bang ba bankakarolo.

Ngwana o tla nka karolo ka boithaupi mme ke ellellwa hore a ka ikgula neng kapa neng ha a batla.

Saene:

Monkakarolo: Lebitso le saene

.....

Mohla:.....

Motswadi: Lebitso le saene

.....

Mohla:.....



UNIVERSITY OF
WESTERN CAPE

Topic: Knowledge, attitudes and sexual practices of high school learners in the era of HIV/AIDS in a rural Free State town

Name: Gladys Nkareng Klaas-Makolomakwe

Degree: Magister of Social Work

University of Western Cape

Instructions:

Please read questions carefully

Where the option **other** appear, please write your answer next to the box

Please always make a tick (✓) where asked to do so

Please use the pencils provided

Please ask for help when needed

Please note: your information is confidential and will be treated with confidentiality

There is no right or wrong answer for any question

PLEASE IDENTIFY YOURSELF BELOW:

Please make a tick (✓) next to your choice:

Male	Female
------	--------

How old are you?	15	16	17	18	Other
------------------	----	----	----	----	-------

You are in grade	Grade 9	Grade 10	Grade 11
------------------	---------	----------	----------

Your home language is	Sesotho	isiXhosa	Setswana	Other
-----------------------	---------	----------	----------	-------

KNOWLEDGE ABOUT HIV/AIDS

1. Who can get HIV/AIDS?

No.	Options	Please tick (✓) one choice per option		
1.1	Only children can get HIV/AIDS	True	False	Unsure
1.2	Only young people can get HIV/AIDS	True	False	Unsure
1.3	Only adults can get HIV/AIDS	True	False	Unsure

1.4	Anybody can get HIV/AIDS	True	False	Unsure
-----	--------------------------	------	-------	--------

2. You can be HIV infected by:

No.	Options	Please tick (✓) one choice per option		
2.1	Shaking hands with a HIV+ person	True	False	Unsure
2.2	Sharing eating utensils with a HIV+ person	True	False	Unsure
2.3	Sharing toilet facilities with a HIV+ person	True	False	Unsure
2.4	Eating food prepared by HIV infected people	True	False	Unsure
2.5	Kissing somebody who is infected and has no open sores in the mouth	True	False	Unsure
2.6	Having unprotected sex	True	False	Unsure
2.7	Having blood contact with the blood of an infected person	True	False	Unsure
2.8 Other ways of getting infected with HIV not mentioned above (please write here)				

3. HIV/AIDS can also be passed on from:

No.	Options	Please tick (✓) one choice per option		
3.1	An infected mother during pregnancy to her unborn baby	True	False	Unsure
3.2	An infected mother to her baby during childbirth	True	False	Unsure
3.3	An infected mother through breastfeeding	True	False	Unsure

4. A healthy looking person can be carrying HIV (Please tick (✓) one choice)

True	False	Unsure
------	-------	--------

5. There is cure for HIV/AIDS (Please tick (✓) one choice)

True	False	Unsure
------	-------	--------

6. You can protect yourself from getting HIV by

No.	Options	Please tick (✓) one choice per option		
6.1	Abstaining from sex	True	False	Unsure
6.2	Using condoms	True	False	Unsure
6.3	Avoiding eating with others	True	False	Unsure
6.4	Not shaking hands	True	False	Unsure
6.5	Avoiding HIV infected blood	True	False	Unsure
6.6	Having sex with a virgin	True	False	Unsure
6.7 What other methods have you heard about that can protect one from getting infected (please write here)				

.....
.....

7. I got information about HIV/AIDS from (please tick (√) all those which are true)

No.		No.		No.	
7.1	Television	7.6	Parent	7.11	Church
7.2	Radio	7.7	Friend	7.12	Peer group
7.3	Newspaper	7.8	Other family member	7.13	Community AIDS group
7.4	Magazines	7.9	School		
7.5	Leaflets	7.10	Clinic		
7.14 Other:					
.....					

8. Getting information about HIV/AIDS is easy (Please tick (√) one choice)

True	False	Unsure
------	-------	--------

9. Do you know your HIV/AIDS status? (Please tick (√) one choice)

1.Yes	2.No
-------	------

10. Do you talk about HIV/AIDS with your partner? (Please tick (√) one choice)

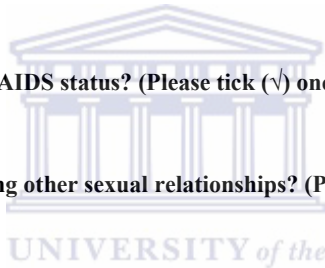
1.Yes	2.No
-------	------

11. Do you know your partner's HIV/AIDS status? (Please tick (√) one choice)

1.Yes	2.No
-------	------

12. Do you think your partner is having other sexual relationships? (Please tick (√) one choice)

1.Yes	2.No
-------	------



ATTITUDE ABOUT HIV/AIDS

13. Do you know someone who told people that he/she has HIV/AIDS? (Please tick (√) one choice)

Yes	No
[if this is your choice, please go to question 14]	[if this is your choice, please go to questions 15]

14. If yes in Q13, how do you treat him or her? (Please tick (√) your answer)

14.1 I avoid him/her because I am not sure how to treat him/her	
14.2 I accept him/her the same way that I accept other people	
14.3 I avoid him/her because I do not want to be associated with HIV infected / AIDS people	
14.4 I avoid him/her because I am afraid of HIV/AIDS people	

15. If no in Q13, Should you know someone who is HIV/AIDS infected in future, how will you treat him or her? (Please tick (√) your answer)

15.1 I will avoid him/her	
15.2 I will accept him/her the same way that I accept other people	
15.3 I will avoid him/her because I do not want to be associated with HIV infected / AIDS people	
15.4 I will avoid him/her because I am afraid of HIV/AIDS people	

16. Do you think you can be infected by HIV? (Please tick (√) one choice)

Yes	No
-----	----

17. Do you think one of your family members can be affected by HIV/AIDS? (Please tick (√) one choice)

Yes	No
-----	----

SEXUAL BEHAVIOUR

18. Have you ever had sex? (Please tick (√) one choice)

<table border="1" style="width: 100%;"> <tr> <td style="width: 50%; padding: 2px;">Yes</td> <td style="width: 50%; padding: 2px;">No</td> </tr> </table> <p style="font-size: small; margin-top: 2px;">[if this is your choice, please go to question 19]</p>	Yes	No	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%; padding: 2px;">No</td> <td style="width: 50%; padding: 2px;"></td> </tr> </table> <p style="font-size: small; margin-top: 2px;">[if this is your choice, please go to questions 31]</p>	No	
Yes	No				
No					

19. If yes in Q18, how old were you when you first had sex? (Please tick (√) one choice)

19.1 Younger than 10 years	
19.2 Between 10 and 15 years	
19.3 Older than 15 years	

20. What was the sex of your partner(s)? (Please tick (√) one choice)

Male	Female	Both
------	--------	------

21. Do you continue having sex since the first time you had it? (Please tick (√) one choice)

Yes	No
-----	----

22. If yes in Q21, how often do you have sex? (Please tick (√) one choice)

Once every week	Once every month	As often as needed
-----------------	------------------	--------------------

23. With how many different partners have you had sex in the last 12 months? (Please tick (√) one choice)

1	2	3	More than 4
---	---	---	-------------

24. How long ago did you last have sex? (Please tick (√) one choice)

Past week	A month ago	A year ago
-----------	-------------	------------

25. The last time you had sex, did you know your partner for more than 7 days? (Please tick (√) one choice)

Yes	No
-----	----

26. The last time you had sex, did you or your partner use anything to prevent pregnancy or prevent getting infected? (Please tick (√) one choice)

Yes	No
-----	----

27. If yes in Q26, what did you or your partner use? (Please tick (√) your answer)

27.1 Condom	27.4 Gel or foam
27.2 Injection	27.5 Withdrawal
27.3 Pill	

28. What are your reasons of having sex? (tick (√) all those which are true)

28.1 Because of natural feelings	28.5 I am forced to do it
28.2 I get paid for it	28.6 I am experimenting
28.3 My friends do it	28.7 It is good for the relationship
28.4 Because adults do it	28.8 My partner wants it
28.9 Other reasons not mentioned above (please write here)	
.....	
.....	

29. How often do you use condoms with your partner(s)? (Please tick (√) one choice)

Never	Seldom	Regularly	Always
-------	--------	-----------	--------

30. If you chose never option in Q29, what are the reasons for not using condoms? Please tick (✓) one choice)

30.1 I don't have condoms		30.4 A condom does not satisfy me	
30.2 My partner does not want to use condoms		30.5. A condom disturbs when having sex	
30.3 I use other preventions			
30.6 Other reasons not mentioned above (please write here)			

31. Do you think it is okay for women to say no to sex? (Please tick (✓) one choice)

1.Yes	2.No
-------	------

32. Do you think it is okay for men to say no to sex? (Please tick (✓) one choice)

1.Yes	2.No
-------	------

SOCIAL FACTORS

33. What are the reasons teenagers have sex?

Please tick (✓) your choice [1=most important, 2=important, 3=less important]

33.1 Parent(s)/guardian(s) don't talk to them	1	2	3
33.2 Because of using alcohol	1	2	3
33.3 Because of using drugs	1	2	3
33.4 Because their friends are having sex	1	2	3
33.5 No proper information about sex is given	1	2	3
33.6 Because they get money for having sex	1	2	3
33.7 Young girls are advised to have sex	1	2	3
33.8 Young boys are advised to have sex	1	2	3
33.9 They are forced to have sex	1	2	3
33.10 Other reasons (please write here)			

34. What problems do teenagers face when wanting information or help at clinics?

.....
.....
.....

35. What problems do teenagers face when wanting information or help from parents?

.....
.....
.....

36. What problems do teenagers face when wanting information or help from teachers?

.....
.....
.....

37. What problems do teenagers face when wanting information or help from other teenagers?

.....
.....
.....

SUGGESTIONS FOR PREVENTION

38. What should be done by parents to prevent risky sexual behaviours among teenagers?

.....
.....
.....

39. What should be done by teachers to prevent risky sexual behaviours among teenagers?

.....
.....
.....

40. What should be done by nurses to prevent risky sexual behaviours among teenagers?

.....
.....
.....

41. What should be done by teenagers to prevent risky sexual behaviours among teenagers?

.....
.....
.....

THANK YOU FOR YOUR TIME

THANK YOU FOR YOUR TIME

