A Primary HIV and AIDS Prevention Intervention with Pre-Adolescent Girls.

Uhlelo oluyisiqalo ekuvikeleni kokugenwa yisandulela ngculazi nengculazi uqobo kumantombazane asakhulayo.

By

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HIV and AIDS Intervention

Abstract

HIV and AIDS present a catastrophic public health threat that is reaching crisis proportions among adolescents and young adults. There is a need to educate pre adolescent female learners before they reach puberty, as females are especially at risk of contracting HIV because of the interplay of biological, economic and cultural factors. This study explored the nature and extent of the pre-adolescent female learner’s knowledge, attitudes and skills regarding HIV and AIDS. An experimental research design, namely, a no-treatment group design with pre test and posttest was applied. An HIV and AIDS prevention intervention programme was designed and implemented. The objectives were to help learners acquire knowledge, attitudes and skills to make informed decisions and practice health promoting behaviours. Life skills, sex and sexuality education and HIV and AIDS as a gendered epidemic were addressed. The science and art of health education was used to frame the intervention and ensured that the learner not only received the correct message but also incorporated it into her repertoire of behaviour. The findings of the study highlighted five critical areas that were vital within an HIV and AIDS education intervention. Firstly, pre adolescent female learners were very interested in sex and sexuality and information on physiological changes during puberty must be disseminated. The issue of morality was attached to sex and sexuality and this reinforced the biopsychosocial and cultural factors that came into play. The importance of peer education was emphasised, as parents were reticent to address these issues. It was found that basic information on all dimensions of HIV and AIDS education was still a powerful tool. It was vital to incorporate more than the ABC messages and look at the social constructs of health promotion and focus on critical thinking and an education for liberation. A manual with a set of guidelines was formulated and presented to educators for use
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with preadolescent female learners. This would help reduce the casualties of HIV and AIDS, as early intervention would protect a vulnerable group in society.
I would like to express my sincere thanks and appreciation to the following people who have in various ways made it possible for me to complete this degree.

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I, Pretha Shah (Student Number: 206001001), declare that this thesis is my own original work and that where use has been made of the work of others, it has been duly acknowledged in the text. This thesis is submitted in partial fulfilment of the degree Doctor of Philosophy (Community Psychology), Faculty of Arts, University of Zululand, KwaZulu-Natal in South Africa.

It has not been submitted before for any degree or examination, or to any other university.

Signature: ___________________________ Date: 15/04/2008
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CHAPTER ONE

INTRODUCTION

Abantu Bayafa – People are dying!

South Africa is caught in the iron grip of the AIDS epidemic. We are a nation at war with the Human Immunodeficiency Virus (HIV). The battle is situated within our communities where it is decimating the lives of our people. At least a third of KwaZulu Natal is believed to have become victims of HIV (Sole, 1999). A survey of 385 University of Durban Westville students' HIV status reveal an infection rate of 23 percent (Govender, 1999). Yet there are many who move about oblivious to the situation created by an alarmingly high incidence of HIV infection in our country.

In spite of the fact that volumes have been written on the subject, there still remains much uncertainty surrounding the silent killer. It is a complex issue with no easy or straightforward answers. HIV cannot be fought in isolation through small community centres, AIDS organisations or government policy. AIDS operates on a much deeper level, affecting every individual whether they are HIV positive or not, because everybody has the potential to become HIV positive. Consequently, everyone is a conscript in this fight against AIDS. This involves the most prominent HIV researchers in the country all the way down to the children of South Africa.

The current AIDS crisis is one that touches on all segments of our society. Regardless of age, gender, race, social class, sexual orientation, culture, belief systems or religion, we all have been forced to confront the reality of this disease. Our challenge, both as individuals and as a society, is to find ways to communicate about AIDS and
the virus that precedes it – the Human Immunodeficiency Virus (HIV). This is particularly true because AIDS has slowly begun to destroy the lives of many young people, particularly women (White, 1999). Two national HIV prevalence surveys in South Africa indicate that the prevalence among women is higher than among men (Department of Health, 2003; Shisana & Simbayi, 2002).

It is the youth who are the fundamental weapons in the war against HIV, more so than the doctors and scientists who diligently seek answers to the AIDS epidemic. Since a vaccine or cure may be still a long way in the future, it is in the hands of youth to stop the spread of the virus today. This study is essentially about the promotion of life skills, well being, sex and AIDS education programmes which need to be fast tracked into the country’s schools and colleges with the intention of educating tomorrow’s leaders about the dangers of HIV; how it is transmitted; and how to prevent infection. Gendering patterns of behaviour, which place the female child at risk of being infected with HIV, need to be exposed and assertiveness training, which allows the female child to take control of her choices, is emphasised.

This thesis is essentially an attempt to understand the pre-adolescent girl in relation to essential features of major psychological theories of development, especially the construction of values, identity, self-concept and the emergence of sexuality. As Leclerc-Madlala (1999, p. 1) states that AIDS is also a “cultural construction” then belief systems, which add meaning to people’s ideologies and myths around HIV and AIDS, will be dealt with. This will influence the way people think about this disease in South Africa and how they respond to it (Asistent, 1991).
1.1. Epidemics are Not Random Events

The Global Programme on AIDS (GPA) is the World Health Organisation’s response to the HIV and AIDS epidemic in the 1980s and 1990s. It is medically and epidemiologically driven and attempts to contain the spread of the epidemic by means of a series of programmes. As this is a sexually transmitted disease, programmes took into account what people know (knowledge), their attitudes and sexual practices. It was soon recognized that what really mattered was what people’s bodies got up to, so a B for behaviour was added to evolve the Knowledge, Attitude, Practice and Behaviour (KAPB) studies (Barnett & Whiteside, 2002). Adding behaviour to the equation moved the focus of concern away from the body to the mind, which controls behaviour.

This opens up a whole new arena of complexities about the origins and the impact of a disease such as HIV and AIDS. The origin of HIV and AIDS lies far back in time and deep within the structures of social, economic and cultural life. The epidemic is not just about medicine or even public health. This is because the pathways of infection are mapped on to social, cultural and economic relations between groups of human beings. As we all share the same world, but unequally, so we are differently exposed to disease organisms, and for that matter to many non-infectious illnesses (Barnett & Whiteside, 2002).

Epidemics do not just happen. They are not random events. They have histories. Histories always depend on how they are told, by whom and for what reason. Histories of infectious disease reflect the ways in which channels and paths of infection have been created as part of the material and cultural lives of societies. HIV
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and AIDS mixes sex, death, fear and disease in ways that can be interpreted to suit the prejudices and agendas of those controlling particular historical narratives in any specific time or place. As Judge Edwin Cameron states in his book, Witness to AIDS, "AIDS is an epidemic enmeshed with sex and death. In Africa the epidemic is enmeshed with the politics of race and sex and death" (Cameron, 2005, p. 75). Fear of infection all too easily translates into fear of the infected. The disease is used to stigmatise various out-groups. Stigmatisation is itself a social process: a feature of social relations, reflecting the tension, conflict, silence, subterfuge and hypocrisy found in every human society and culture. Parker and Aggleton (2003, p. 13) further show that "stigma feeds upon, strengthens and reproduces existing inequalities of class, race, gender and sexuality". While illness and death are the public facets of HIV and AIDS it has more private facets of which people may be ashamed or frightened (Barnett & Whiteside, 2002, p. 66). This leads to the sometimes painful and embarrassing public discussion of sexuality, of sexual practices, of child sexuality, of women's dependence on and therefore vulnerability to men. All these disturbing issues have been exposed to examination as the epidemic has progressed.

Issues of gender and the role of women in society also need to be explored as these issues influence behaviour choices (Patton, 1994; Wilton, 1997). Richardson (1994) highlights some commonalities of women's experiences in relation to the AIDS epidemic and the need to address the issue of relative power in sexual relations. Gender differences play a role in the construction of promiscuity and deviance; many sexual partners are a testament to a man's manhood, whereas women with many sexual partners are regarded as dirty (Shefer, Strebel, Wilson, Shabalala, Simbayi, Ratele, Potgieter, & Andipatin, 2002). According to Preston-Whyte (1999) as cited in Barnett & Whiteside (2002) women are socially positioned and culturally defined to
expect to be fertile and in many societies, to achieve this speedily. Fertility confirms social identity as a woman and also ensures care in old age. Marriage is seen as an investment in the future and in parts of South Africa they say: “Children are what we give iLobolo (bridewealth) for” (Preston-Whyte, 1999, p. 143). Thus at the core of African society is its emphasis on ancestry and descent. While people may want to avoid HIV infection and they may want to defer childbearing and marriage; the pressures of lineage, family, gender roles and short life expectancy may often result in a need for sex now rather that deferred sex and the use of a condom.

Furthermore studies indicate that women are economically, psychologically and socially dependent on men and this directly influences the way AIDS affects women (Ankrah & Long, 1996; Leclerc-Madlala, 1999; Strebel & Lindegger, 1998). Ankrah and Long (1996, p. 390) refer to the “feminisation of poverty” and argue that poverty places women at greater risk of AIDS, since they may feel the pressure to engage in transactional sex in order to survive. Hoosen and Collins (2004) explore another dimension of gender relations, which constructs sex as an expression of romantic love. Women may view sexual behaviour as a means of ensuring men’s pleasure and as an expression of affection and commitment. Sex is seen as most pleasurable for a man when it is penetrative and condomless and in order to satisfy her partner it is implied that she have condomless sex with him (Campbell, 1995; Strebel & Lindegger, 1998; Wood & Foster, 1995). Thus HIV and AIDS prevention intervention programmes must take into account the impact of cultural and societal norms and the pressure this exerts on peoples’ behaviour especially those of women.
1.2. The Importance of Early Programme Intervention

“A nation’s future is only as promising as its next generation of citizens” (Homestead, Nelson Mandela, June 16, 1995, p. 7).

There is no doubt that the AIDS epidemic has significantly changed the nature of childhood. Historically, children living in poorer communities have always assumed adult responsibilities, such as domestic work, childcare and contributing to household income. In households where parents are sick and dying, the burden on children is immense, and South Africa is currently facing an unprecedented growth in the number of child-headed households (Walker, Reid & Cornell, 2004).

Being a child in South Africa does not match the realities of childhood in countries not experiencing the ravages of HIV and AIDS. In South Africa, children are increasingly vulnerable as parents die on an unprecedented scale. Children are more susceptible to HIV infection through violence and abuse (Walker et al., 2004). Measures to protect them are inadequate. Family structures are being stretched to breaking point as they try to absorb the growing number of AIDS orphans.

Within all of this we must take special note of that person, Rabbi Hillel Aviden of the Jewish Congregation, refers to as the “most vulnerable member of our society - the girl child” (Mohanalall, 2006, p. 3) when he spoke at an interfaith gathering highlighting the plight of many young girls. They are not only affected by the social consequences of the epidemic, they are also at risk for being infected with HIV. Girl children are offered no social protection and are vulnerable to rape, child abuse and
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HIV. The only protection society offers her is free abortion, condoms and antiretroviral drugs. Bongi Zengele who represents the African Traditional religious view said that no religion could afford to ignore the “silent screams of abuse victims” (Mohanlall, 2006, p. 3).

The simple fact is this: to defeat HIV and AIDS, we need to reduce the number of people who become infected. Throughout the epidemic, prevention has remained the most effective defense against HIV and AIDS. A comprehensive approach aimed at the youth must be used to prevent the further spread of HIV infection (National HIV Prevention Conference, 2007). The future of too many young people will depend on their ability to avoid contracting HIV. According to An American Agenda (1996) as cited in White (1999, p. 125) “Adolescents need the tools to successfully navigate an increasingly dangerous world...they must be shown the dangers they may encounter and taught negotiation and decision-making skills...and they need to exert personal responsibility to protect both themselves and others from infection”.

AIDS diagnoses however have increased most in the adolescent (13 to 19 year old) and young adult (20 to 24 year old) groups, indicating that the highest rate of HIV transmission occurs among adolescents (Bartlett, Keller, Eckholdt, & Schleifer, 1995). This means that these children must have been infected much earlier in their young lives. This has resulted in young people being rocketed to the forefront of HIV and AIDS prevention campaigns in South Africa. As HIV continues to spread — and neither a vaccine nor cure exists — prevention remains the key strategy for curbing the epidemic. The most common mode of HIV transmission is sexual contact; thus, HIV prevention is closely linked to men’s and women’s sexual behaviour and reproductive health. Effective prevention programmes include interventions that promote
abstaining from sex. Key challenges for the future include controlling further spread of the epidemic in infants and young adults (Ashford, 2006). In order not to close the stable door once the horse has bolted, we need to engage in prevention work with pre-adolescents. They need to be given skills to negotiate safe behaviours and to build a personal value system independent of peer influence. Furthermore, these young people are already located within an institutional framework, namely schools, within which programmes can be implemented (Campbell, 2003).

1.3. South Africa- Present and Future

“There are only two kinds of people in Africa: those infected with HIV and those affected by it” (Orr, 2002, p. 3).

Fear and denial has gripped the people in the face of the HIV and AIDS epidemic. As in the words of Barnett & Whiteside (2002, p. 5) “It is difficult to see what is happening, harder to measure, easiest to deny”. A sad example of the peoples’ hysterical reaction was the murder of AIDS field worker, Gugu Dlamini who was stoned and stabbed to death outside a shebeen in KwaMashu in 1998 after going public with her HIV status (Ollerman, 1999).

AIDS-related deaths are altering the age structure of populations in severely affected countries such as South Africa. As Aids deaths are concentrated in the 25 to 45 year age group, communities with high rates of infection lose disproportionate numbers of parents and experienced workers and create gaps that are difficult for society to fill. Women are more vulnerable than men in some regions, and their deaths rob families
of primary caregivers. According to Ashford (2006) HIV infections are higher among women than among men in sub-Saharan Africa and in the Caribbean, where the virus is predominantly spread through heterosexual contact.

Pretorius (1999) in her article, “HIV and AIDS set to wreak havoc in schools” estimated that 45,000 South African teachers are infected with HIV. Experts warn that there will be a projected shortage of teachers, a decline in effective teaching as more people become ill and a general disruption in schooling as more teachers and learners take time off to care for family members with AIDS.

Households experience the immediate impact of HIV and AIDS, because families are the main caregivers for the sick and suffer AIDS related financial hardships. Health care systems also experience enormous demands as HIV and AIDS spreads. Expenses have been rising for the treatment of AIDS and AIDS-related opportunistic infections. Allocating resources for HIV and AIDS can divert attention from other health concerns and as public funds for health care grow scarce, the costs are increasingly borne by households and individuals.

Business and agriculture have also been seriously affected as loss of workers; absenteeism; the rising costs of health-care benefits; and the payment of death benefits impact on employers. Economic stability is therefore compromised as business and agriculture suffer. It is difficult to account for the loss of human capital as children’s education, nutrition and health suffers directly and indirectly due to AIDS (Pretorius, 1999).
1.4. Traditional belief systems

Our belief systems are the lens through which we view many issues, from daily tasks to fundamental life threatening experiences. Our belief systems are shaped by many factors, including our cultural, religious and ethnic background; our family and personal history; our gender; and our economic circumstances (Green, Zokwe, & Dupree, 1995). Belief systems impact directly on how we understand health and respond to illness. They influence how we make sense of the causes of disease and help us to understand how healing takes place. Some individuals and communities understand disease to be caused by magical and spiritual forces; others draw on scientific reasoning; and many apply both models (Walker et al., 2004).

South African society is characterized by cultural complexity and difference. In explaining, preventing, treating and managing HIV and AIDS in South Africa, different cultures and belief systems have collided. Throughout the world and in South Africa, the biomedical model lies at the heart of most AIDS research, intervention and education programmes. The language of AIDS is the language of western science and policy. All programmes in Africa, whether medical or social have been dominated by the World Health Organisation (WHO), and more recently UNAIDS as well as other western-based Non Governmental Organisations (Walker et al., 2004). According to Van Dyk (2001b) many western-based AIDS education and prevention programmes have failed dismally in Africa and they may succeed if traditional African beliefs and customs are taken into account. This sentiment was echoed by educators conducting a life skills programme in primary schools in KwaZulu-Natal who found it necessary to develop a culturally sensitive approach.
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based on aspects of “Zulu cultural meaning systems” (Walker et al., 2004, p. 91). This was in response to western programmes, which the educators found unhelpful and inappropriate.

The message is clear; we need to look to the world and within our own borders for expert guidance and information on how to handle this epidemic. We then need to shape it to suit our particular South African needs so that our message will be received.

1.5. Rationale for the Study

The Medical Research Council (2002) estimates that 6.5 million people in South Africa are already living with HIV and AIDS. The highest rate of increase, that is 64%, is among teenage girls (Caelers, 1999). Shisana and Simbayi (2002) as cited in Freeman (2004) found that 11.4% of all South Africans below the age of fifteen years were HIV-infected. Whatever the mode of transmission, this percentage translates into a large number of people.

Acquired Immunodeficiency Syndrome (AIDS) presents a new and unique type of challenge to society. With the researcher's roots firmly entrenched in the field of education, the researcher is interested in how HIV and AIDS education can help meet this challenge. In the researcher's masters research, the nature of and extent to which secondary schools included HIV and AIDS education into their curriculum, was researched. Quantitative results reflected that 75 percent of schools surveyed had an AIDS activity and these were all private schools and ex Model C schools. Qualitative results indicated that these activities were occasional, had no specific timetable, were
generally addressed during guidance lessons and were being taught to different grades at different terms (Shah, 2001). The schools that did not implement an AIDS activity cited financial constraints, time constraints, lack of school personnel and just a lack of being aware that schools should implement such a programme as possible reasons for an absence of an AIDS activity.

The results of the above research highlighted the need to develop guidelines for a more age and developmentally appropriate, socially, culturally and gender aware HIV and AIDS education intervention programme aimed at the pre-adolescent female child, which would assist educators in the dissemination of information. Furthermore we need to focus on arming our learners with age-appropriate health promoting knowledge, attitudes and skills early, so that they are prepared for the onslaught of the epidemic (Naran, 2006).

According to Tjelele-Mqaise (2004, p. 60) gender roles are learned at a young age where young men are taught to be assertive and masculine; and young women are expected to be subordinate and submissive. Schools, as institutions which many preadolescents attend, can be used in the dissemination of health promotion information. This was reinforced by the World Health Organisation (1991, p. 53), which has viewed schools as important agencies that can make a valid contribution to reducing the HIV infection rate among the youth.

1.6. Purpose of the Study

The purpose of this study is to explore the nature and extent of the pre-adolescent female child’s knowledge, attitude and skills regarding HIV and AIDS and to
implement a prevention intervention programme especially with pre adolescent girls from urban informal settings. This intervention will help generate guidelines for an HIV and AIDS education intervention programme aimed at pre adolescent girls, which educators can use in their life skills programmes at school. Hoosen and Collins (2004, p. 492) conducted research with a group of women at clinics and a focus group member stated: “People get AIDS because they don’t know, not because you sleep around, because you don’t know”. This emphasizes the need for the HIV and AIDS education of a vulnerable population group. Pre-adolescent girls will be empowered with knowledge regarding their sexuality and HIV and AIDS information so that they can make informed decisions. A healthy attitude towards people living with AIDS will be fostered and pre-adolescent girls will be skilled in assertiveness training and in adopting risk-free behaviour. Guidelines will be created which educators can use within the life skills education programme.

1.7. Objectives of the Study

The objectives of the study are:

- To ascertain the extent and nature of pre-adolescent girls’ knowledge, attitudes and behaviour regarding HIV and AIDS.
- To plan and implement a primary HIV and AIDS prevention intervention programme aimed at empowering pre-adolescent girls.
- To evaluate the impact of an HIV and AIDS prevention intervention programme on pre-adolescent girls’ knowledge, attitudes and behaviour regarding HIV and AIDS.
- To create guidelines to assist educators in implementing an HIV and AIDS intervention programme with pre-adolescent girls.
1.8. Value of the study

This study provides baseline data on the extent and nature of pre-adolescent girls’ knowledge, attitude and skills regarding HIV and AIDS. The intervention programme aims to increase the pre-adolescent girls’ knowledge about the nature of HIV and AIDS, its modes of transmission and how to practice healthy behaviours so as to prevent infection. Attitudes favouring empathy and respect towards people with HIV and AIDS will also be encouraged within the intervention programme. Life skills focusing on positive body image; the acceptance of bodily changes that occur during puberty; the role of gender and how it influences our decisions; and the use of critical thinking skills to analyse complex situations that require decisions in a variety of situations will be highlighted. This will empower the pre-adolescent girl with age appropriate HIV and AIDS knowledge, skills and health promoting attitudes.

Information elicited from exploring the objectives of this research would serve to create guidelines for an educational response to the high rates of adolescent HIV infection and has the potential to add to literature, nationally and internationally, aimed at educating the preadolescent female child.

The value of the study is highlighted when we take into account that gender surveys, especially in South Africa and other developing countries, place the female child at greater risk than the male child (Naran, 2006).
1.9. Research Methodology

An experimental research design, in particular, a No-Treatment Group Design with pre test and post test was implemented. This was a powerful design in terms of controlling the threats to internal validity (Mantell, Di Vittis, & Auerbach, 1997). The greater Durban area caters to the educational needs of many learners from the urban informal settlements. Two primary schools in the Ethekwini Region, district of Umlazi, Mayville ward were randomly selected. Variables such as age of children, gender, demographics of the school and knowledge of HIV and AIDS information disseminated by the schools were matched. All the girls in Grade five were selected. A pre test questionnaire was firstly administered to a group of girls from a third school to ensure its easy administration and to iron out any difficulties. The questionnaire was then administered to the two schools. The schools were randomly assigned as control and experimental groups. The experimental group received an educational intervention. This consisted of four, one and a half hour-long sessions over two weeks. Sessional evaluations of three sessions were conducted. In the fourth session, an overall evaluation was administered. Following the intervention, the pre test questionnaire was readministered to both the experimental and the control groups.

1.10. Presentation of Content

Chapter One serves as an introduction to the study. This chapter has outlined the context within which the study has taken place and has provided the rationale for, and the purpose of the study. The value of the study concerning the dire need to educate the pre-adolescent girl with health promoting knowledge, attitudes and skills has also been explored.
Chapter Two reviews the literature around HIV and AIDS education; national and international prevention programmes; the role of the school, family and community in health promotion; and the South African Government’s HIV and AIDS school programmes. All this has been reviewed within a larger framework, which explores theories of child development that focus on sexuality and pre-adolescent girls; and the role of gender and the extent to which it may influence health-promoting behaviours. Literature on traditional African beliefs and customs regarding illness and its impact on people’s conceptualisation of the HIV and AIDS epidemic has been reviewed. The psychological and social dimensions of AIDS in Africa cannot be fully understood and appreciated without an exploration of this topic.

Chapter Three presents the theoretical framework and methodology of this research. Theories of health promotion and their relation to preventive AIDS education have been reviewed. Details relating to the methodological process of the study will be presented in this chapter.

Chapter Four provides an analysis of both quantitative and qualitative data captured from the pre and post test questionnaires and the intervention programme. A discussion of the results of the study follows.

Chapter Five presents the findings, limitations, recommendations and conclusions.

Chapter Six consists of guidelines that educators can use for an HIV and AIDS prevention intervention programme with pre-adolescent girls.
Chapter 2

Review of Relevant Literature

2.1. HIV and AIDS - A Biopsychosocial Phenomenon

The purpose of this study is to design and implement an HIV and AIDS prevention intervention programme with pre adolescent girls and draw a set of guidelines which educators can use when planning programmes in schools. While we need to incorporate appropriate knowledge, important attitudes and relevant skills within the programme, cognizance is taken of the separate yet sometimes overlapping areas of biological, psychological, social and cultural/spiritual influences on the development of the pre-adolescent female child (Bronfenbrenner, 1970). These areas shape the pre adolescent girls' concept of self and others and are an important facet in the concept of well being. This thesis, which explores how educators can best impart health-promoting behaviours, essentially looks across disciplines and focuses on conscientization while disseminating information and providing the opportunity for critical reflection on socio-cultural assumptions about gender and behaviour and the impact of traditional belief systems (Leclerc-Madlala, 1999).

Add to this cauldron of influences, a disease that has been described as

...a behaviourally transmitted disease. AIDS is an immune system disease.
AIDS is a social disease. AIDS is a disease affecting the neurological functions. AIDS is a disease of the brain. AIDS is a disease the prevention and transmission of which is affected by culture. All of these are true. AIDS is an excellent example of a biopsychosocial phenomenon, since it probably
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involves mutual interactions of the neural, immune and endocrine systems, and all of these with behaviour, in a socio-cultural context. If one were asked to invent a disease that was more fascinating, more perplexing, more challenging scientifically, socially, ethically and legally than AIDS, one would be hard put to do so. (Mays, Albee, & Schneider, 1989, p. 351).

One can then begin to understand that the preadolescent female child is faced with a new and unique type of challenge in the journey towards adulthood. The onus, therefore, is on society and the institutions of society to assist the female child on her perilous journey. Schools, as institutions of society, can aid in this responsibility. The challenge for educators is to provide foundational answers to guide the child. This would involve understanding the clinical nature of HIV and AIDS; major theories of childhood development; the role and impact of gender on childhood development; our belief systems and how they influence our behaviours; and education as a strategy for effective change.

2.2. HIV and AIDS: Origin and Nature of the Disease

The first recognized cases of Acquired Immune Deficiency Syndrome (AIDS) occurred in the United States of America in 1981 (Granich, & Mermin, 1999; Van Dyk, 2001). A very rare form of pneumonia and Karposi’s sarcoma suddenly appeared simultaneously in several patients. These patients had a number of characteristics in common: they were all young homosexual men with compromised immune systems (Adler, 1988 as cited in Van Dyk, 2001a). Soon afterwards, a new disease that undermined the immune system and caused diarrhoea and weight loss was identified in central Africa in heterosexual people. According to Van Dyk
(2001a) it was only in 1983 that it was discovered that a virus that was eventually named Human Immunodeficiency Virus (HIV) in May 1986 caused the disease.

There are many far-fetched theories about the origin of AIDS. These range from a belief that the virus was developed as an instrument of biological warfare to a view that the virus is being used by aliens from outer space to kill people of planet Earth! A more sober view, now generally accepted by scientists, is that HIV crossed the species barrier from primates to humans at some time during the twentieth century (Barnett & Whiteside, 2002; Evian, 2003; Korber, 2000 as cited in Van Dyk, 2001a). HIV is related to a virus called SIV (simian immunodeficiency virus), which is found in primates such as chimpanzees and African green monkeys. The virus probably crossed from primates to humans when contaminated animal blood entered open lesions on the hands of humans who were butchering SIV infected animals for food (Barnett & Whiteside, 2002; Van Dyk, 2001a). Many factors such as migration, improved transportation and multiple sexual partners ultimately caused the virus to spread all over the world.

AIDS is the acronym for Acquired Immune Deficiency Syndrome. This disease is acquired, as it is not inherited. It is caused by the human immunodeficiency virus (HIV), which is a member of a family of viruses known as Retroviruses that are uniformly fatal. Immunity refers to the body’s natural inherent ability to defend itself against infection and disease. Deficiency refers to the fact that the body’s immune system has been weakened so that it can no longer defend itself against passing infections. A syndrome is a medical term, which refers to a set or collection of specific signs and symptoms that occur together and that are characteristic of a particular pathological condition (Evian, 2003; Van Dyk, 2001a).
There are a number of stages through which infected person will pass. Immediately after infection, there is a period during which the person is infected and infective, but does not have sufficient antibodies for the virus to be detectable through laboratory testing. This period is known as the seroconversion phase. This is followed by the latent phase during which the virus is detectable. The person is healthy but infective, and the virus is replicating and beginning its attack on the immune system. This is followed by the onset of the disease, possibly initially through AIDS-related complexes (ARC) and then full blown AIDS, ending in death.

Both seroconversion time and the latent phase vary from one infected individual to the next. According to Whiteside (1990), seroconversion time can range from six weeks to 15 months. The mean seroconversion time is put at three months. The latent period – the time from HIV positivity to full-blown AIDS can range from one week to 15 years, and possibly longer (Evian, 2003; Whiteside, 1990).

While the progress of the disease is being recorded in the developed world, unfortunately, the methodology used and the lessons learnt cannot readily be applied in Southern Africa. The reason for this is that the pattern of the epidemic is very different in the West. According to Whiteside (1990) there are four distinct patterns that have been identified. Pattern I is the variety prevalent in the West, Pattern II in Africa and Pattern III in Asia. Latin America has a combination of Patterns I and II.

The key features of Pattern I that is prevalent in the West are:

1. It began to spread mainly from the late 1970’s to the early 1980’s.
2. Most cases are in homosexual / bisexual men and intravenous drug users, with a few instances of heterosexual transmission.

3. The male:female ratio is 10:1 thus paediatric AIDS is uncommon.

4. Other transmission routes are uncommon.

5. The level of HIV infection is low.

Pattern II AIDS is the epidemiological pattern found in Africa. Here, key features are:

1. It began to spread in the late 1970’s and early 1980’s.

2. Most cases are among heterosexual men and women.

3. Transmission via contaminated blood and blood products remains significant in many countries.

4. National prevalence of HIV infection can exceed one percent and in some urban areas up to 25 percent of those aged 15-49 years (Sato as cited in Whiteside, 1990).

HIV infection is transmitted primarily through sexual intercourse, when HIV infected blood is passed directly into the body of another person, or when a mother infects her baby during pregnancy, childbirth or as a result of breastfeeding. It is also transmitted through intravenous drug use with contaminated needles. HIV has been identified in various body fluids but is especially highly concentrated in blood, semen and vaginal fluids. Although HIV is present in saliva, tears, sweat and urine, the concentration of the virus in these fluids is very low (Blake, 1990). HIV is therefore transmitted through sexual activity (anal, vaginal or oral sex); through contact with infected blood in the presence of broken skin; and from an infected mother to her baby (Islamic Medical Association of South Africa, 2001).
2.3. International HIV and AIDS Statistics

According to the World Population Data Sheet (2006), world population has reached 6.6 billion in 2006, up from 6 billion in 1999, and is heading toward 8 billion by 2025. Ninety-nine percent of this growth will be in developing countries. Even accounting for AIDS-related mortality, sub-Saharan Africa’s population is projected from 767 million in 2006 to 1.7 billion in 2050.

Since AIDS was first identified less than three decades ago, the pandemic is one of the most destructive health crises of modern times, ravaging families and communities throughout the world. By 2005, more than 25 million people worldwide had died and an estimated 39 million were living with HIV. An estimated 4 million people were newly infected with HIV in 2005 – 95 percent of them in Sub-Saharan Africa, Eastern Europe or Asia. The number of people infected (Table 2.1) and the effects on their families, communities and countries are staggering (Ashford 2006; Center for Disease Control, n.d; UNAIDS, 2006).
Table 2.1.

<table>
<thead>
<tr>
<th>Region</th>
<th>% of adults with HIV and AIDS</th>
<th>Number of Adults and children living with HIV and AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>1.0</td>
<td>38,600,000</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>6.1</td>
<td>24,500,000</td>
</tr>
<tr>
<td>Caribbean</td>
<td>1.6</td>
<td>330,000</td>
</tr>
<tr>
<td>Eastern Europe/Central Asia</td>
<td>0.8</td>
<td>1,500,000</td>
</tr>
<tr>
<td>North America</td>
<td>0.6</td>
<td>1,300,000</td>
</tr>
<tr>
<td>South/Southeast Asia</td>
<td>0.6</td>
<td>7,600,000</td>
</tr>
<tr>
<td>Latin America</td>
<td>0.5</td>
<td>1,600,000</td>
</tr>
<tr>
<td>Oceania</td>
<td>0.3</td>
<td>78,000</td>
</tr>
<tr>
<td>Western/Central Europe</td>
<td>0.3</td>
<td>720,000</td>
</tr>
<tr>
<td>North Africa/Middle East</td>
<td>0.2</td>
<td>440,000</td>
</tr>
<tr>
<td>East Asia</td>
<td>0.1</td>
<td>680,000</td>
</tr>
</tbody>
</table>


In recent years, national representative surveys have enabled researchers to lower the previously published HIV prevalence estimates for some countries (Ashford, 2006). According to Haub (2006a) globally, HIV and AIDS prevalence is lower than previously estimated. Not so long ago, many wondered if the population of Africa would be "wiped out" by the HIV and AIDS epidemic. As serious as the situation was and is, those doomsday projections were unwarranted. Part of this understandable
confusion resulted from a lack of solid information on the spread of the disease. That, in turn, resulted from a virtually complete lack of vital statistics such as births and deaths.

Much of the early research on AIDS was carried out at testing sites which were often called "sentinel" sites, and that is indeed what they were - a type of early warning system (Barnett & Whiteside, 2002; Haub, 2006b). These sites and clients included pregnant women coming to prenatal clinics and patients coming to clinics for treatment for sexually transmitted diseases. One advantage of sentinel sites is the inexpensive testing that can be conducted regularly as part of routine medical care. Sentinel site data presented a significant statistical problem. In most countries, groups that had been tested were not representative of the total population. Such groups might have an urban "bias" in that testing might have been done in urban centres. The government of the Indian state of Tamil Nadu, for example, has pointed out that, since about 40 percent of pregnant women use private hospitals, testing only in government hospitals may overstate HIV prevalence in the state (Haub, 2006a).

While vital statistics are still largely absent in many countries, these sentinel sites resulted in many more fragmentary pieces of evidence that now allowed for more reliable measurements. Since 2001 a new source of information and data on HIV prevalence levels has become available for a growing number of countries: demographic and health surveys (DHS) with nationally representative samples. On average, the DHS figures were about 20 percent below UNAIDS sentinel site-based estimates. According to Haub (2006a) with this new data comes new controversy: The HIV and AIDS situation in Africa may not be as serious as once thought. However, just as earlier fears were an overreaction, this revelation may lead to an under
reaction, but prevalence remains catastrophically high in many countries such as 24 percent in Botswana and 20 percent in Zimbabwe (Haub, 2006a).

Figure 2.1.

National Infection rates for HIV in 2005. No data are available for areas coloured white.


According to Kondwani and Caesar (2003), all indicators show that the numbers of new HIV infections are increasing and that the Southern African Development Community (SADC) region is the epicenter of the epidemic (see Figure 2.1). By 2001, approximately 28 million, or seventy eight percent, of almost 40 million people living with HIV and AIDS globally were living in Sub-Saharan Africa alone. In 2000, AIDS was the leading cause of death in Africa – seventeen times higher than the average global rate. Nine of the twelve SADC member states contain populations of which more than ten percent of adults between the ages of fifteen and forty-nine were
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living with HIV and AIDS at the end of 2001. In three of these countries, at least one in every three adults is purported to be living with HIV or AIDS, while in a further four countries at least one-fifth of all adults were HIV positive (Kondwani & Caesar, 2003).

Some of the inter-linking factors that facilitated the creation of this scenario are that the HIV strain in the SADC region is said to be more infectious and more deadly; there is a high prevalence of sexually transmitted infections with irregular health-seeking behaviour; lack of access to medical and educational infrastructure; almost total absence of universal access to treatment and care, including effective and accessible treatment of opportunistic infections; high levels of gender-based violence; social, cultural and legal practices that place women in an unequal position in society and thus increases their exposure to HIV and AIDS; absence of a comprehensive human rights approach and strategy; high mobility and varied patterns of migration; and high levels of politically motivated conflict and violence for at least the last twenty years in individual countries within the region (Kondwani & Caesar, 2003). Thus a combination of pre-existing social, cultural, legal, economic and political conditions provided fertile ground for the spread of HIV and set the stage for a full-scale epidemic.

2.4. Prevalence and Projections of HIV and AIDS in South Africa

South African society is susceptible to the spread of HIV and vulnerable to its impact and is said to have more people living with HIV than any other country (Walker, Reid, & Cornell, 2004). South Africa has the highest rates of infection as compared to other African countries to the north amongst people aged between 15 to 44 years old.
In the first major household survey on HIV prevalence, the Nelson Mandela/Human Science Research Council HIV and AIDS study (Shisana & Simbayi, 2002) found that 11.4% of all South Africans (over two years of age) were infected. The provinces with the highest prevalence were Free State (14.9%), Gauteng (14.7%), Mpumalanga (14.1%) and KwaZulu-Natal followed with 11.7%. The locality with the highest number of HIV infected people was urban informal settings (28.4% of adults aged 15 to 49 years). People living in farms and tribal areas were least infected (11.3% and 12.4% respectively).

In 2000, it was estimated that there were 2.5 million HIV positive women aged 15-49 and 2.2 million HIV positive men aged 15-49 in South Africa. Recent projections of HIV infected individuals indicate that these figures could reach 7.5 million by 2010. This represents a fifth of the population (Walker et al., 2004). In the period 2000 and 2010 between four and seven million South Africans may die of AIDS related illnesses. The number of AIDS deaths will be much larger than the number of those due to any other causes.

A very high proportion of the South African population is under the age of 20 years. This amounts to eighteen million people or 44% of the population. According to Mjele (2002) it has been estimated that there are at least 4.2 million people infected with HIV in South Africa. At least 1800 people are infected with HIV everyday and half of the daily infection rate is reported to be young people between the ages of 15 to 25 years and large numbers of these are young women. Eaton, Flisher, and Aaro (2003) reported that in 1998, HIV infection rates among South Africans aged between 14-19 years and 20-24 years were 21.0% and 26.1% respectively. It has been found that young people are having sex earlier and unplanned teenage pregnancies and the
rates of sexually transmitted diseases are increasing. This is highlighted when teenage pregnancies accounted for one-third of all live births in South Africa in 1995 (Walker et al., 2004).

By 2005, most Africans will die before they reach their 48th birthday. The World Health Organisation (WHO), estimates that by 2010 life expectancy in South Africa will be 43 years. This is seventeen years less than it would have been before the epidemic (Walker et al., 2004).

HIV and AIDS therefore has the potential to have a devastating effect on social, economic and human development in South Africa. Young people are a vulnerable group in terms of access to education, employment, housing and health. They are also particularly vulnerable to HIV infection (especially young girls). The culture of crime and violence also affects young people with a significant proportion of sexual abuse occurring among adolescents. According to police crime statistics, between January and December 2000, 13 540 children under 17 years of age were raped, 7 899 of whom were under the age of eleven (Walker et al., 2004).

There is no doubt that the AIDS epidemic has significantly changed the nature of childhood. Historically, children living in poorer communities have always assumed adult responsibilities, such as domestic work, childcare and contributing to household income. In households where parents are sick and dying, the burden on children is immense, and South Africa is currently facing an unprecedented growth in the number of child-headed households (Walker et al., 2004).
2.5. Theoretical Perspectives on Child Development

Scientists propose theories so that they can better comprehend what they have learned and to impose at least a degree of order on related types of information. Theories perform two valuable functions: They organize and give meaning to facts, and they guide research. Ideally a theory should be logical and supply clear definitions. It should make specific predictions about behaviour that are publicly verifiable. Finally, a theory of development should call attention to changes in types of behaviour that occur as a child develops. There are many theories of development and while these have made it possible to organize facts and have guided research, none of them meet the criteria for an ideal theory (Baldwin, 1980).

Theories call attention to the overall sequence, continuity and interrelatedness of aspects of development, but typically account for only limited facets of behaviour. Texts organized in terms of age levels make the reader aware of varied aspects of children's behaviour at a given age but sometimes tend to obscure how particular types of behaviour emerge and change. Although texts organized according to types of behaviour do not have the limitation of age-level approach, they may make it difficult for the reader to grasp the overall pattern of behaviour at a particular stage of development (Erikson, 1963).

According to Walker et al. (2004), childhood spans the years from six to puberty. This is a critical stage for children to develop intellectually, socially and physically. It is a time when they should be encouraged to experience childhood fully and be allowed to encounter their environment free of adult responsibility. Pre-adolescence is the period
of childhood just before the onset of puberty (The American Heritage Dictionary, 2003) and it is often designated as between the ages of 10 years and 12 years in girls and 11 years and 13 years in boys. Adolescence is a turbulent time, when young people develop a sense of their own identity as distinct from their parents. It is also a time of engaging with and making sense of the world around them. It is a time of social and sexual experimentation. The boundaries between the different age groups are of course fluid and context-specific. In South Africa, the definition of childhood has always been unclear. Children and young people have been at the forefront of political struggle and conditions of extreme poverty have resulted in children assuming adult responsibilities.

According to the Erikson (1968, p.100) the developmental span of children is divided into five levels, corresponding to common grade groupings in schools: preschool (three to six years), primary grades (one, two, and three; six to nine years), elementary grades (four, five and six, nine to twelve years), junior high (seven, eight and nine; twelve to fifteen years) and senior high (ten, eleven and twelve, fifteen to eighteen years). It is important for an educator to be aware of the physical, social, emotional and cognitive behaviour of children at each level, to help establish a general conception of children.

A logical first step for educators planning an intervention programme is to take into account what students are like and how much they know. According to Erikson (1963) the term entering behaviour is sometimes used to refer to the characteristics and knowledge that students possess at the beginning of a sequence of instruction. Within human development it is necessary to trace how each type of behaviour changes as a child matures.
For the purpose of this study, the researcher will focus on the development of female children in the elementary grades (four, five and six) nine to twelve years. A growth spurt occurs in most girls and the onset of puberty is heralded. The average age of puberty for girls in the United States is eleven (Erikson, 1963); the range is eight to eighteen years. The average age of onset of puberty has shown a trend towards earlier occurrence (Moore & Rosenthal, 1993) and this is thought to be due to improvements in nutrition and living conditions. On the average, girls between the ages of ten and fourteen are taller and heavier than boys of the same age. As children approach puberty, concern and curiosity about sex are almost universal, especially among girls. Since sexual maturation involves drastic biological and psychological adjustments, children are concerned and curious.

The peer group becomes powerful and begins to replace adults as the major source of behaviour standards and recognition of achievement. The development of interpersonal reasoning leads to greater understanding of the feelings of others. According to Schell (1975) interpersonal reasoning is the ability to understand the relationship between motives and behaviour among a group of people. Children gradually grasp the fact that a person’s overt actions and words do not always reflect inner feelings. Towards the end of this phase, children become capable of taking a somewhat detached and analytical view of their own behaviour and the behaviour of others. This permits them to understand the expectations of themselves and of others in a variety of situations as if they were spectators. In addition, a societal perspective begins to develop where actions are judged by how they might influence all individuals not just those who are immediately concerned. Conflict between the group code and adult rules may cause difficulty, including juvenile delinquency. Behaviour
A brief survey of the theories of some of the most reputable theorists in the field of personality and identity development reveals that widely divergent views exist on this matter, not only concerning the structure of personality, but also with regard to the factors that determine the development of personality (Gouws & Kruger, 1994). Some theorists concentrate on biogenetic factors (Stanley Hall and Sigmund Freud) while others regard social influences (Margaret Mead), the organism and self-perception (Carl Rogers) or interpersonal relationships (Harry Sullivan) as the principal determinants of personality development. Robert Havighurst and Erik Erikson regard identity acquisition as the central task of adolescence. What the educator must understand is that the personality of the individual develops as a result of the interaction between heredity and environment (Gouws & Kruger, 1994). Thus the individual can be assisted by exposure to suitable experiences that are likely to positively influence personality development. From this perspective it is necessary to take note of a wide variety of theories and those areas that would give foundational answers to guide the child to knowledge.

The two most important psychoanalytic theories of development are those of Sigmund Freud and Erik Erikson. Erik Erikson (1902-1994) bases his description of personality development on the *epigenetic principle*. In foetal development, certain organs of the body appear at certain specified times and eventually “combine” to form a child. Erikson hypothesizes that just as parts of the body develop in interrelated ways in a human foetus, so the personality of an individual forms as the ego progresses through a series of interrelated stages. All these ego stages exist in the beginning in some
form, but each has a critical period of development. In Erikson’s view, personality development is a series of turning points, which grows out of successful resolution of dichotomies of desirable qualities and dangers (Miller, 1983; Baldwin, 1980). The pre-adolescent child is at the stage that Erikson describes as Industry versus Inferiority (six to eleven years). The goal at this stage is the development of ego identity. The danger at this stage is role confusion, particularly doubt about sexual and occupational identity. If adolescents succeed in integrating roles in different situations to the point of experiencing continuity in their perception of self, identity develops. If they unable to establish a sense of stability in various aspects of their lives, role confusion results.

According to behaviour-learning theories (B.F Skinner, Albert Bandura) behaviour is primarily learned in the following ways: classical conditioning which takes place when a response which has been linked with one stimulus is associated with a new stimulus; operant conditioning where the person plays an active role; and observational learning or modelling where people learn behaviour by observing the behaviour of others (Gouws & Kruger, 1994).

The conception of intellectual development according to the cognitive theory of development (Jean Piaget) postulates that human beings inherit two basic tendencies: organisation (the tendency to systematize and combine processes into coherent general systems) and adaptation (the tendency to adjust to the environment) (Piaget, 1963; Schell, 1975). For Piaget, these tendencies govern both physiological functioning and mental functioning. The organizational capacity of the child makes thinking processes efficient and powerful and allows for a better fit or adaptation of the individual to the environment. Schemes are organized patterns of behaviour or
thought that children formulate as they interact with the environment. When a child encounters a new experience that does not easily fit into an existing scheme, adaptation is necessary.

Adaptation is the process of creating a good fit or match between one’s conception of reality (one’s schemes) and the real life experiences one encounters. Adaptation is accomplished by two sub-processes: assimilation and accommodation. A child may adapt either by interpreting the experience so that it does fit an existing scheme (assimilation) or by changing an existing scheme to incorporate the experience (accommodation). It must be noted that the concepts of organization, adaptation and schemes are all related. One more basic principle of Piaget’s theory refers to equilibration, which is the tendency to construct schemes that allow better understanding of experiences. Children are always thinking and learning and this allows them to reconcile new knowledge and experiences with the schemes they currently have for understanding and interacting with the world.

Criticism of Piaget’s theory highlights that he underestimated children’s abilities, not only because of stringent criteria he imposed for inferring the presence of particular cognitive abilities, but also because the tasks he used were often complex and far removed from children’s real life experiences. Within the last decade researchers have focused more on what preoperational children can do and their results suggest that preschooler’s cognitive abilities are more advanced in some areas than Piaget’s work suggested (Gelman & Baillargeon, 1983).
2.5.1. Piaget and Kohlberg: Moral development

A general concept underlying all major theories of development is that certain types of behaviours and relationships may be of special significance at different age levels (Erikson, 1963). At the pre-adolescent and adolescent level the search is primarily for a sense of identity. Classroom discussions on sex roles, changes in attitude regarding masculinity and femininity and family responsibilities, and for girls to be more achievement oriented assist in reducing identity problems.

The various ways, in which people come to think, act and feel morally depend partly on developmental changes in their cognitive understanding (Schell, 1975). According to Piaget there are changes in the interpretation of rules according to age. Four to seven year olds learning the game of marbles, view rules as interesting examples of the social behaviour of older children. They do not understand them but try to go along with them. Seven to ten year olds regard rules as sacred pronouncements handed down by older children or adults. At about the age of eleven or twelve, children begin to see rules as agreements reached by mutual consent. Piaget concludes that younger children see rules as absolute and external. After the age of eleven, children become increasingly capable of grasping why rules are necessary. At this point, Piaget concludes that, they tend to lose interest in adult imposed regulations and take delight in formulating their own variations of rules to fit a particular situation.
Piaget (1952a) refers to the moral thinking of children up to the age of ten or so as the morality of constraint and the thinking of children of eleven and older as the morality of co-operation.

Morality of constraint: The child holds a single, absolute moral perspective (behaviour is right or wrong). They believe rules are unchangeable. They determine the extent of guilt by the amount of damage. They define moral wrongness in terms of what is forbidden or punished. They believe that punishment should stress atonement and does not need to fit the crime. They believe that an external authority should punish peer aggression. They believe that children should obey because those in authority establish the rules.

Morality of co-operation: They are aware of different viewpoints regarding rules and believe that rules are flexible. They consider the wrongdoer’s intentions when evaluating guilt. They define moral wrongness in terms of violation of spirit of co-operation. They believe that punishment should involve either restitution or suffering the same fate as one’s victim. They believe that children should obey rules because of mutual concern for the rights of others.

Lawrence Kohlberg elaborated Piaget’s ideas of types of moral thinking. According to Biehler and Hudson (1986) Kohlberg’s six stages of moral reasoning are:

Level one: Preconventional Morality – typical of children up to the age of nine. (called preconventional because young children do not really understand the conventions or rules of a society)
Stage one: Punishment — obedience orientation where the physical consequences of an action determine goodness and badness. Those in authority have superior power and should be obeyed. Punishment should be avoided by staying out of trouble.

Stage two: Instrumental relativist orientation where obeying laws should involve an even exchange and should bring some sort of benefit in return.

Level two: Conventional Morality — typical of nine to twenty year olds.

Stage three: Good boy – Nice girl orientation, The right action is the one that would be carried out by someone whose behaviour is likely to please or impress others.

Stage four: Law and order orientation where in order to maintain the social order, fixed rules must be established and obeyed. It is essential to respect authority.

Level three: Postconventional morality— the moral principles that underlie the conventions of a society are understood.

Stage five: Social contract orientation – Rules that are needed to maintain the social order should be based, not on blind obedience to authority, but on mutual agreement. At the same time, the rights of the individual should be protected.

Stage six: Universal Ethical Principle Orientation – Moral decisions should be made in terms of self-chosen ethical principles which should be applied in consistent ways.

Erikson, 1963; Gouws and Kruger, 1994; Lickona, 1976 and Schell, 1975 reviewed the similarities and differences between Piaget and Kohlberg. They reported that the first four of Kohlberg’s stages are roughly equivalent to moral realism as described by Piaget. Kohlberg’s preconventional and conventional moral thinkers and Piaget’s moral realists all tend to think of rules as edicts handed down by external authority. The postconventional thinker of Kohlberg shares some similarities with the older children observed by Piaget: rules are established by individuals who come to mutual
agreement, and each moral decision is made by taking into account special circumstances (Biehler & Hudson, 1986).

While there are similarities in the conclusions drawn by Piaget and Kohlberg, there are important differences. Piaget believes that moral thinking changes as children mature. He does not, however, believe that the changes are clearly related to specific ages, nor are they considered to be sequential. Piaget feels that the different types of moral thinking often overlap. Kohlberg, by contrast, maintains that the order of the stages he has described is universal and fixed and that a person moves through the stages in sequence. Not everyone reaches the top stages, but all individuals begin in stage one and work their way up (Biehler & Hudson, 1986).

Another difference concerns the acceleration of moral reasoning. Piaget believes that the children in the preoperational and concrete operational stages cannot be helped to understand the logic behind moral relativism until the elements of formal operational schemes have begun to form. Kohlberg, on the other hand, believes that the progress through his six stages can be accelerated with the proper type of instruction.

In contrast with Kohlberg's view that moral reasoning and judgment is cross-culturally universal, researchers such as Gielen and Markoulis (1994) and Huebner and Garrod (1991) as cited in Ferns and Thom (2001) hold the viewpoint that the stages of moral development and the nature of morality are determined by social, cultural and historical factors and may therefore differ cross-culturally. Based on his analysis of research on moral development, Hoffman (1980) feels that although Kohlberg's sequence of stages may not be true of every individual in every culture; it may provide a useful general description of how moral reasoning develops in
American society. Research on Kohlberg’s view that moral development can be accelerated has produced some limited but moderately positive results. Most of these studies have used a teaching method known as direct discussion or dilemma discussion. After reading a set of moral dilemmas and identifying those issues that could help resolve the dilemma, students, under the teacher’s guidance, discuss the different ways each of them chose to resolve the dilemma. This can involve challenging one another’s thinking, reexamining assumptions, building lines of argument and responding to counter arguments.

Kohlberg’s theory has been criticized for reflecting a male bias. Gilligan (1982) describes three aspects of Kohlberg’s work that make it susceptible to the charge of gender bias: the six stages were derived from a longitudinal study of eighty four boys; the moral dilemmas that are used to assess the level of moral development revolve around the concepts of justice, fairness and the preservation of human rights; and these concepts are reflected most strongly in the postconventional level of morality. Gilligan (1982) argues that because females are socialized to focus more on understanding, helping and co-operating with others than on preserving individual rights and because this orientation is reflected most strongly in the two conventional stages, they are more likely than males to be judged as deficient in moral development. Gilligan (1982) also argued that when females are faced with their own real life moral dilemmas (abortion, civil rights, environmental pollution) they are more likely to favour a caring/helping/co-operation orientation than a justice/fairness/individual rights orientation.

Piaget’s description of cognitive development and Kohlberg’s theory of moral development shed light on the results of an exhaustive series of studies of morality.
supervised by Hugh Hartshorne and Mark May (1929, 1930a, 1930b). This study intended to explore whether moral thinking leads to moral behaviour. They observed thousands of children at different age levels reacting in situations that revealed their actual moral behaviour. They discovered that many children who were able to describe right kinds of behaviour in hypothetical situations indulged in wrong behaviour in real life situations. Another significant, and dismaying discovery by Hartshorne and May was that children who went to Sunday school or belonged to the scouts were just as dishonest as children who were not exposed to moral instruction (Biehler & Hudson, 1986). Hartshorne and May (1929, 1930a, 1930b) however concluded that one of the reasons for this was that stress was placed on children to memorise moral platitudes. They suggested that it would be more effective to invite children to discuss real life moral situations as they occurred.

After reviewing research carried out in the last forty-five years since Hartshorne and May published their findings, Lickona (1976a, p.15) reports that “a huge and ever expanding body of research...has replicated Hartshorne and May’s basic finding: variations in the situation produce variations in moral behaviour”. Lickona adds that recent research also supports another of Hartshorne and May’s conclusions: some children are more integrated or consistent than others in reacting to moral situations. It would be a mistake therefore to assume that there is no consistency in moral thinking and behaviour. If that hypothesis is endorsed, there would be little reason to assume that a child develops any kind of personal code of ethics or that parents and teachers should try to promote the development of a strong conscience in children. Piaget’s description of cognitive development and Kohlberg’s description of moral reasoning development help explain some of Hartshorne and May’s conclusions. Elementary school children are in the concrete operational stage. They think in terms of actual
experiences and treat situations that look different in different ways. As many of these youngsters are at Kohlberg's third stage, their moral behaviour is influenced by their eagerness to please or impress others. Thus the inability of elementary grade children to comprehend and apply general principles in varied situations and their desire to do what they think will please or impress authority figures may explain, in part, the ineffectiveness of moral instruction that stresses the memorisation of abstract principles.

Hartshorne and May (1930a, p. 413) therefore recommend that educators promote discussions of actual situations in detail so that children who found themselves in similar situations would recognize commonalities and be helped to choose a desirable course of action. Hersh, Paolitto and Reimer (1979) recommend to educators the following procedures for implementing what they refer to as developmental moral education: to recognize that younger children will respond to moral conflicts differently to older children; to stimulate perspective taking abilities of children; to develop awareness of moral issues by using a variety of real and hypothetical moral dilemmas to heighten moral awareness; and to create an atmosphere that will enhance open discussion, foster listening and communication skills and encourage student to student interaction.

2.5.2. The Development of Adolescent Identity and Self-Concept

The concept of identity is described as "...a sense of psychosocial well-being.... a feeling of being at home in one's body, a sense of knowing where one is going and an inner assuredness of anticipated recognition from those who count" (Erikson, 1968, p. 155).
Erikson (1963) suggests that adolescence is a critical period in development because new identifications are no longer characterized by the playfulness of childhood. The adolescent is forced into choices and decisions that will lead to commitments for life. Beliefs about appropriate sex role behaviour are one area where changes are affecting identity formation. Erikson believes that sex roles are particularly important in the development of identity because they establish a pattern for many types of behaviours. The role of women in society today is changing. They are likely to feel more in charge of their destiny than their mothers did when they were the same age (Rokeach, 1973 as cited in Biehler & Hudson, 1986). Change in social values is gradual and this can create confusion and problems especially for the adolescent who is trying to develop a clear sense of what it means to be a male or female in our society.

According to Louw and Edwards (1994), the self or identity is essentially social in nature, since it is a social construction formed in and through interaction with others. It is the human capacity for reflexivity (being conscious of ourselves as objects) that forms the basis for the notion of self. Reflexivity has two aspects: being conscious of self; and being conscious of others being conscious of self. It is through reflections that we construct: ideas, images and beliefs (cognitions); feelings and emotions such as self-esteem (affects); and intentions and desires (conative components) about ourselves.

The self or identity does not develop or exist in a vacuum. It is generally accepted that identities are embedded within wider frameworks. Hornuth (1990, p. 3) terms this "the ecology of self; in other words, the self is not separate, free-floating or
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disembodied, but exists in interdependence with its ecology of others, objects and environments”. We are both, authors of scripts as well as central actors.

Rosenberg (1979) suggests three main components: the extant self (how people see themselves); the desired self (how people would like to see themselves); and the presenting self (how people present their identities to others). We may define attitudes as an inner state that has to be inferred from external behaviour; it is learned or acquired; it is a relatively stable, enduring disposition of the individual and it evaluates matters or objects from positive to negative (Louw & Edwards, 1994).

Burns (1979, p. 3) as cited in Gerdes (1988) defines self-concept “as a composite image of what we think we are, what we think we can achieve, what we think others think of us and what we would like to be”. Aspects of self-concept include the physical self-concept, the intellectual self-concept, the psychological self-concept, the social self-concept, the moral self-concept and the gender self-concept. During adolescence, the self-concept is increasingly measured against the standards of peers who become a major influence.

2.5.3. The Development of Adolescent Sexuality

“If you’re not talking to your child about sex, who is?” (Love Life, 2004, p. 7).

Sexual socialization is the process of becoming sexual, of taking on a gender identity, learning sex roles, understanding sexual behaviour and generally acquiring the knowledge, skills and dispositions that allow a person to function sexually in a given culture (Lerner & Spanier, 1980, p. 289 as cited in Moore and Rosenthal, 1993, p. 34).
The girl child makes sense of herself as a sexual being from the interaction between her physical and psychological realities and the messages she takes in from her family and from society. Sexual socialization reaches an important phase in adolescence, as hormonal balances change, genitals develop to their adult form, bodily functions alter and new feelings are experienced.

In terms of sexual development, it would appear that children’s first sensory experience that might be defined as “sexual” might be the pleasure derived from nursing at the mother’s breast. Considerable anecdotal evidence suggests that infants and children are capable of experiencing pleasure from sensory and tactile stimulation of their genitals very early in life (Daniluk, 1998). Normal sexual development for children, then, appears to include “autostimulation and self-exploration, kissing, hugging, peeking, touching and/or exposing genitals to other children and perhaps simulating intercourse” (Gil & Johnson, 1993, p. 42 as cited in Daniluk, 1998).

A number of biological and physical changes occur during puberty that marks a girls’ physical and sexual maturation. They may begin as early as nine years old and are generally complete for most girls by the age of sixteen. Increases in hormone production and the physical changes of puberty signal another significant biological transition in the lives of adolescent girls. Menarch, the onset of menstruation, marks a mature stage in the development of the uterus and endocrine system. Whether or not they are emotionally ready to cope with these changes, based on their genetic predispositions and unique life circumstances at puberty, adolescent girls are faced with adapting to bodies that are significantly altered from their child-like amorphous states (Daniluk, 1998).
In terms of psychological development, there is very little literature specifically addressing the sexual development of children or the problems experienced by children as they attempt to understand and make sense of their feelings and experiences (Daniluk, 1998). Freud’s theory of psychosexual development in 1948 is the only theory that attends explicitly to the developing sexual self-structure of the child. The primary contention of the psychodynamic theory is that sexual instincts, in terms of the pleasure principle, are the driving force motivating all human behaviour from birth until death. Freud linked the sexual development of the child with her psychosocial development. He posited that the first five years of life are a time of considerable sexual upheaval where children form attitudes about physical pleasure and what constitutes appropriate masculinity and femininity. Freud conceptualized a period of sexual latency where the child’s struggle with sexual pleasure and possession are replaced with an interest in the development of interpersonal relationships and the mastery of practical life skills.

Many of Freud’s theorizing has been soundly criticized. However, most developmental theorists agree that puberty is a critical time period for girls in terms of their increasing physical and psychological maturity and the evolution of a cohesive self-structure (Daniluk, 1998).

It is important to note that based on gender-role socialization, girls and women may be particularly sensitive to the attitudes of others in the development of sexual meanings and self-constructions (Belenky, Clinchy, Goldberger, & Tarule, 1986; Hare-Mustin & Marecek, 1990; Kaschak, 1992 as cited in Daniluk, 1998). They contend that young girl-children develop greater relational acuity and heightened sensitivity to the opinions and feelings of others. This sensitivity may play itself out in
the way desires; needs and preferences are experienced and acted upon throughout life. It will also influence the development of girls' sexual selves and their emerging sexual meanings.

In a discussion of the development of sexuality in adolescence, Miller and Simon (1980) point out that puberty, a biological event, causes adolescents to function as self-motivated sexual actors, which is a social event. In addition, the young person may be further confused because “the sex education of the adolescent is emphatically attached to moral education” (Biehler & Hudson, 1986, p. 544). Miller and Simon (1980) believe this is the case because gender role expectations establish attitudes towards sexual morality. Even though they may endorse the traditional view that premarital sex is wrong, however the youth are motivated to engage in such relationships. They may feel that they are expected to have early sexual experience and to develop a high level of competence. Jessor and Jessor (1975) as cited in Biehler and Hudson (1986) point out that the youth may be motivated to have sexual relations as early as possible because of one or more of these reasons: to prove to themselves that they have achieved a mature status, to establish a sense of independence, to affirm sexual identity, to gain support for the belief that they are attractive to others, to reject social conventions or behave in a socially unacceptable manner, and to gain respect from peers. These factors explain why premarital sex may seem appealing to adolescents and youth, even when they partially endorse the view that such an activity is morally wrong.

According to Harrison, Xaba, Kunene and Ntuli (2001) while our understanding of adolescent sexual relationships, partnering practices and specific behaviours related to HIV and AIDS risk, remains limited, it is important to focus on issues related to
sexuality and attitudes regarding gender issues and how this feeds into the HIV and AIDS epidemic. With regards to the importance of sex education, Biehler and Hudson (1986), report that since half of all teenage pregnancies occur during the first six months of sexual activity, sex education needs to target younger girls if they are to be effective.

A few years ago, a song by hip-hop group Salt-n-Pepa called “Let’s talk about sex” was popular. This song generated a maelstrom of controversy, for it was perceived as pro-sex, pro-condoms, and thus too dangerous for teenage listeners (White, 1999). Public response among many adults was negative. The fact that the song appeared to give advice to its listeners, and to encourage discussion, was apparently troubling. This controversy does show that as a society we might be of at least two minds when it comes to talking about sex and sexuality. There is the presumption that someone is to be responsible for educating young men and women and the most likely parties (parents, mentors, teachers and public figures) are made uncomfortable by the task. According to White (1999), while parents, adult role models, mentors and caretakers provide the framework in which children are to develop; many other social factors influence the attitudes and behaviours of youth. Peer groups are one source of socialization along with family, school, religious institutions and so on. The way teens and preteens teach each other about sex and AIDS would affect how they subsequently behave. Young people who seek group acceptance and approval are more willing to behave in ways that they think reflect their peer’s behaviours. They are also more likely to reject behaviours that are identified with unpopular groups (White, 1999). Self-image and esteem influence how susceptible a young woman will be to peer pressure.
Sexuality is at the core of human identity and personhood and is intimately linked to gender and is often shaped by gender driven expectations and norms (Harrison et al., 2001).

2.6. HIV and AIDS - A Gendered Epidemic

In the HIV and AIDS epidemic, gender - defined as the array of societal beliefs, norms, customs and practices that define “masculine” and “feminine” attributes and behaviours - plays an integral role in determining an individual’s vulnerability to infection, his or her ability to access care, support or treatment, and the ability to cope when infected or affected (WHO, 2003). Gender determines to a great extent how we think, how we feel and what we believe we can and cannot do as women and men. Gender norms that create an unequal balance of power between women and men are deeply rooted in the socio-cultural context of each society and are enforced by that society’s institutions, such as school, workplaces, families and health systems (Wingood & Di Clemente, 2000).

There has been a strong argument, especially from the United States and United Kingdom, that central to considerations of AIDS as a problem, must be an understanding of sexuality and gender (Farmer, 1992; Strebel, 1993). Gender relations are based on differential relations of power in which patriarchy exerts substantial control over women in a variety of spheres. Feminists have suggested that an alternative response to the threat of AIDS would be the need to change the power dynamics between men and women towards greater equality and more female-centred notions of sexuality (Berer & Ray, 1993).
As adolescents attempt to define themselves as sexual beings, the degree to which they take on the prescribed roles of their gender or peer group may play a significant part in defining their risk acts and condom use. Sex or gender roles are characteristics, behaviours and interests defined by a society or culture as appropriate for each sex. Society’s rules or scripts pertaining to appropriate role behaviour including sexual behaviour therefore affect adolescents, (O’Leary & Jemmot, 1995). The playing out of such gender identities and roles will influence the resolution of questions concerning sexual activity and contraception use.

Sexual behaviour and decision-making are therefore individualized, personal processes that are affected by social forces (Parker & Gagnon, 1995). White (1999) highlights a concern that teenage sexuality and/or AIDS infrequently includes an analysis of the role sex plays within a given range of options. He posits that by defining sex as a private behaviour that occurs behind closed doors, the various social factors that underlie sexual behaviour may be overlooked. Since sex involves more than biological drive, studying sexual behaviour must always include how one is socialized to be a sexual being and how this socialization is manifested in decisions and action. Suddenly sex and risk assume different meanings.

Parents play an important part in instilling values about sexuality in their children (Daniluk, 1996; Moore & Rosenthal, 1993). Certainly, most parents do not intentionally set out to make their daughters feel shame or discomfort related to their bodies, or guilt about their developing sexuality. However parents are a product of their social worlds and are also limited by the inadequacy of language, repressive cultural norms and the paradoxical messages that characterize much of the social communication related to the sexuality and sexual expression of girls and women.
There is a shift at adolescence with peers becoming more important in forming teenagers' beliefs and regulating their behaviour. Media images can also be very influential in informing the girl child about gender-role appropriate behaviours and expectations (Gil & Johnson, 1993 as cited in Daniluk, 1996). Social institutions such as schools, religious groups and the law, have broad frameworks for defining what is deviant or normal adolescent sexuality (Moore & Rosenthal, 1993).

In this connection, it has been suggested (Rivers & Aggleton, 2001) that adolescents are socialized to believe that prescribed sex role behaviours for women includes passivity, feigning sexual naivété, disinterest and denial of sexual activity and a reluctance to make requests about protected intercourse. The traditional sex role stereotype is for the man to be the hunter and initiator of sexual activity, the one with the more powerful and demanding sex drive, and the powerful one in the relationship. While dominant ideologies of femininity promote ignorance, innocence and virginity, dominant versions of masculinity encourage young men to seek sexual experience with a variety of partners (Rivers & Aggleton, 2001).

Developing sexuality occurs in a culture replete with mixed messages about its acceptability. It has been suggested by Fine (1988) as cited in Moore and Rosenthal (1993) that four themes dominate the public and private discourse about sexuality and these provide conflicting messages about how adolescents should conduct their sex lives. The themes revolve around morality and responsibility, desire, danger and victimization. The discourse of morality focuses on the moral reprehensibility of sex before marriage. Inherent in this discourse is the underlying message that if intercourse is wrong, then planning for it is wrong. The discourse of desire is Fine’s second theme, one that is portrayed in the media but is often ignored in parents’ or
schools’ or churches’ responses to young peoples sexuality. The discourse of danger as the possibility of pregnancy, the emotional pain of abandonment and the social disgrace of loss of reputation is more frequently communicated to girls. Finally the discourse of victimization portrays the power balance in sexual encounters as residing with men. Hence women are potential victims and must be protected by parents and society. Conflicts between these four discourses lead to confusion for teenagers about the appropriate way to act. Sexual development therefore occurs against a backdrop of forces that are in a constant state of flux (Moore & Rosenthal, 1993).

Hoosen and Collins (2004) highlight the need for future AIDS programmes to challenge practices that disempower women, to include men as committed partners who are willing to share the responsibilities of decision making and child rearing and to take into account how women and men relate to each other. This will facilitate better communication since it is primarily women who are trying to influence and change men’s behaviour.

Strebel (1993) stresses the importance of effectively addressing gender imbalances that exist which is demonstrated in the dilemma of AIDS being seen as a women’s responsibility, although women lack the power and means to implement safe sex. Peltzer (2003) in his study with rural adults in South Africa reinforces the need for women to be empowered with skills to negotiate the means to ensure safer sex

The impact of HIV and AIDS on the lives of women is one of the most critical reproductive health concerns of our times. In sub-Saharan Africa, where the epidemic has spread to the general population mainly through sexual contact, women make up 59 percent of adults living with HIV. Young women ages 15 to 24 years in that region
are two to six times as likely to be infected as young men (Ashford, 2006; Women’s Net, 2007). Women are especially at risk of contracting HIV because of the interplay of biological, economic and cultural factors. Powerlessness, dependence and poverty tend to diminish women’s ability to negotiate when or with whom to have sex or whether to use a condom. As most women are of childbearing age, they risk infecting their children and thus face difficult choices about childbearing. As caregivers, women are usually caring for the ill and children orphaned by AIDS. All these factors make the empowerment of women a critical component of programmes aiming to curb the epidemic and mitigate its consequences (Ashford, 2006).

The risk of becoming infected with HIV during unprotected vaginal intercourse is two to four times higher for women than it is for men (Van Dyk, 2001a). According to Barnett & Whiteside (2002) infection rates in African teenage girls are over five times higher than in African teenage boys. One of the reasons why women are more susceptible to HIV infection than men is that women as recipients of semen are exposed to semen for a longer time. Furthermore, there may also be higher concentration of HIV present in semen than in vaginal fluids, transmission to women is more likely. Women also possess a larger surface area of mucosa (the thin lining of the vagina and cervix), which is exposed to their partner’s secretions during sexual intercourse. Transmission of HIV is also more likely to occur just before, during or immediately after menstruation because of the large, raw area of the inner uterine lining that is exposed (Evian, 2000 as cited in Van Dyk, 2001a). Younger women are especially vulnerable to HIV infection because their genital tracts are not yet fully mature, their vaginal secretions are not so copious, and because they are more prone to vaginal mucosa lacerations (UNICEF, 2007). Rape, rough sex, previous genital mutilation and anal sex can cause tearing and bleeding and this further increases the
risk of HIV transmission. Apart from their biological vulnerability, women can also be vulnerable in societies, which accord women a lower status. This means that in sexual relationships women may not have the authority to express or enforce their needs. They are not in a position to negotiate safer sex practices because they fear violence and abandonment should they try to do so. Sometimes poverty drives women to prostitution as a means to survive (Barnett & Whiteside, 2002; UNICEF, 2007). Rape and coerced sex is common (Van Dyk, 2001a).

The HIV and AIDS epidemic reflects unequal gender relations or gender power imbalances (Kondwani & Caesar, 2003). It is for this reason that effective management of the epidemic also depends on mainstreaming gender analysis in the understanding of determinants and also in the response to the epidemic. One of the ways of decreasing women’s vulnerability to HIV and AIDS and addressing the fundamental aspects of gender inequality is by increasing access to education for girls. Schools and education systems have the opportunity to reach children and young people early; when they are still uninfected. They can provide prevention education and support activities that reduce overall vulnerability to HIV and AIDS, such as focusing on girls and addressing young people who use drugs. Education can influence behaviour change by imparting knowledge and life skills. Education systems are also important to mitigate the impact by ensuring that the curriculum is re-oriented so as to address HIV and AIDS-related issues and prevent a loss of skills and knowledge they may need in the future (HIV and AIDS, Schools and Education: Global Strategy Framework, February, 2002 as cited in Kondwani & Caesar, 2003). Thus the promotion of life skills among young people, together with parental involvement, would empower young people with sexual and reproductive health information long before they are sexually active.
2.7. HIV and AIDS – Impact on Adolescents

According to Bartlett, Keller, Eckholdt and Schleifer (1995) HIV and AIDS poses a catastrophic public health threat that is reaching crisis proportions among young people. Aids diagnoses increase most between the adolescent (13 to 19 years old) and young adult (20 to 24 years old) groups. This indicates that the highest rate of HIV transmission occurs among adolescents (Apelgren, 2006; Peters, 2006; UNICEF, 2007). This has resulted in young people being rocketed to the forefront of HIV and AIDS prevention campaigns in South Africa.

Age intersects with gender in determining the distribution of power in any society; therefore younger members of a society typically have less power than older individuals and younger men or boys. Moreover the power imbalance characteristic of gender relations has many of its roots in adolescence (Weiss & Whelan, 2002).

Apelgren (2006) and Collins and Stadler (2001) indicate that the age of onset of sexual activity is decreasing, with a large portion of the population becoming sexually active at thirteen or fourteen years of age. Walker et al., (2004) purport that sexual initiation is occurring at a much younger age. In a study of rural areas in the Eastern Cape, some 22% of young respondents had had sexual intercourse at or below the age of 11 (Lemba, 2002). According to Lemba (2002) children’s first sexual contact starts as early as eight years of age. More young people are having sex now than in the past and there are often extreme age differences between the initiated and the initiator. Older male relatives, family friends and men in positions of power and influence, such as teachers, often sexually abuse young women. The girls face an increased risk
of HIV exposure because of the unequal power relations between them and the fact that older men may have a greater sexual network (Campbell, 2003).

Exposure to HIV occurs through personal behaviour, including intimate sexual contact and shared-needle injection drug use (Premdev, 2007). In South Africa, research shows that the use of glue, paint thinners and alcohol is common among street children (Jansen, Richter & Griesel, 1991 as cited in Parry & Abdool Karim, 1999). Drug use and alcohol use have also been associated with risk taking behaviours, including sexual behaviours (Premdev, 2007). According to Macdonald (1987) as cited in Bartlett et al. (1995), sexually active adolescents are more likely to resort to alcohol and/or drug use than sexually inactive ones. This may contribute to their failure to take proper precautions, such as using condoms. These behaviours, which play a critical role in the transmission of HIV, commonly begin during adolescence (Kandel, 1982 as cited in Bartlett et al., 1995). They report that adolescents have been reported to become sexually active at an average age of 13 years. Zabin and Clark (1981) as cited in Bartlett et al. (1995) report that the onset of sexual intercourse usually precedes contraceptive use by at least one year. During that time sexual activity tends to be sporadic and protection inadequate or nonexistent. Only about twenty five percent of sexually active adolescents in their study used condoms correctly and regularly, despite knowing how AIDS is transmitted. This reveals a high rate of unsafe heterosexual behaviours among adolescents and Bartlett et al. (1995) suggest that abstinence and/or safe sexual practices must be fostered through programmes targeting adolescents.

Cognizance must also be taken of the economic context of adolescent sexuality where sex is exchanged for gifts (Campbell, 2003) and the young women’s ability to
negotiate condom use then becomes limited. Adverse economic conditions affect young people’s capacity to deal with the threat of sexual ill health in a range of complex and indirect ways, and not simply through the commercialisation of sexual encounters. However, a recent newspaper article by Saneka, Zondo and Leclerc-Mdlalala (2007, p. 22) reports that “our pet explanation that economic desperation causes HIV and AIDS” is woefully inadequate. They state that in South Africa, it would seem that while some women are economically desperate, others want luxuries that range from lotions to cellular phones, are dissatisfied with their husband’s performance or are seeking revenge for a partner’s infidelity.

Inappropriate beliefs or myths about sexuality and AIDS can, in part, explain why young sexually active people engage in risky behaviour. One of these we may refer to as the “trusting to love” myth (Moore & Rosenthal, 1993). Many young people justify their non-use of condoms because their current relationship is monogamous and promises to be long-term. Trust becomes a significant element in making decisions about using condoms.

Another myth focuses on the belief that they may be invulnerable to the risks and hazards that befall other people. Also, that you can tell by looking whether or not people are infected with HIV and AIDS. Whatever the basis for their misconception, it is vital that adolescents learn to look beneath the external packaging to the realities of transmission of HIV.

Many adolescents are unreceptive to AIDS education because they are immature and unable to see the consequences of their actions; feel embarrassed and fear peer
rejection; deny and dismiss risky behaviours and generally mistrust and disregard adults’ advice (Rodrick-Athans & Peshotan Bhavnagri, 1997).

Shocking statistics released by KwaZulu-Natal Childline reveal that not only have sexual offences among children increased, but that children as young as six are involved in sexual activity which leads them to committing child on child sexual offences (Naidu & Sookha, 2006). Director of Childline in KwaZulu-Natal, Linda Dabicharan reports that 65 percent of children monitored by Childline are found to be committing sexual offences (Naidu & Sookha, 2006). This has increased the high number of children contracting HIV and girl children are more sensitive than boys, so even when there is no actual penetration during sexual intercourse, they can contract HIV as the skin around the vagina ruptures or tears and bodily fluid is exchanged. One of the contributing factors for this behaviour could be the easy access of pornography via cellular phones, which normalizes inappropriate sexual behaviour, and children repeat what they have seen. According to Naidu & Sookha (2006) children have to be taught about sex, condoms and HIV from a young age as they are in direct contact with it.

University of Natal academics, Robert Morrell and Lebo Moletsane presented a paper on research at schools at the University of London’s Conference on Gender and the Politics of Education (Goodenough, 2001). They report that the girls’ knowledge of HIV and AIDS was set in a powerful context of their first-hand experience of rape and sexual assault. This once again highlighted the plight of the female child.
2.8. HIV Prevention Intervention Approaches with Female Adolescents

Prevention programmes to reduce adolescents’ risk of HIV infection have benefited from earlier research on interventions to reduce cigarette smoking, alcohol use, substance abuse and teenage pregnancy (O Leary & Jemmot, 1995). These programmes demonstrated that prevention efforts can change adolescents’ behaviour (Dryfoos, 1990 as cited in O Leary & Jemmot, 1995) and provided guidelines to identify critical programme components. Successful programmes have concentrated on providing access to accurate information, personalising this information to motivate change, providing training in behavioural skills so that these decisions can be implemented in real-life situations, and reinforcing and rehearsing these skills to build confidence and enhance self-esteem.

In a review of literature on interventions it was noted that a prevention programme by Rotheram-Borus, Koopman, Haigene and Davies (1991b) as cited in O Leary and Jemmot (1995) was effective in targeting change in high-risk sexual behaviour with adolescents from two shelters in New York. The effectiveness of the programme was positively correlated with the number of intervention sessions the adolescents attended and the promotion of increased skills in negotiation, the generation of problem solving alternatives and the use of condoms.

O’ Leary and Jemmot (1995) in their study of inner-city African American adolescents revealed that adolescents who were exposed to a social cognitive intervention registered greater behavioural change than those adolescents who were exposed to knowledge or health promotion only.
2.9. Education to Liberate

The tenets of Paulo Freire’s “education for liberation” as a base for HIV and AIDS education offers us a possibility of creating more culturally sensitive, effective and sustainable AIDS interventions (Leclerc-Madlala, 1999, p. 236). Freire identified three stages of consciousness that may be of particular relevance to the challenge of AIDS education. These include: the naïve, the mythological and the critical. According to Freire, the naïve and mythological stages embody fantasies and distortions from which people need to be liberated in order to participate fully as critical and conscious members of society. Education would need to incorporate critical reflection on the part of learners. This can be likened to Crosby’s (1996) notion of initial dissonance, which assists learners in moving from apathy and complacency towards conscious and critical decision-making behaviours.

By redefining AIDS education as a consciousness-raising endeavour, AIDS prevention intervention programmes can be used to develop an awareness of where one’s self concept, issues of gendered behaviour, sexuality and HIV and AIDS come from. Learners could be assisted to develop the necessary skills to initiate action that may give different meanings and directions to their lives (Leclerc-Madlala, 1999). Leclerc-Madlala (1999) therefore argues that desocialisation and resocialisation need to be a part of HIV and AIDS interventions in South Africa.

2.9.1. Education as a vaccine against AIDS

President Thabo Mbeki, in an address to the nation on World AIDS Day, 1 December 1999 stated:
"There can be no talks of an African Renaissance, if AIDS is at the door of our continent. When the history of our time is written, let it record the collective efforts our societies responding to a threat that put the future of entire nations in the balance. Let future generations judge us on the adequacy of our response" (Fox, 2002, p. 285).

As South Africans we need to respond to the onslaught of HIV and AIDS. According to the WHO (1991; 2003) the first most fundamental source of power for individuals in society is access to information, education and skills. There is, however, a growing body of literature revealing the limitations of such individualistic approaches in HIV and AIDS management (Campbell, 2003; MacPhail, 1998). Without effective vaccines and interventions to curtail the virus’s spread many additional persons will become infected, thus Baptiste, Bhana, Petersen, McKay, Voisin, Bell and Martinez (2006) report that prevention especially among adolescents and young adults has to be prioritized. We must give women and men basic information about their bodies, sexuality, disease and reproduction. Access to information is vital for individuals to protect themselves in the HIV and AIDS epidemic and more importantly, it is a basic human right.

Griffiths (1987); Peters, 2006; Piot and Seck (2001); UNAIDS (2001); UNICEF (2007) and Visser (1996) highlight the importance of the role of behavioural and educational programmes in tackling the spread of HIV. Educational programmes that consist solely of providing people with information about the means to reduce AIDS exposure risk, assume that this information can be readily put into practice. At times, this assumption is accurate. Some individuals seem able to modify their own behaviour quite easily and reduce high-risk practices with little outside assistance.
However, information alone may be insufficient to promote meaningful change in risk behaviour especially when that behaviour is immediately reinforcing, when it is well established and when negative consequences of the activity are temporarily distant or uncertain. As sex is a powerful motive and because sexual practices are maintained by past experiences, immediacy of gratification, reinforcement by fantasies, and often, interpersonal influence or coercion, one would suspect that sexual activities are relatively difficult to change through the provision of information alone (Kelly & St Lawrence, 1998; LeClerc-Madlala, 1998; MacPhail, 1998; Valdiserri 1989; White, 1999).

In terms of HIV and AIDS general knowledge, transmission and prevention information; young people know about the connection between AIDS and death but they do not personalise this knowledge to perceive themselves as high-risk (DiClemente, Zorn, & Temoshok, 1986; Strebel, 1993). There is a growing belief that knowledge about HIV is no longer related to risk-taking behaviour and that HIV prevention programmes are not likely to produce greater reductions in risk-taking behaviour unless they do substantially more than increase knowledge (DiClemente & Peterson, 1994). Kuhn, Steinberg and Mathews (1994) in their HIV and AIDS intervention programme with students in South Africa found that while there was improved knowledge and a change in attitudes towards people with AIDS, there was low belief in self risk and an insignificant move towards changing personal behaviour. MacPhail and Campbell (1999) argue that HIV prevention programmes will succeed or fail in changing peoples’ lives to the extent that they increase levels of perceived self-efficacy amongst target groupings. That is, the greater control people have over the important aspects of their lives, the greater likelihood there is that they will adopt health-promoting behaviours.
However, it would be premature to conclude that knowledge had no impact whatever on behaviour (Bartlett et al., 1995). They suggest that the influence of HIV and AIDS related knowledge on behaviour is greater when it is available before the development of the risk behaviour. Thus, offering such knowledge in the early years of school should be considered an essential component of any HIV and AIDS prevention strategy.

Amer-Hirsch (1989) and Batty (1987) stressed direct contact when disseminating information on HIV and AIDS by someone who was qualified to answer questions. Teenagers do not want detailed information about the virus; they want to know what it means to them. According to Keller (1991) as cited in Bartlett et al. (1995, p. 86), while passive education (including the use of pamphlets, didactic instruction, news media) may increase the level of AIDS-specific knowledge, the desired change in risk behaviours as a result of this increased knowledge has not occurred. The reason they put forth is that adolescents fail to personalize that knowledge. In a program that was more personalized and based on the individual subjects’ reported behaviours where subjects were asked to comment on their actions and predict potential consequences, a change in behaviour was reported in a six month follow up interview. The decline in sexual risk behaviour is encouraging. Bartlett et al. (1995) therefore conclude that, since behavioural change in adolescents is time-limited, ongoing personal intervention offered at six-month intervals is recommended.

Programmes must also provide the opportunity for members to renegotiate their sexual and social identities at the collective level. That is, sexual behaviour is more likely to occur through the influence of peers than through conscious rational choices.
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made by individuals in isolation. Programmes must also promote the development of community contexts that support the sexual behaviour changes that HIV programmes seek to bring about. That is the context of the community and the message of the programmes must be in sync for the programmes to be effective. This point of view is reinforced in the review of current HIV programmes, which are more participatory and emphasise community led peer education and group discussions (Batty, 1987; MacPhail & Campbell, 1999; Piot & Seck, 2001). Asthana and Oostvogels (1996) in their study in Madras, India, and Rodrick-Athans and Peshotan Bhavnagri (1997) in their study in Michigan, also recognise the importance of the role of community participation, social and economic determinants of HIV for the success of HIV programmes.

According to Piot and Seck (2001) and Svenson (2000) there exists enormous experience, skills, wisdom and know-how in the area of peer education. Peer education is one of the most popular methods of HIV prevention in the world. However, this involves a partnership between young people and adults where each retain their identity. It doesn't involve young people as tokens to endorse adult agendas or programmes. The idea is not to develop little messengers but to enable and empower young people to take responsibility for themselves and their communities.

Adolescent years provide a window of opportunity to bring about changes in levels of knowledge, attitudes and behaviours before they are fully formed. In order for HIV and AIDS interventions to use this window of opportunity to reduce young people's vulnerability to HIV and address their needs within this epidemic – it is critical not only to ensure that boys and girls get accurate information and skills but that
intervention also helps them develop more equitable and respectful gender norms of behaviour (UNICEF, 2007; WHO, 2003).

Knowledge about HIV and AIDS has been investigated in both preadolescent and adolescent populations. Fassler, McQueen, Duncan and Copeland (1990) as cited in Bartlett et al. (1995) conducted research with Vermont schoolchildren and reported that by the fourth and fifth grade they were fairly knowledgeable about HIV and AIDS although misconceptions persisted. This finding was reinforced by Bartlett et al. (1995) in their study of inner city, New York, preadolescent children.

According to Siame (1998) there are many reasons why working with young people is of such special importance: the school-age population accounts for over 30 percent of the people in Sub-Saharan Africa; they are vulnerable to HIV and suffer from the experience of HIV and AIDS; they are young, optimistic and hopeful; they are at a period of sexual awakening, learning and experimentation; and most important, they are the window of hope for the future.

A study conducted by Burkholder, Harlow and Washkwich (1999) found that adolescents who have had classroom education regarding HIV and AIDS; know people with HIV and AIDS; and who have open communication with their families tend to be better informed about AIDS information. White (1999) argues that behaviour change requires more than providing information. For information to result in transformative behaviour, a young woman needs a reliable source for facts, a social network that supports behaviour change and strong problem-solving skills. Preteens and teenagers need educational initiatives that improve their HIV and AIDS prevention skills. They need a knowledge base to deal with prevention-related
decisions, and they need the skills to resist peer pressure. As inequality, racism, sexism and class-related phenomena collectively affect sexual behaviour, it seems logical to require their elimination in order to fight HIV infection among teenagers. Then they can effectively translate knowledge into safe behaviours (Capaldi, Stoolmiller, Clark, & Owen, 2002).

Kelly (1999) in his paper for presentation to the Sub-Saharan Africa conference on education for all, stated that education can generate hope because of its potential to work at the three levels where AIDS-related interventions are needed: by providing knowledge and skills that will inform self-protection while there is as yet no protection; by strengthening the ability to cope with personal and or family protection; and by helping to cope with grief and loss when AIDS has brought death. Kelly (1999) also proposes that the formal education system integrate sexual health and HIV and AIDS education into the curriculum for all levels and that a fourth “R” be introduced, namely relationships with oneself and with others. This implies that schools in an AIDS-infected world cannot be the same as schools in an AIDS-free world.

When faced with the argument that sexual health and HIV education promotes promiscuity, the UNAIDS (1999b) study reports that sexual education is more effective when it occurs before puberty and that programmes need to be sensitive to the different requirements of boys and girls.

2.9.2. Creating a Receptive School Environment for HIV and AIDS Education

Educational resources are usually understood to be material things with a monetary value. However when we look at HIV and AIDS and sex education, they should also
be conceptualized as the lives and identities of learners (Pattman, 2006). Educators can tap into the rich potential of learners by developing appropriate teaching materials and pedagogies. Gender and sexuality emerge as key categories through which boys and girls define themselves and others, yet sexuality is also reported as a topic, which is rarely discussed with adults including educators. HIV and AIDS education as a subject on the school curriculum may be resisted not only by reluctant educators but also by other adults in the community, notably parents. While this may be a difficult task, parents need to be persuaded about the importance of HIV and AIDS and life skills education for their children. The emphasis of these programmes would not be to promote sex but to empower young people and help them to protect themselves (Pattman, 2006).

Education has been described in Southern Africa as a vaccine against AIDS (Coombe & Kelly, 2000) because of the coincidence between lower rates of HIV infection and higher levels of educational participation. This vaccine is less available to girls than boys, with girls, in sub-Saharan Africa, tending to drop out of school earlier than boys. The ratio of girls’ to boys’ enrolment in primary and secondary school in sub-Saharan Africa, in 1999 was 82 percent (UNICEF, 2004). Girls drop out of school for a number of reasons, such as domestic and caring obligations at home (emphasized in the light of AIDS), sexual harassment at school and parental concerns over mixing with boys, pregnancy and parents prioritizing their sons’ over their daughters’ education when negotiating school fees. Girls are more likely to contract HIV than boys (UNICEF, 2004) with more than two out of three newly infected 15-24 year olds in sub-Saharan Africa being female and out-of-school girls are especially vulnerable.
Girls, who pursue schooling for longer, develop life skills, confidence and enhance their employment prospects and consequently are more likely to delay heterosexual relations and enter into it on an equal footing (UNESCO, 2003). This is contrasted with the situation of girls who drop out of school early, who are more dependent on men and are more likely to engage in early and risky heterosexual behaviour.

The UNESCO (2003) monitoring report advocates a state funding of school fees for primary education so that poorer families may not have the option of prioritising schooling for their sons over their daughters. A spin off of this would be the need to channel more resources for classroom space, teachers and books. Creating equal opportunities for primary and secondary education is essential for establishing equal and non-exploitative gender relations, which is particularly pertinent in the light of HIV and AIDS. Pattman (2006) argues for learners not to be passive recipients of AIDS education, but for an education, which engages with the culture and identities of the learners, the significance they attach to gender and sexuality while encouraging self-reflective talk. In this way the development of polarized gender identities may be broken down.

The UNICEF (2004) report highlights the importance of single sex groups in sex education classes as girls in particular felt freer to express themselves, their desires and concerns without being labeled in derogatory ways. Mixed groups are also advocated as boys and girls would be able to learn from each other. Sex education should not focus only on relations, which people enter into outside the class but on gender dynamics, and identities, which are being forged in class.
Encouraging a voice to girls and by putting gender power relations on the agenda, sex education might be perceived as aligning with girls against boys. The effect of this would be to entrench stereotypical constructions of boys as naughty and girls as good. It is vital, therefore, that sex educators do not address boys as the common homogenous enemy oppressing girls, as this can alienate boys and produce misogynist attitudes (Redman, 1996 as cited in Pattman, 2006).

2.9.3. Health Promotion Programmes at schools

In a health-promoting school, health education to prevent HIV and STI's is designed to help students acquire the knowledge, attitudes, beliefs, skills and support to make informed decisions, practice healthy behaviours and create conditions conducive to health. The design must consider the developmental level of the students and health promotion should start at primary levels and continue to secondary school levels, building on and reinforcing previous learning experiences. There needs to exist close collaboration between education and health officials, as well as with parents, students and community members so as to determine the necessary and most important and appropriate content to provide so as to help young people avoid HIV and STI.

With young children, health education should encompass knowledge, attitudes, beliefs, values and skills related to HIV transmission (Appendix 1). Health promotion education to prevent HIV and STI and related discrimination should be combined with education about life skills, reproductive health and alcohol/substance use so that the learning experiences will complement and reinforce each other (Piot & Seck, 2001; UNAIDS, 1999). There is a need to link these issues, organize them into a
school health education curriculum and/or coordinate the simultaneous or sequential presentations of related topics in different classes.

Co-teaching, sharing teaching resources, referring students to related lessons and involving students from different classes in group activities so as to also link health, HIV and STI prevention and other relevant topics are essential.

Scientific terms and biological-technical details may seem important; however, for the purposes of health education, they are less important than practical and basic information that will enable students to avoid infection. It is more important for a student to learn how the virus is spread and how to negotiate safe sex, for example, than to learn about the composition of the virus.

Students need to also learn about the fears that surround HIV and AIDS and STI's. Some students may fear risk when abstaining from sexual intercourse or engaging in common sexual activities such as masturbation. Some students may experience fear when engaging in expressions of affection such as hugging, kissing and touching genitals. Some students may fear being near or touching someone who may have acquired HIV infection. As a result of misconceptions about how HIV is and is not transmitted, some students may suffer undue anxiety and concern. Students must be taught how the virus is and is not spread. When they overcome fear, their understanding and empathy toward people who have HIV and AIDS can grow.

Interviews, informal discussions or questionnaires can be used to gain useful information from students and parents about values, beliefs and attitudes that may influence behaviours and conditions associated with HIV infection. Such
information will enhance understanding among teachers, other school personnel and health workers, and will help them focus interventions on the factors that contribute most to HIV infection in the community. This information is also important in developing complementary educational efforts such as those carried out by mass media, health workers, religious groups and other organizations. Due importance must be given to issues of confidentiality.

The influence of mass media on behaviour choices is important to consider. Young people are frequently exposed to and influenced by the media. While schools teach one set of messages, the media may be providing quite different messages. School-based programmes should take into account information provided through the mass media and take steps to refute unhealthy messages (UNAIDS, 1999).

Personnel teaching HIV and AIDS should possess confidence in teaching abilities, be comfortable with sensitive issues; and be knowledgeable of HIV and AIDS. They must also be able to deal with cultural and religious traditions that perhaps hinder discussion about sex and sex-related matters in the school. They must possess innovative participatory techniques, skill-building exercises, referral skills and ways to access health and social services.

The school environment strongly affects the success of classroom interventions. The physical and psychosocial environment should support principles and interventions related to HIV/STI prevention. Information about HIV and AIDS must be found in the school library; posters and relevant materials as part of a public awareness must be displayed and parents and the community must supplement school programmes.
Brink (2006) implemented an intervention programme to reduce HIV infection rates amongst young people in Cato Manor. They believe that it is possible to reduce risk-taking behaviour and infection rates once children understand that they are valuable and that they have a future and a destiny. The results of this research show that the program has helped young people who initially displayed low 'risk-taking' behavior to remain in this category of behavior. The high percentage of “still not at risk” responses is a great accomplishment given the realities of their context (Cato Manor is an urban informal settlement and can be considered to be a low socio-economic area). Furthermore our belief was also confirmed by the research that a holistic support structure for the children is essential in order to motivate and sustain behavioral change.

2.9.4. The South African Governments Response

According to Coombe (2001) the Department of Education had no policy on HIV and AIDS until late in 1999. In August 1999, the Department’s Corporate Plan 2000-2004 identified action on HIV and AIDS as one of its five priorities. The Department of Education (1999b; 2000b; 2000c) has highlighted three objectives related to HIV and AIDS that relate to the raising of awareness of HIV and AIDS among educators and learners; integrating HIV and AIDS into the curriculum; and developing models for analysing the impact of HIV and AIDS on the system. Education’s HIV and AIDS policy is entirely consistent with the priorities of the Department of Health’s strategic plan but goes further to provide guidance on discrimination in schools and institutions, workplace advocacy and sensitisation and sports safety. Among the many points specified it was stressed that educational institutions will ensure that learners
acquire age-appropriate and context-appropriate knowledge and skills to enable them to behave in ways that will protect them from infection (Coombe, 2001).

Schools are encouraged to develop their own policies on HIV and AIDS (refer to Appendix 4 for a copy of the experimental school’s HIV and AIDS policy). Principals are responsible for implementing policy in their institutions and government bodies are expected to supplement budgetary allocations for health, safety and other equipment (Coombe, 2001). Some headway is being made in teaching safe sex, but progress is slow. The Human Science Research Council (2000) as cited in Shah (2001) reports that only 15 percent of schools have a policy on HIV and AIDS. Of the schools that do have a policy, 75 percent of them are private or ex Model C schools (Shah, 2001).

The South African government’s response to this explosive spread of HIV includes public awareness campaigns, condom promotion, syndromic management of sexually transmitted diseases and life skills programmes targeted at youth in school (Abdool-Karim, 2001). She further argues that the extent to which these strategies are used vary within urban and rural communities.

In unprecedented co-operation, the South African government and civil society have wrestled together with the new five-year national plan to combat HIV and AIDS (Gray & Harrison, 2007). Priorities are listed for the first 100 days of implementation. Among these priorities is a need to scale up behaviour change interventions especially among young people. Many schools still don’t have adequate life skills programmes in place. There is acknowledgement that while media campaigns help shape attitudes, sustained personal interactions seems to trigger change. A legitimate, if unpopular
question to pose at the unveiling of the new AIDS plan is why it took the government this long to produce a comprehensive, widely backed plan to tackle the worst pandemic of our times.

Umerah-Uduzulu and Williams (2004) propose that most of the problems around current interventions in schools is related to the fact that there is a lack of proper health education programmes resulting in myths, misconceptions, stigma, apathy and poor health knowledge and attitude about HIV and AIDS resulting in high risk sexual behaviour among learners and the general population. Although information about HIV and AIDS has been introduced to learners, there are still communication gaps between the few professional public health educators and health promoters.

Pillay (1999) reports on the controversial and sensitive nature of HIV and AIDS education when Mr. Reggie Chiliza, the chairman of the provincial association of school governing bodies says that the growing AIDS problem left him with no choice but to support the move for condom distribution at schools. He says that one had to be realistic and that pupils are engaging in sexual activity. Furthermore, the availability of condoms at schools must be part of a larger AIDS education programme, which should discourage pupils from engaging in sexual activity at an early age. This was received with a great deal of resistance from the more conservative sectors of the community.

2.10. Traditional African View of Illness

A forward-looking South African HIV and AIDS education intervention that draws upon Paulo Freire's conscientisation and liberation would need to look at the
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traditional African worldview. The people of Africa experience the world in a very special and different way than westerners do. The traditional African worldview is based on a holistic and anthropocentric ontology (Van Dyk, 2001b). This means that man forms an inseparable whole with the cosmos and that everything (including God, spirits and nature) is seen in relation to man who is the centre of the universe. Within this cosmic whole, Sow (1980) distinguished three cosmic orders to explain the worldview of the traditional African. The macro-cosmos which is the highest universe and consists of God and the ancestors; the meso-cosmos is the intermediate universe which functions as a no-man’s land where genies, evil spirits, witches and sorcerers dwell; and the micro-cosmos which represents the everyday practical, social and collective life of man in Africa.

In the explanation of illness on a macro-cosmic level, the incidence of ancestor-caused illness is less frequent and is seldom serious or fatal. Balance is restored through sacrifices and offerings. There is no literature that indicates that AIDS represents the wrath of God or the ancestors. The influence of Christianity is seen in the beliefs of some black Christians who believe that AIDS is God’s punishment for immorality and sins (Van Dyk, 2001b).

Knowledge of the meso-cosmic level is important for understanding behaviour as nearly all forms of illness, disease, conflict, suffering, misfortunes, accidents and deaths are ascribed to this level. Witchcraft is believed to be the causal agent in HIV transmission and AIDS in many African countries, especially among the rural poor or least-educated people (Barbour & Huby, 1998; Boahene, 1996; Bond, 1993; & Yamba, 1997 as cited in Van Dyk 2001b). To blame external factors such as witches and sorcerers for AIDS has a protective function as it prevents feelings of guilt and
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alleviates anxiety. It also has a very negative implication for AIDS education in Africa as it implies that individuals cannot be held responsible or accountable for their own behaviour. As such they may not value the importance of using HIV preventive methods.

Leclerc-Madlala (1999), reports that in the course of her research, promiscuous behaviour and unsafe sexual practices were rationalised as being traditional. The “pursuit of isoka status by young men which entails the sexual conquest of many women” was considered to be acceptable behaviour and a traditional birthright of African men (Leclerc-Madlala, 1999, p. 243). In the era of AIDS such traditions assist rather than stop the HIV and AIDS epidemic. A South African HIV and AIDS intervention programme would need to address such culturally constructed complexities critically as they may be used to justify risky behaviour. According to Leclerc-Madlala (1999, p. 244) “traditional virginity testing is essentially a way of placing women’s bodies and sexualities under greater patriarchal control”. New rituals and traditions are needed that aim to empower women physically and sexually. The core issue is that what may be considered to be traditional, customary and often sacred may need to be addressed and reviewed. Western based education and prevention programmes will therefore never succeed if the diverse traditional, cultural and belief systems in Africa are not understood and integrated into the programme (Green et al., 1995).

We are products of our history, culture, society and economy. This has led to educators conducting a life skills programme in primary schools in KwaZulu-Natal to develop a culturally sensitive approach based on aspects of “Zulu cultural meaning
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systems” (Walker et al., 2004, p. 91). This is in response to western programmes that the educators found unhelpful and inappropriate.

In Africa traditional healers can be used as valuable partners in the fight against HIV and AIDS. Traditional healers often give sound advice to their patients that are also conducive to AIDS prevention. There are some illnesses such as influenza, colds, sexually transmitted diseases (STD’s) and diarrhoea that are attributed to the presence of germs within the micro-cosmic level. AIDS educators must therefore be aware of and understand the traditional African worldview of illness and incorporate these within their prevention and education programmes. Africa can only succeed if biomedical workers are prepared to collaborate with traditional healers (Green et al., 1995; Van Dyk, 2001b).

Millions of people consult medical doctors as well as healers located within other healing systems. In Botswana and South Africa, people seek advice from a combination of western doctors, diviners, herbalists and prophets based in independent spirit churches. Traditional healers are increasingly being seen as legitimate health practitioners. Many people in Africa believe in the power of witchcraft and attest to its effects on their daily lives. Witchcraft may explain misfortune, bad luck, illness and death where no other reason can be found (Walker et al., 2004). The obvious injustice of a disease that, in addition to being incurable primarily affects the most vulnerable – the poor, the youth and the blameless – fuels suspicions of witchcraft. Witchcraft interpretations of HIV and AIDS can have an extremely negative impact as it often results in social isolation and violence.
AIDS is greatly feared. Popular beliefs can result in stigma and discrimination against people with the disease. Health is associated with cleanliness and moral hygiene and disease is seen as the outcome of forbidden exchanges and even witchcraft. HIV positive people may therefore keep their status a secret so as not to be ostracized. These negative responses are not limited to particular communities or groups of people. Stigmatising and rejecting people with HIV and AIDS has been a universal response, which may arise out of fear or may be explained in religious or cultural terms (Walker et al., 2004).

2.11. Conclusion

HIV and AIDS is a physical disease, the conceptualisation of which, is firmly embedded in a social, cultural, economical, psychological and spiritual world. When it is linked with adolescent and pre adolescent girls, then the complexities of puberty and sexual and social interaction translates all of this into an explosive situation. Society needs to unravel the various convoluted threads that run through this epidemic with a view to ameliorating its impact and controlling the rates of infection.

Chapter three focuses on the theoretical and conceptual framework within which issues relating to HIV and AIDS preventive behaviour among preadolescent girls will be highlighted. It also deals with the research design and methodology of this research, the questionnaire and HIV and AIDS prevention intervention programme that was administered to capture qualitative and quantitative data on health promoting behaviours.
Chapter 3

Theoretical Framework and Methodology

3.1. Theoretical Framework – Introduction

A theory is a systematic group of relationships that can be observed and verified and usually produce particular results under specified conditions (Mantell, Di Vittis, & Auerbach, 1997). It explains why an event occurs as it does. According to Prochansky, as cited in Valdiserri (1989), there is no single theory that satisfactorily predicts and controls the wide variety of behaviours that are linked to health status. AIDS prevention specialists will therefore do well to apply more than one theoretical perspective to any given problem, as in this sensitive area, problems are likely to be multifaceted and influenced by many forces. Adherence to a single theory may well be counter-productive (Valdiserri, 1989).

According to Leviton (1989) and Mantell et al. (1997) there are five ‘families’ of theories and models useful in AIDS-prevention efforts:

1. Cognitive and decision-making models and theories, including the theory of risk communication, the health belief model, and the theory of reasoned action.

2. Learning theories, including the theory of operant conditioning, social learning theory, and sub theories of self-efficacy, relapse and self-regulation.

3. Theories of motivation and emotional arousal, including theories of fear and fear-arousing communications, helplessness and coping strategies.

4. Stages of change models and theories.
5. Community level or macro, models and theories.

The researcher will look at a theory or model within each of these five ‘families’ and their implications for AIDS prevention. Theory can contribute to the development of an effective HIV preventive intervention by highlighting specific variables believed to bring about behavioural change. While these theories address the perception of risk/susceptibility and demonstrate empirical support for perceived vulnerability as a key variable in the process of behaviour change, little has been done to examine the psychosocial process of overcoming perceived vulnerability (Crosby, 1996). The researcher will then look at Crosby’s (1996) five-stage model as a means of overcoming perceived invulnerability. This model depicts the health educator as an artist and a scientist who lays the groundwork for successful behaviour change. Self-motivated behaviour change can occur after intensive preliminary work and this model, which works at an emotional level, can be advantageous when working with adolescents.

3.2. Cognitive and Decision-Making Theories

The general assumption underlying cognitive and decision-making theories is that people are processors of information. These theories focus on biases in thinking that might prevent people from acting rationally, and work on the assumption that many behaviours, attitudes and beliefs can be explained without considering emotion or motivation. Although they may be limited in this respect, cognitive and decision-making theories can be extremely useful for understanding AIDS interventions. The following is a model under the umbrella of cognitive and decision making theories which will be reviewed further.
3.2.1. The Health Belief Model and HIV Risk Behaviour Change

The health belief model (HBM) is a commonly used model to predict and explain individual health behaviours (Becker & Maiman, 1975; Janz & Becker, 1984; Rosenstock, 1966). The HBM includes several families of variables that predict behaviour:

1. Perceived susceptibility or vulnerability to a health threat.
2. Perceived severity of the consequences of disease or health threat.
3. Perceived effectiveness of protective actions.
4. Perceived costs or barriers to protective actions.
5. Cues to action, such as physician advice or symptoms.
6. Demographic, structural and social/psychological factors that 'enable' behaviour.

Janz and Becker's (1984) comprehensive literature review of research studies on the HBM from 1974 to 1984 show that perceived barriers are the most predictive component of predicting behaviour while perceived severity is the least predictive component across a range of health-related behaviours. In 1977, Bandura introduced that concept of self-efficacy, or efficacy expectation, as distinct from outcome expectation, which Rosenstock, Strecher and Becker (1994) believe must be added to the HBM in order to increase its explanatory power. Rosenstock et al. (1994) define outcome expectation as a person's estimate that a given behaviour will lead to certain outcomes. Self-efficacy is defined as the conviction that one can successfully execute the behaviour required to produce the outcomes (Bandura, 1977). The updated HBM assumes that individuals must feel the need to change (perceived susceptibility and
severity) and believe that change will be advantageous and that they are competent to make the change.

Even the updated HBM has several shortcomings, as it does not address the influence of culture, class, economics, environment, and life experience in shaping health behaviours. It fails to consider the role of both habit and social network influence in health behaviour decisions and it does not provide recommendations for ways to persuade persons to change their behaviours (Mantell et al., 1997). An additional limitation unique to adolescents is that the HBM constructs are insensitive to maturational issues (Brown, DiClemente & Reynolds, 1991).

Thus while the HBM has its values, other models should be explored as there is evidence that with the use of the HBM, knowledge of HIV and its transmission is extremely good but risky behaviour persists (Di Clemente & Peterson, 1994; MacPhail, 1998; Valdiserri, 1989; Visser, 1996).

3.3. Social Learning Theory

Social learning theory (SLT) assumes that behaviour and environment are reciprocal systems that interact continuously. The environment shapes, supports and constraints behaviour, while people create their surroundings (Mantell et al., 1997). We do not need to experience reinforcement directly in order to learn about contingencies of reinforcement. We can also observe others and hear about their experiences. Social learning theory takes into account thoughts about oneself in addition to one’s direct learning and posits that such thoughts mediate the relationship between information
and action. Emerging from social learning theory are several concepts that are highly relevant to preventive behaviour: behavioural capability, expectations, self-efficacy, observational learning and reinforcement (Glanz, Lewis, & Rimer, 1990).

According to Mantell et al. (1997) learning and behaviour are achieved from direct experience, indirect experience (from observation or modelling), storing and processing complex information that enables one to anticipate the consequences of actions, skills enhancement (rehearsal and feedback) and social support (reinforcement). Self-efficacy has been an important mediating factor between health attitudes, beliefs and behavioural change. To implement protective health behaviours, one needs to have compelling reasons, knowledge, resources, social support and skills (Bandura, 1990).

AIDS prevention interventions based on social learning theory have focused on self-efficacy and the development of cognitive and behavioural skills to implement risk reduction. Mantell et al. (1997) in their review of numerous studies have found self-efficacy to be a significant determinant of HIV sexual risk reduction and social norms, peer pressure and communication have been successful in delaying adolescent’s sexual activity. This suggests that prevention programmes should use supportive group interventions directed towards peer networks within existing organisations.

3.4. Theories of Fear, Arousal, Motivation and Emotion

The Protection Motivation theory (PMT) developed by Rogers (1975) is a theory of fear arousal, motivation and emotion that addresses the effects of fear on attitude change through the use of persuasive messages. Three components that control fear
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are the magnitude of the obnoxious event (an illness), the probability of the occurrence of the event if there is no intervention to prevent it, and the efficacy of a protective action (Rogers, 1975).

Managing fear and other emotions is a central problem in risk communication, especially about AIDS. Some fear is inevitable because health professionals, the media and other information sources are describing the dangers posed by high-risk behaviour. Although fear can motivate behaviour change, it can also produce dysfunctional effects, which may interfere with behaviour change (Rogers & Mewborn, 1976). Risk communications must therefore strike a balance between the positive and negative effects of fear.

Leventhal, Meyer and Gutmann (1980) as cited in Valdiserri (1989) list several reasons why fear arousal should be used with caution in dealing with any risk communication. Firstly, high fear messages are not always superior to low-fear messages in motivating behaviour change. Secondly, fear can cause anger in people and lead them to disregard health messages if they think the messages are manipulative. Thirdly, people may become fatalistic or resigned to health dangers because they feel helpless to protect themselves, a perception that health matters are beyond their control. A fourth reaction involves denial of the danger posed in the fear communication. Denial in the case of AIDS prevention would seem to be dysfunctional in that it would mean a rejection of the risk-reduction advice.

3.5. Stages of Change - Models and Theories

A model of intentional stages of behavioural change, the transtheoretical model (TM) suggests that behaviour change is often a gradual process with identifiable stages
through which individuals pass but not necessarily in a linear fashion and they may be in more than one stage simultaneously. These stages are, namely, precontemplation in which people do not seriously consider protecting themselves; contemplation, in which they begin to consider self-protection and may seek out information about the hazard and self-protection; preparation, when people seriously commit to changing the behaviour; and maintenance, where people incorporate the behaviour change into their daily life (Mantell et al., 1997; Valdiserri, 1989). Relapse, however, can occur at any stage. The TM has focused heavily on cognitive variables, often not taking into account the mediating role of social influence processes and contextual factors, that is, social norms, social networks, the media, community and organisational participation, gender roles, culture and power in bringing about changes in sexual-related behaviours (Mantell et al., 1997). The AIDS risk-reduction and modified AIDS risk-reduction models address these issues.

3.5.1. AIDS Risk-Reduction Model and Modified AIDS Risk-Reduction Model

The AIDS risk-reduction model (ARRM) (Catania, Kegeles & Coates, 1990) integrates elements of the HBM, SLT, and TM to explain AIDS preventive actions. It acknowledges behaviour change as a multistep process with different psychological and social determinants for each stage. Important factors within the ARRM are knowledge of risk levels of sexual activities; perceptions of HIV risk susceptibility; perceived cost-benefits of reduced high-risk behaviour; self-efficacy beliefs; emotional states; and social factors. The model views behaviour change proceeding in three stages: labelling of high-risk behaviour where individuals become knowledgeable about HIV transmission and their perceived susceptibility; commitment to changing high-risk behaviour and learning effective ways to reduce
their risky behaviours (response efficacy and self-efficacy are key elements at this stage); and enactment of risk-reduction behaviour where communication skills and peer support play important roles (Catania et al., 1990).

Movement from one stage to another depends on achieving the goals and objectives of the prior stage. It is imperative to understand the different conditions that influence the outcomes of the various stages of the change process. This informs intervention strategies that facilitate movement toward change for people at different stages in the process. The ARRM is applicable to diverse populations including teenagers (Kegeles, Coates, Christopher, & Lazarus, 1989).

Ehrhardt, Exner, Miller, and Stein (1992) highlight and recognize the role of sexuality to personal identity and developed the modified AIDS risk-reduction model (M-ARRM) to specifically explain sexual behaviour. The M-ARRM includes elements of the ARRM (Catania et al., 1990) and adds new components based on extensive research with heterosexual women and men (Ehrhardt et al., 1992). In M-ARRM, the labeling stage of the ARRM has been renamed the susceptibility stage and determinants include knowledge of HIV transmission, sexual relationship factors, norms, and risk characteristics of self and partners. The ARRM commitment stage has been renamed the intention stage and determinants include quality of relationship, prevention methods, gender scripts, and peer norms. Two new stages have been added: prioritizing and maintenance. The prioritizing stage acknowledges the need to see HIV risk prevention as important within the context of competing life issues and stresses (housing, unemployment, health status and pregnancy intentions). The maintenance stage addresses long term behaviour change and determinants of this
stage include long-term cognitive beliefs, modified sexual behaviour and the influence of peer norms over time (Ehrhardt et al., 1992).

3.6. Community Level Model and Theories

While health interventions and models of health behaviour change directed toward individuals are necessary, community-level health promotion intervention, theories and models are also needed. These models try to effect change by assuring that advocacy and policy are targeted to the community. One model under the umbrella of community level model and theories is the PRECEDE-PROCEED model (Green & Kreuter, 1991).

3.6.1. PRECEDE-PROCEED Model

The PRECEDE-PROCEED model (PPM) developed by Green and Kreuter (1991) is a comprehensive planning model that provides a framework for assessing a community’s needs. It identifies factors that contribute to health problems that must be changed to initiate and sustain the process of behavioural and environmental change, analyses policies and resources that can facilitate or hinder development of health promotion programmes, and identifies strategies for implementation and evaluation of interventions.

According to Green and Kreuter (1991) the PPM seems to begin at the end (outcomes) rather than the beginning (inputs), however, for planning needs it is essential to identify potential determinants of an outcome before an intervention is designed. According to Mantell et al. (1997) the nine phases of PPM are:
Phase one: Social diagnosis: subjective problems and priorities of the individual or the community are addressed.

Phase two: Epidemiological diagnosis: health problems are prioritised according to their magnitude and severity and impact on the economy.

Phase three: Behavioural and environmental diagnosis: behavioural and environmental indicators of health, such as risk factors, are identified, ranked and understood in terms of their impact on personal behaviour.

Phase four: Educational and organisational diagnosis: this stage delineates the predisposing (knowledge, attitudes, beliefs, values), enabling (availability and access to health and social services, supportive governmental policies, and health-related skills), and reinforcing (supportive family, colleagues, friends, communities, and health and social service providers) factors that facilitate or hinder the motivation for change and its maintenance.

Phase five: Administrative and policy diagnosis: this stage involves a critical evaluation of the capabilities and resources available and barriers to implementing a programme.

Phase six: Implementation: the plan is converted into health education intervention, policy, organisation, and regulation.

Phase seven: Process evaluation: this occurs because early identification of problems in a feedback loop helps the educator to adjust programme content, teaching styles, presentations and materials.

Phase eight: Impact evaluation: this type of evaluation directly assesses the effect of the educational intervention.

Phase nine: Outcome evaluation: the effect of the intervention on long-term changes in quality of life, social indicators, disability, morbidity and mortality rates is assessed.
In the application of the PPM to HIV and AIDS behaviour the PRECEDE component of the model helps develop objectives to decrease the incidence of HIV infections and the PROCEED component of the model focuses on implementing and evaluating the programme.

Figure 3.1.

PRECEDE - PROCEED Model

PHASE 5  PHASE 4  PHASE 3  PHASE 2  PHASE 1
Administration and Educational and Behavioural and Epidemiological Social
Policy Diagnosis Organisational Environmental diagnosis Diagnosis Diagnosis

Health Promotion

Health Education

Policy regulation

Predisposing Factors

Reinforcing Factors

Enabling Factors

Behaviour and Lifestyle

Environment

Health

Quality of life

Source: Green and Kreuter (1991)
3.7. Application of the Theories and Models to Adolescents and Pre Adolescents

We have yet to gain a complete understanding of risky behaviour, their causes and effective intervention. However the framework provided within the theories and models discussed here can be applied to prevention programmes conducted with adolescents without overlooking the limitations inherent in their structure. As this research targets the pre-adolescent girl an attempt is made to look at perceived invulnerability and the illusion of pre-adolescent and adolescent invincibility to HIV and AIDS as a barrier to HIV and AIDS prevention interventions.

Each period of development brings with it new challenges for coping efficacy. With growing independence during childhood and pre-adolescence some experimentation with risky behaviour is not all that uncommon (Vasta, 1992). When considering the adolescent, issues pertaining to the strength of the sex drive, power of the peer group norms, the emergence of sexual identity and the urge to engage in sexual activity, come to the fore. Adolescents may feel that health and happiness are natural outcomes of living happily ever after. It is therefore quite natural that resistance to efforts designed to shatter the illusion is strong. Forms of resistance with regard to AIDS include homophobia, denial of mortality, a trust that the government will protect us and a general resistance to schooling and education (Crosby, 1996). The challenge is to work through these forms of resistance and create initial dissonance.

The first step in penetrating the adolescent mind is to cast doubt on currently held beliefs. This works best when emotional aspects precede cognitive issues. This is
when imparting knowledge of HIV and AIDS preventative and high-risk behaviour, AIDS testing procedures, AIDS-related discrimination, statistics on HIV positive prevalence rates among the youth, all serve to expose the adolescent to new realities.

With time and continued exposure to new realities, the adolescent soon needs to overcome dissonance either by assimilation or accommodation. The signal for accommodation will be the transitional event. As the event can be vicarious, the educator may attempt to create this in the classroom through role-play, working through scenarios or by inviting a student speaker who experienced the anxiety of suspecting HIV infection, being tested and waiting for the results to speak to the class. Enhancing motivation for safe acts is an implicit agenda in the design of the context of the intervention. Motivation can be spurred by fear (Rogers, 1975) although individuals will be more likely to change their health behaviours if they perceive themselves to be at risk (O’Leary, Goodhart, & Jemmot, 1991).

Creating a transitional experience in the classroom is a delicate and fragile process and success depends on an open and honest atmosphere and a caring relationship between teacher and students. Once the transitional event is experienced, perceived invulnerability is lost, the death of illusion occurs and a new dissonance fills the void. The drive for security and self-preservation creates introspection, inquiry and long term learning which culminates in self-motivated behaviour change and a new set of beliefs and behaviour (Brehm & Cohen, 1962). Remember there is much preliminary work before self-motivated behaviour change can occur and this preliminary work is the art of health education.

Crosby’s (1996) model of the process of overcoming perceived invulnerability and the relationship between the art and the science of health education would be
reviewed with regards to HIV and AIDS prevention with pre-adolescents. The art of health education lies in skilfully moving the learner beyond the perception of invulnerability. Once beyond this barrier the learner is free to become an active member of the change process, thereby increasing the probability of a successful outcome (Crosby, 1996).

3.7.1. The Relationship between the Art and the Science of Health Education in Respect to Overcoming Perceived Invulnerability (Crosby, 1996)

According to Crosby (1996) a five-stage model represents the psychodynamics of overcoming perceived invulnerability. Figure 3.2 provides a schema of these stages, order of procession and a visual depiction for the illusion of invulnerability.

**FIGURE 3.2.**

A Schema for the Process of Overcoming Perceived Invulnerability

<table>
<thead>
<tr>
<th>Perceived Invulnerability</th>
<th>Breaking the Illusion of Invulnerability</th>
<th>Vulnerability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Creation of initial dissonance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Uncovering hidden realities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-motivated behaviour change</td>
<td></td>
</tr>
</tbody>
</table>

Source: Crosby (1996)
Stage one: Facts and figures-transmitting basic intellectual information are the mode in school health education. Knowledge alone is not enough to produce a change in outcome; it is however, the first step in labelling high-risk behaviour.

Stage two: Initial dissonance-Carl Rogers and Jean Piaget cited dissonance as a starting point for behaviour change (Crosby 1996). Rogers posits the theme that incongruity between cognition and experience is a necessary precondition for behaviour change. Piaget postulates that the dual processes of assimilation and accommodation are driven by the human desire to achieve consonance between cognition and experience. Thus stage one information can be valuable when it creates stage two dissonance. When current cognitive structures are challenged by new information, the individual is forced either to deny the new information or accept the new information and experience dissonance (Brehm & Cohen, 1962).

Stage three: Uncovering hidden realities-once dissonance appears, it must be accelerated to a threshold that will move the client from thinking (at an intellectual level) to feeling (at an emotional level). Once these realities have been experienced, thereby accelerating dissonance, the individual is ready for the final step to perceived invulnerability—the transitional event.

Stage four: The transitional event—the growing emotional awareness described in stage three eventually culminates in one experience that serves as a marker for the end of perceived invulnerability. Usually the event is the death of a known individual. The event can be vicarious (knowledge of the positive HIV status or death of a famous person) or direct (watching a friend or family member succumb to the disease). Whether direct or vicarious, the person who experienced extreme dissonance
HIV and AIDS Intervention

receives the transitional event as the final crumbling of a once solid but deadly illusion of invulnerability. The importance of this event cannot be understated; it represents the true beginning of mutual learning between the student and teacher.

Yet, barriers against this event are strong, primarily as a result of the long period of clinical latency of HIV. Adolescents are unlikely to have experienced the death of a peer from AIDS and many may rationalise AIDS as a disease for older people.

Stage five: New dissonance—with the illusion of invulnerability now completely shattered, people finally perceive themselves as vulnerable for the first time. This feeling of vulnerability is uncomfortable and requires immediate action. The individual is now ready to equilibrate (change) to create a new sense of security. At this point learning and behaviour change are self-motivated processes. Partner negotiation, responses efficacy, self-efficacy and peer group norms lie ahead as obstacles. Figure 3.3 depicts the relationship between the five stages of behaviour change and the art of health education.
FIGURE 3.3.
The Relationship between the Art and the Science of Health Education in Respect to Overcoming Perceived Invulnerability

Science of Health Education  Art of Health Education  Science of Health Education

- Initial dissonance
- Uncovering hidden realities
- Transitional events
- The illusions of invulnerability

The health educator as scientist opens the show with an array of facts and figures. The health educator, as an artist, lays the groundwork for successful behaviour change. The health educator, as scientist facilitates behaviour change with information.

Source: Crosby (1996)
The greatest fallacy in AIDS education today is the belief that adolescents can be moved from stage one to stage five without bothering to break the illusion of invulnerability by going through stages two, three, and four (Crosby, 1996).
3.8. Conclusion

Crosby’s (1996) five stages outlined here are less oriented toward pedagogy and more in line with psychotherapy practice. Working at an emotional level of understanding (stages two through four) is a dramatic departure from education tradition. However, in the times of the onslaught of the AIDS epidemic, standard measures often become inadequate. Health educators should respond to this epidemic with practices that show a promise of creating substantial behaviour change, rather than employing familiar methods with which they have become comfortable. Literature surveyed by the researcher attests to the fact that further research and inquiry should focus on unique sexual dynamics of adolescents (Crosby, 1996; De Muth Allensworth & Symons, 1989; Everatt & Milner, 1994; Grossman, 1991; Keller, 1993; Leclerc-Madlala, 1998; MacPhail, 1998; Olivier, 1996; Valdiserri, 1989; Visser, 1996). Issues of relapse into perceived invulnerability and the psychosocial circumstances that promote high-risk behaviour must also be addressed with vigour if prevention efforts are to save a generation at risk.

3.9. Methodology - Introduction

According to Mantell et al. (1997) to conduct effective research, you have to know three things: what you are going to do, to whom you are going to do it, and when you are going to do it. The ‘who’ refers to the sample or group of participants, the ‘what’ to the evaluation design and protocol, and the ‘when’ to over what period of time the data will be collected. The aim of this research is to implement an HIV and AIDS prevention intervention programme with pre-adolescent girls. The intent is to improve
HIV and AIDS preventive behaviour by focusing on various methods of disseminating HIV and AIDS knowledge, enhancing empathic attitudes, and promoting well-being and self-care skills. It is imperative, therefore, that the extent and nature of pre-adolescent girls’ knowledge be ascertained before and after the intervention so that the intervention programme can be evaluated. This would inform on a set of guidelines, which the educator can use in the life skills programme to educate the pre adolescent girl on HIV and AIDS and related education.

3.9.1. Research Design

In order to assess the effectiveness of a primary HIV and AIDS prevention intervention programme with pre-adolescent girls, primary schools were selected as the units of analysis. Primary schools provide easy access to a relatively large number of pre-adolescent girls who would be able to participate for many sessions over a period of time. According to Shisana and Simbayi (2002), the Nelson Mandela/Human Science Research Council HIV and AIDS study found that the locality with the highest number of HIV infected people was urban informal settings. With this in mind the researcher focused on primary schools surrounding urban informal settlements. Primary schools in the Ethekwini Region, District: Umlazi, Ward: Mayville, Circuit: Cluster A were selected as there were six schools on the periphery of the Foreman Road, Wandsbeck Road, Elf Place and Clare Road informal settlements; all within approximately five kilometres of each other. This location is in the greater Durban area bordering the suburbs of Clare Estate and Reservoir Hills in the province of Kwa Zulu Natal. This area was also easily accessible to the researcher. Learners at these schools came from the Black, Coloured and Indian population groups. These schools therefore shared common racial, cultural and economic
backgrounds. These schools cater for children from the informal settlements as well as children from low-income areas of Clare Estate, Sydenham, Mayville and Chesterville. Three primary schools were randomly selected and randomly assigned to control group, experimental group and school where the piloting of the questionnaire was implemented.

According to the American Heritage Dictionary of the English language (2003) the pre-adolescent phase includes girls who are ten to twelve years old. The researcher then targeted girls who were in grade five as these girls fall within this age range. The control school had 62 girls in grade five and the experimental school had 41 girls grade five. All of these girls participated in the research.

3.9.2. Ethical Considerations

Departmental permission to conduct research at these schools was obtained and a copy of this was forwarded to the relevant principals so that parental permission could be granted. Parental permission was obtained by the principals’ concerned on behalf of the researcher.

3.9.3. Measuring Instruments

The researcher developed a self-administered questionnaire, which was used as a pre test and post test questionnaire. This questionnaire quantitatively assessed the HIV and AIDS knowledge, attitudes and behaviour/skills of the participants. Relevant personal and biographical details were also ascertained. The absolute validity and reliability of the measuring instrument were not tested, as this was its initial use. Face
validity was established by submitting the questionnaire to two HIV and AIDS professionals for feedback on clarity and relevance of the questions and format. A statistical analyst edited the questionnaire for easy capturing and analysis of the data. A pilot study was also conducted by administering the questionnaire to 30 grade five girls at a school within the circuit targeted by the researcher. Feedback was positive and relevant comments were incorporated into the final draft of the pre test and post test questionnaire.

The researcher visited the experimental school six times. The first and last visits were to conduct the pre test and post tests, which took approximately forty-five minutes to administer. The HIV and AIDS prevention intervention programme constituted four sessions each consisting of one and a half hours duration. While the actual didactic programme was planned for an hour, thirty minutes was allocated for the students to settle down, stop talking and get into groups. Three sessions were evaluated individually and a general overall evaluation, which was more detailed, was obtained in the fourth session. The first three sessions imparted new knowledge and the fourth session reviewed what was covered earlier. Qualitative information was obtained during the sessions when the girls asked questions and reported on various tasks that they were engaged in. The sessional evaluations and detailed overall evaluation generated quantitative and qualitative information on the impact of the researcher's HIV and AIDS prevention intervention programme on the nature and extent of the learners' HIV and AIDS knowledge, attitudes behaviours and skills.
3.9.4. Important Considerations in the Design of the Questionnaire and the Intervention

Firstly, the overall design of the questionnaire and the intervention considered the developmental and cognitive level of the preadolescent girls. Their pre-existing knowledge in the area of HIV and AIDS was ascertained from an interview with the respective principals. The school had previously conducted no formal teaching on HIV and AIDS with these girls. While scientific, biological and technical terms and details may be important, for purposes of health education promotion, practical and basic information was provided in this intervention programme. Knowledge, attitude and skills relating to HIV and AIDS information were combined with life skills education, reproductive health, and the influence of gender and culture on behaviour so that the learning experiences would complement and reinforce each other.

As a large number of the sample group of girls came from the Black population group, traditional South African belief systems and customs regarding HIV and AIDS were researched to provide background information and to contextualise the intervention programme. The UNAIDS (1999) programme on promoting HIV and AIDS health with preadolescent girls was researched and provided guidelines for the structuring of the pre-test and post-test questionnaire and the intervention programme (Appendix 1).

The intervention programme was designed to be interactive with the learners taking control of the discussions. Various methods of teaching were adopted to provide variety and sustain interest and attention. The first session was generally introductory with a transmission of factual knowledge on puberty, sex, sexuality and HIV and AIDS. The gravity of the impact of HIV and AIDS especially on adolescents was
explored. The dissonance created in the first session was emphasised in the second session where the illusion of invulnerability was shaken (Crosby, 1996). This was achieved by asking the girls to explore scenarios where either a loved one or they were HIV positive. They had to explore feelings and emotions surrounding this and review personal ways of coping with this. The development of a non-judgmental and an empathic attitude towards people with AIDS was stressed. Session three imparted coping mechanisms, assertiveness training and decision-making skills so that learners were able to feel confident about their ability to keep healthy. Session four was a review and reinforcement of the previous three sessions.

3.9.5. Details of the Pre and Post Test Questionnaire

The self administered pre test and post test questionnaire was designed to assess the extent and nature of the pre-adolescent girls’ knowledge, attitude and skills with regards to HIV and AIDS (Appendix 2). Section A – This section comprised questions eliciting personal details and demographic information from the girls. Section B and C – Assessed the extent and nature of the girls’ HIV and AIDS knowledge, in particular, information on transmission methods, statistics on prevalence and misconceptions around HIV and AIDS. Section D – Explored the preadolescent girls’ attitudes toward sexuality, belief systems, self-awareness, impact of gender and peer pressure and empathy for People with AIDS (PWA). Section E – Highlighted important skills that pre-adolescent girls may need in negotiating health-promoting behaviours. These included assertiveness skills, the importance of having a personal value system, response to peer pressure and issues
surrounding denial of risk. Information was also ascertained surrounding the girls’ personal perception of keeping themselves safe from HIV infection.

3.9.6. Details of the HIV and AIDS Intervention Programme

The HIV and AIDS prevention intervention programme with pre-adolescent girls was implemented over four sessions. Each session was one hour long. See Appendix 3 for more detail on the actual intervention programme, including different techniques used to meet the various objectives and time frames. Crosby’s (1996) emphasis on the science and art of health education was used to frame the intervention programme. As such, the researcher worked at an educational and more importantly, at an emotional and psychological level to ensure that the pre-adolescent girl not only received the correct message but also incorporated it into her repertoire of behaviour. At an educational or didactic level, different techniques were employed to impart knowledge. That is, group work was interspersed with role-play; scenarios of relevant HIV and AIDS issues were discussed in groups and displayed on graffiti charts for discussion and a class quiz generated healthy competition. The evaluation sessions gave individual learners enough time for personal reflection. At an emotional and psychological level, the girls were made to feel comfortable within the group. This was achieved by eliciting from the girls a set of group rules which was reinforced at the beginning of each session and subsequently when necessary. This reinforced the premise that each one of them was important within the group and boosted their self-esteem. In addition, the researcher focused on exploring feelings and emotions, whether they were good or bad and slowly bringing the girls to a point of understanding and realisation that while feelings were important, it had to be
harnessed constructively to either promote healthy behaviours or cope with being HIV positive.

Session one addressed issues around HIV and AIDS and imparted information on HIV and AIDS, methods of transmission, sex and sexuality. An icebreaker was used to create a relaxed atmosphere in the classroom and to introduce everyone. A group contract was drawn up by the girls, which afforded a safe environment so that everyone could share information and ask questions without restraint. The girls were divided into five groups of approximately eight girls. Each group was given different questions to brainstorm and report to the class. The purpose was to ascertain prior knowledge and to build on this. Also any misconceptions would surface and would be addressed appropriately. The evaluation of session one by the girls was completed.

Session two examined the girls’ attitudes towards HIV and AIDS and assisted in the development of non-judgmental attitudes. Group work focusing on artistic and creative tasks was adopted to explore a potentially fearful and sombre task of exploring living with someone with HIV and AIDS or being diagnosed as being HIV positive. The girls were again divided into groups and had to explore their feeling towards people with AIDS or if they were diagnosed as being positive themselves. In this manner initial dissonance was created and the girls’ feelings of personal invulnerability were shaken. Non-judgmental and non-discriminatory behaviour towards people with HIV and AIDS was discussed. The session evaluation was completed.

Session three discussed assertiveness training, the handling of peer pressure, explored decision making skills and problem solving techniques. The girls were divided into
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three groups and presented with scenarios in which they had to role-play passive
documentation, aggressive behaviour and assertive behaviour. Self esteem, assertive
behaviour techniques, decision-making skills, abuse and good-touch bad-touch,
handling of peer pressure and overtures by boys of a sexual nature were explored and
positive coping techniques were elicited from the girls. Lifestyle changes, healthy
nutritional habits and medical support were also explored as a way of keeping healthy
for people who were already HIV positive. The session was evaluated.

Session four reinforced HIV and AIDS knowledge, attitudes and skills. It allowed the
girls to ask questions about HIV and AIDS in a non-threatening and non-judgmental
environment. A class quiz created a vibrant, healthy atmosphere where HIV and
AIDS information was assessed. Open time where the girls could ask HIV and AIDS
and related questions allowed an opportunity for non-directed interaction. This was
followed by a task where the girls focused on positive things about themselves and
their group members. The overall assessment concluded this session.

3.10. Conclusion

This research design generated both qualitative and quantitative data. Chapter Four
deals with the analysis of this data and a discussion of the results of the HIV and
AIDS prevention intervention programme. The objectives of the programme will be
reviewed and the discussion of results will focus on whether the objectives have been
met.
Chapter Four

Analysis of Data and Discussion of Results

4.1. Objectives of the Research

The objectives of the study are to ascertain the nature and extent of the pre-adolescent girl’s knowledge, attitude and skills regarding HIV and AIDS and to implement and assess the impact of a prevention intervention programme, which is aimed at empowering these girls. This will generate guidelines for an HIV and AIDS education programme aimed at pre adolescent girls, which educators can use in their life skills programmes at school.

4.2. General Observations

This information was generated from interactions with the school principals, staff and learners at the schools used in this study.

School personnel – the principals of both the control and experimental schools were very supportive and eager for the researcher to carry out the programme at their schools. They valued the intervention as an area that was vital for the healthy development of the girls. They accommodated the researcher with regards to time schedule, venue and splitting the grade fives as the programme was for girls only. It must be noted that these schools are co educational.

Research sample – the girls were enthusiastic and eager to engage in the programme. They participated without any restraint. In the second session, the girls in the
experimental school reported that some of the boys were teasing them and said that they were 'HIV positive' infected as they were in the researcher's programme. The programme was well received and the researcher received two notes which stated 'we thank you for teaching us such personal things. We learnt a lot. You are a star. God bless' and 'we enjoyed it, ma'am. Thank you'.

4.3. Statistical Analysis

The Statistical Package for Social Sciences programme was used to analyse quantitative data and quantify qualitative data that was generated from the self-administered pretest and posttest questionnaires, the intervention programme and the evaluations. Descriptive statistics were used to explore the data and a cross-tabulation test was used to provide a count and percentage of the respondents who selected different options in each question in the pre and post tests. The Pearson Chi Square and Fisher's Exact Tests were used to indicate whether differences between the pre and posttest responses were significant. T-tests for paired samples were used to further analyse responses, which focused on specific areas within HIV and AIDS knowledge, attitudes and skills.

4.4. Analysis and Discussion of Descriptive Statistics

A total of 103 girls participated in the pre and posttests from both schools (Table 4.1). There were 41 girls involved in the experimental school and 62 girls in the control school. Only one girl was absent for the posttest in the experimental school.
Table 4.1. Number of Girls participating in the study

<table>
<thead>
<tr>
<th>Group</th>
<th>Experimental</th>
<th>Control</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PreTest</td>
<td>41</td>
<td>62</td>
<td>103</td>
</tr>
<tr>
<td>PostTest</td>
<td>40</td>
<td>62</td>
<td>102</td>
</tr>
</tbody>
</table>

4.4.1. Personal and Biographical Details of the Participant

This intervention targeted pre adolescent girls. The American Heritage Dictionary (2003) defined pre adolescence as between the ages of ten and twelve years. Table 4.2 reflects that 73.9% of the girls in the experimental and control groups fall within this age range.

Table 4.2. Chronological Age of the Participants

<table>
<thead>
<tr>
<th>Age</th>
<th>Experimental</th>
<th>Control</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
<td>Count</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>4.9%</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td>12.2%</td>
<td>17</td>
</tr>
<tr>
<td>11</td>
<td>9</td>
<td>22.0%</td>
<td>27</td>
</tr>
<tr>
<td>12</td>
<td>8</td>
<td>19.5%</td>
<td>10</td>
</tr>
<tr>
<td>13</td>
<td>8</td>
<td>19.5%</td>
<td>4</td>
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<tr>
<td>14</td>
<td>3</td>
<td>7.3%</td>
<td>0</td>
</tr>
<tr>
<td>15</td>
<td>1</td>
<td>2.4%</td>
<td>0</td>
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<tr>
<td>16</td>
<td>1</td>
<td>2.4%</td>
<td>0</td>
</tr>
<tr>
<td>17</td>
<td>1</td>
<td>2.4%</td>
<td>0</td>
</tr>
<tr>
<td>Not indicated</td>
<td>3</td>
<td>7.3%</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0%</td>
<td>62</td>
</tr>
</tbody>
</table>

This research intervention was located in schools situated near the Foreman Road, Wandsbeck Road, Elf Place and Clare Road informal settlements as Shisana and Simbayi (2002) reported that the locality with the highest number of HIV infected people were from urban informal settlements. Table 4.3 reflects that 22.3% of the participant’s in the experimental and control groups reside in the urban informal
settlements and the rest in surrounding areas, which can be described as lower socio economic. In the experimental group alone, 39% of the participant’s live in the informal settlements. It was reported that the average number of people residing in each participant’s home was six and there were as many as 14 people sharing 1% of the participant’s home. There was an average of three people sharing the participant’s bedroom in the experimental group and two people in the control group.

Table 4.3. Areas in which Participant’s Reside

<table>
<thead>
<tr>
<th>Area</th>
<th>Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental</td>
<td>Control</td>
</tr>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
</tr>
<tr>
<td>Point</td>
<td>9</td>
<td>22.0%</td>
</tr>
<tr>
<td>Umbilo</td>
<td>1</td>
<td>2.4%</td>
</tr>
<tr>
<td>Clare Estate - informal settlements</td>
<td>16</td>
<td>39.0%</td>
</tr>
<tr>
<td>Westville</td>
<td>1</td>
<td>2.4%</td>
</tr>
<tr>
<td>Sydenham</td>
<td>3</td>
<td>7.3%</td>
</tr>
<tr>
<td>Durban</td>
<td>5</td>
<td>12.2%</td>
</tr>
<tr>
<td>Mayville</td>
<td>2</td>
<td>4.9%</td>
</tr>
<tr>
<td>Overport</td>
<td>1</td>
<td>2.4%</td>
</tr>
<tr>
<td>Chesterville</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Inanda</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>KwaMashu</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Not indicated</td>
<td>3</td>
<td>7.3%</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The participants were asked to list what they would like their future work or occupation to be. They listed medicine as the most desired occupation (31.1%), teaching (14.6%), businesswoman (11.7%) and nursing (10.7%) followed as subsequent choices (Table 4.4). This highlighted information on the girl’s perception of their future in terms of ambition, capability and ability to achieve despite difficulties.
Table 4.4. Desired Future Occupation of the Participants

<table>
<thead>
<tr>
<th>Desired Future Occupation</th>
<th>Experimental Count</th>
<th>Experimental %</th>
<th>Control Count</th>
<th>Control %</th>
<th>Total Count</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lawyer</td>
<td>5</td>
<td>12.2%</td>
<td>4</td>
<td>6.5%</td>
<td>9</td>
<td>8.7%</td>
</tr>
<tr>
<td>Doctor</td>
<td>18</td>
<td>43.9%</td>
<td>14</td>
<td>22.6%</td>
<td>32</td>
<td>31.1%</td>
</tr>
<tr>
<td>Teacher</td>
<td>6</td>
<td>14.6%</td>
<td>9</td>
<td>14.5%</td>
<td>15</td>
<td>14.6%</td>
</tr>
<tr>
<td>Nurse</td>
<td>5</td>
<td>12.2%</td>
<td>6</td>
<td>9.7%</td>
<td>11</td>
<td>10.7%</td>
</tr>
<tr>
<td>Worker-just have a job</td>
<td>2</td>
<td>4.9%</td>
<td>5</td>
<td>8.1%</td>
<td>7</td>
<td>6.8%</td>
</tr>
<tr>
<td>Jeweller</td>
<td>1</td>
<td>2.4%</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td>Business</td>
<td>0</td>
<td>0.0%</td>
<td>12</td>
<td>19.4%</td>
<td>12</td>
<td>11.7%</td>
</tr>
<tr>
<td>Pilot</td>
<td>0</td>
<td>0.0%</td>
<td>3</td>
<td>4.8%</td>
<td>3</td>
<td>2.9%</td>
</tr>
<tr>
<td>Police</td>
<td>0</td>
<td>0.0%</td>
<td>5</td>
<td>8.1%</td>
<td>5</td>
<td>4.9%</td>
</tr>
<tr>
<td>Singer</td>
<td>0</td>
<td>0.0%</td>
<td>3</td>
<td>4.8%</td>
<td>3</td>
<td>2.9%</td>
</tr>
<tr>
<td>Not indicated</td>
<td>4</td>
<td>9.8%</td>
<td>1</td>
<td>1.6%</td>
<td>5</td>
<td>4.9%</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0%</td>
<td>62</td>
<td>100.0%</td>
<td>103</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The researcher tried to determine those aspects that the girl's enjoyed and brought them happiness. Table 4.5 indicates that the areas that the girl's enjoyed most are being with their family (34%), school (16.5%), mother (9.7%), friend (7.8%), and taking part in games and sports (6.8%).

Table 4.5. Indication of what makes the Participant’s happy

<table>
<thead>
<tr>
<th>What Gives the girls happiness</th>
<th>Experimental Count</th>
<th>Experimental %</th>
<th>Control Count</th>
<th>Control %</th>
<th>Total Count</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church</td>
<td>3</td>
<td>7.3%</td>
<td>0</td>
<td>0.0%</td>
<td>3</td>
<td>2.9%</td>
</tr>
<tr>
<td>Helping others</td>
<td>2</td>
<td>4.9%</td>
<td>3</td>
<td>4.8%</td>
<td>5</td>
<td>4.9%</td>
</tr>
<tr>
<td>Family</td>
<td>12</td>
<td>29.3%</td>
<td>23</td>
<td>37.1%</td>
<td>35</td>
<td>34.0%</td>
</tr>
<tr>
<td>School</td>
<td>3</td>
<td>7.3%</td>
<td>14</td>
<td>22.6%</td>
<td>17</td>
<td>16.5%</td>
</tr>
<tr>
<td>Mother</td>
<td>7</td>
<td>17.1%</td>
<td>3</td>
<td>4.8%</td>
<td>10</td>
<td>9.7%</td>
</tr>
<tr>
<td>Shopping</td>
<td>3</td>
<td>7.3%</td>
<td>1</td>
<td>1.6%</td>
<td>4</td>
<td>3.9%</td>
</tr>
<tr>
<td>Games or Sport</td>
<td>4</td>
<td>9.8%</td>
<td>3</td>
<td>4.8%</td>
<td>7</td>
<td>6.8%</td>
</tr>
<tr>
<td>Television</td>
<td>1</td>
<td>2.4%</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td>Friend</td>
<td>3</td>
<td>7.3%</td>
<td>5</td>
<td>8.1%</td>
<td>8</td>
<td>7.8%</td>
</tr>
<tr>
<td>Dad or father</td>
<td>1</td>
<td>2.4%</td>
<td>1</td>
<td>1.6%</td>
<td>2</td>
<td>1.9%</td>
</tr>
<tr>
<td>Fun</td>
<td>0</td>
<td>0.0%</td>
<td>5</td>
<td>8.1%</td>
<td>5</td>
<td>4.9%</td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
<td>2.4%</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>1.0%</td>
</tr>
<tr>
<td>Not indicated</td>
<td>1</td>
<td>2.4%</td>
<td>4</td>
<td>6.5%</td>
<td>5</td>
<td>4.9%</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0%</td>
<td>62</td>
<td>100.0%</td>
<td>103</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Table 4.6. Indication of what makes the Participant’s Afraid

<table>
<thead>
<tr>
<th>Things they are afraid of</th>
<th>Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental</td>
<td>Control</td>
</tr>
<tr>
<td>God</td>
<td>1</td>
<td>2.4%</td>
</tr>
<tr>
<td>Strangers</td>
<td>5</td>
<td>12.2%</td>
</tr>
<tr>
<td>HIV and AIDS</td>
<td>5</td>
<td>12.2%</td>
</tr>
<tr>
<td>Abuse</td>
<td>2</td>
<td>4.9%</td>
</tr>
<tr>
<td>Father</td>
<td>1</td>
<td>2.4%</td>
</tr>
<tr>
<td>Mother</td>
<td>2</td>
<td>4.9%</td>
</tr>
<tr>
<td>Death</td>
<td>1</td>
<td>2.4%</td>
</tr>
<tr>
<td>Being alone</td>
<td>4</td>
<td>9.8%</td>
</tr>
<tr>
<td>Menstruation</td>
<td>2</td>
<td>4.9%</td>
</tr>
<tr>
<td>Crime</td>
<td>8</td>
<td>19.5%</td>
</tr>
<tr>
<td>Rape</td>
<td>1</td>
<td>2.4%</td>
</tr>
<tr>
<td>Animals</td>
<td>2</td>
<td>4.9%</td>
</tr>
<tr>
<td>No response</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Sex</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Not indicated</td>
<td>7</td>
<td>17.1%</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 4.6 lists those things that make the girls very afraid. Fears that rank the highest are being infected with HIV and AIDS (16.5%); crime (15.5%); animals (12.6%); being alone (10.7%); strangers (9.7%); rape and death rank the same at 6.8% each. It is interesting that while being infected with HIV is the greatest fear (16.5%), the occupation most frequently chosen was medicine (31.1%).

The descriptive statistics reflect that 13.6% of the participants know of someone close to them who is HIV positive (Table 4.7) and 24.3% knew of someone in their community who is HIV positive (Table 4.8). This reinforces that HIV and AIDS information and how to care for people with AIDS is vital.
Table 4.7. Knowing a friend or family member who is HIV positive

<table>
<thead>
<tr>
<th>Family /friend who is HIV+</th>
<th>Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental</td>
<td>Control</td>
</tr>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>17.1%</td>
</tr>
<tr>
<td>No</td>
<td>31</td>
<td>75.6%</td>
</tr>
<tr>
<td>Not indicated</td>
<td>3</td>
<td>7.3%</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 4.8. Knowing a Community member who is HIV Positive

<table>
<thead>
<tr>
<th>Community member who is HIV+</th>
<th>Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental</td>
<td>Control</td>
</tr>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
<td>24.4%</td>
</tr>
<tr>
<td>No</td>
<td>29</td>
<td>70.7%</td>
</tr>
<tr>
<td>Not indicated</td>
<td>2</td>
<td>4.9%</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

4.5. Analysis and Discussion of Various Dimensions that Assess HIV and AIDS Knowledge, Attitudes and Skills

In order to assess the impact of a programme, there must be an assessment of the existing levels of knowledge and characteristics that the girls possess at the beginning of a sequence of instruction (pre test). Erikson (1963) refers to this as entering behaviour. These same dimensions must be assessed at the end of the intervention, so as to assess the impact of the intervention programme (post test). Table 4.9. reflects that in the experimental group there is an increase in the average number of correct responses between the pre and post test in each dimension assessed. The T-test (Table 4.10) indicates that in 11 of the 18 dimensions assessed, the levels of significance between the pre and posttest responses (experimental group) are significant at the 95% level (p< 0.05).
Table 4.9. T-test for the Various Dimensions that Assess Knowledge, Attitudes and Skills Related to HIV and AIDS Information (Experimental Group)

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>2.4054</td>
<td>37</td>
<td>1.01268</td>
</tr>
<tr>
<td>Post</td>
<td>3.6486</td>
<td>37</td>
<td>0.82382</td>
</tr>
<tr>
<td>Transmission of HIV and AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>4.1951</td>
<td>41</td>
<td>1.79192</td>
</tr>
<tr>
<td>Post</td>
<td>6.1463</td>
<td>40</td>
<td>0.96335</td>
</tr>
<tr>
<td>Testing procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>1.3415</td>
<td>41</td>
<td>0.79403</td>
</tr>
<tr>
<td>Post</td>
<td>1.6585</td>
<td>40</td>
<td>0.81684</td>
</tr>
<tr>
<td>Statistics regarding HIV and AIDS in South Africa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>1.8780</td>
<td>41</td>
<td>1.02944</td>
</tr>
<tr>
<td>Post</td>
<td>3.1951</td>
<td>40</td>
<td>0.87234</td>
</tr>
<tr>
<td>Seriousness of epidemic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>0.4390</td>
<td>41</td>
<td>0.50243</td>
</tr>
<tr>
<td>Post</td>
<td>0.7073</td>
<td>40</td>
<td>0.46065</td>
</tr>
<tr>
<td>Discrimination of people with HIV and AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>2.8537</td>
<td>41</td>
<td>1.40643</td>
</tr>
<tr>
<td>Post</td>
<td>3.9024</td>
<td>40</td>
<td>0.94353</td>
</tr>
<tr>
<td>Impact of traditional belief systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>1.2683</td>
<td>41</td>
<td>0.63342</td>
</tr>
<tr>
<td>Post</td>
<td>1.7561</td>
<td>40</td>
<td>0.48890</td>
</tr>
<tr>
<td>Emotional support of people with HIV and AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>0.6585</td>
<td>41</td>
<td>0.48009</td>
</tr>
<tr>
<td>Post</td>
<td>0.8049</td>
<td>40</td>
<td>0.40122</td>
</tr>
<tr>
<td>Impact of gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>0.2195</td>
<td>41</td>
<td>0.41906</td>
</tr>
<tr>
<td>Post</td>
<td>0.6585</td>
<td>40</td>
<td>0.48009</td>
</tr>
<tr>
<td>Uncomfortable talking about sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>0.3659</td>
<td>41</td>
<td>0.48765</td>
</tr>
<tr>
<td>Post</td>
<td>0.5610</td>
<td>40</td>
<td>0.50243</td>
</tr>
<tr>
<td>Information overload</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>0.4878</td>
<td>41</td>
<td>0.50606</td>
</tr>
<tr>
<td>Post</td>
<td>0.5854</td>
<td>40</td>
<td>0.49878</td>
</tr>
<tr>
<td>Self protection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>0.8293</td>
<td>41</td>
<td>0.38095</td>
</tr>
<tr>
<td>Post</td>
<td>0.9512</td>
<td>40</td>
<td>0.21808</td>
</tr>
<tr>
<td>Cultural construction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>1.8049</td>
<td>41</td>
<td>0.71483</td>
</tr>
<tr>
<td>Post</td>
<td>2.6341</td>
<td>40</td>
<td>0.62274</td>
</tr>
<tr>
<td>Self esteem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>0.8293</td>
<td>41</td>
<td>0.38095</td>
</tr>
<tr>
<td>Post</td>
<td>0.9512</td>
<td>40</td>
<td>0.21808</td>
</tr>
<tr>
<td>Sex role stereotype</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>0.2195</td>
<td>41</td>
<td>0.41906</td>
</tr>
<tr>
<td>Post</td>
<td>0.6585</td>
<td>40</td>
<td>0.48009</td>
</tr>
<tr>
<td>Personal invulnerability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>1.1463</td>
<td>41</td>
<td>0.93704</td>
</tr>
<tr>
<td>Post</td>
<td>1.8537</td>
<td>40</td>
<td>0.98896</td>
</tr>
<tr>
<td>Stigma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>1.7317</td>
<td>41</td>
<td>0.92262</td>
</tr>
<tr>
<td>Post</td>
<td>2.0976</td>
<td>40</td>
<td>0.86037</td>
</tr>
<tr>
<td>Non-discrimination of people with HIV and AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>0.6585</td>
<td>41</td>
<td>0.48009</td>
</tr>
<tr>
<td>Post</td>
<td>0.8049</td>
<td>40</td>
<td>0.40122</td>
</tr>
</tbody>
</table>
Table 4.10. T-test results for Significant Differences between Pre and Post Test

Results (Experimental Group)

Paired Samples Statistics (Experimental Group)

<table>
<thead>
<tr>
<th>PreTest - PostTest</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is AIDS</td>
<td>-6.365</td>
<td>36</td>
<td>0.000*</td>
</tr>
<tr>
<td>Transmission of HIV and AIDS</td>
<td>-5.992</td>
<td>40</td>
<td>0.000*</td>
</tr>
<tr>
<td>Testing procedures</td>
<td>-1.875</td>
<td>40</td>
<td>0.068</td>
</tr>
<tr>
<td>Statistics regarding HIV and AIDS in South Africa</td>
<td>-6.335</td>
<td>40</td>
<td>0.000*</td>
</tr>
<tr>
<td>Seriousness of epidemic</td>
<td>-2.899</td>
<td>40</td>
<td>0.006*</td>
</tr>
<tr>
<td>Discrimination of people with HIV and AIDS</td>
<td>-4.207</td>
<td>40</td>
<td>0.000*</td>
</tr>
<tr>
<td>Impact of traditional belief systems</td>
<td>-4.189</td>
<td>40</td>
<td>0.000*</td>
</tr>
<tr>
<td>Emotional support of people with HIV and AIDS</td>
<td>-1.290</td>
<td>40</td>
<td>0.205</td>
</tr>
<tr>
<td>Impact of gender</td>
<td>-4.179</td>
<td>40</td>
<td>0.000*</td>
</tr>
<tr>
<td>Uncomfortable talking about sex</td>
<td>-1.840</td>
<td>40</td>
<td>0.073</td>
</tr>
<tr>
<td>Information overload</td>
<td>-1.000</td>
<td>40</td>
<td>0.323</td>
</tr>
<tr>
<td>Self protection</td>
<td>-1.705</td>
<td>40</td>
<td>0.096</td>
</tr>
<tr>
<td>Cultural construction</td>
<td>-6.151</td>
<td>40</td>
<td>0.000*</td>
</tr>
<tr>
<td>Self esteem</td>
<td>-1.705</td>
<td>40</td>
<td>0.096</td>
</tr>
<tr>
<td>Sex role stereotype</td>
<td>-4.179</td>
<td>40</td>
<td>0.000*</td>
</tr>
<tr>
<td>Personal invulnerability</td>
<td>-3.567</td>
<td>40</td>
<td>0.001*</td>
</tr>
<tr>
<td>Stigma</td>
<td>-2.108</td>
<td>40</td>
<td>0.042*</td>
</tr>
<tr>
<td>Non-discrimination of people with HIV and AIDS</td>
<td>-1.290</td>
<td>40</td>
<td>0.205</td>
</tr>
</tbody>
</table>

*significant difference at 0.05 level

Table 4.11. reflects the t-test of the average number of correct responses between the pre and post test responses (control group). An examination of the means in table 4.12 reflects that there are no significant changes in the control group’s responses between the pre and post test (p< 0.05) at the 95% level.
Table 4.11. T-Test for the Various Dimensions that Assess Knowledge, Attitudes and Skills Related to HIV and AIDS Information (Control Group)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is AIDS</td>
<td>Pre</td>
<td>2.7500</td>
<td>60</td>
</tr>
<tr>
<td>Post</td>
<td>2.6500</td>
<td>60</td>
<td>1.20486</td>
</tr>
<tr>
<td>Transmission of H/A</td>
<td>Pre</td>
<td>4.7541</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>4.6557</td>
<td>61</td>
<td>1.26340</td>
</tr>
<tr>
<td>Testing procedures</td>
<td>Pre</td>
<td>1.5738</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>1.7377</td>
<td>61</td>
<td>0.57450</td>
</tr>
<tr>
<td>Statistics regarding H/A in South Africa</td>
<td>Pre</td>
<td>2.1639</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>2.1967</td>
<td>61</td>
<td>0.98013</td>
</tr>
<tr>
<td>Seriousness of epidemic</td>
<td>Pre</td>
<td>0.5246</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>0.6066</td>
<td>61</td>
<td>0.49257</td>
</tr>
<tr>
<td>Discrimination of people with H/A</td>
<td>Pre</td>
<td>3.5574</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>3.7213</td>
<td>61</td>
<td>1.18506</td>
</tr>
<tr>
<td>Impact of traditional belief systems</td>
<td>Pre</td>
<td>1.6230</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>1.6393</td>
<td>61</td>
<td>0.54872</td>
</tr>
<tr>
<td>Emotional support of people with H/A</td>
<td>Pre</td>
<td>0.8525</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>0.8689</td>
<td>61</td>
<td>0.34036</td>
</tr>
<tr>
<td>Impact of gender</td>
<td>Pre</td>
<td>0.2295</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>0.2787</td>
<td>61</td>
<td>0.45207</td>
</tr>
<tr>
<td>Uncomfortable talking about sex</td>
<td>Pre</td>
<td>0.4754</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>0.5246</td>
<td>61</td>
<td>0.50354</td>
</tr>
<tr>
<td>Information overload</td>
<td>Pre</td>
<td>0.5902</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>0.6885</td>
<td>61</td>
<td>0.46694</td>
</tr>
<tr>
<td>Self protection</td>
<td>Pre</td>
<td>0.9672</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>0.9508</td>
<td>61</td>
<td>0.21804</td>
</tr>
<tr>
<td>Cultural construction</td>
<td>Pre</td>
<td>2.3770</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>2.3770</td>
<td>61</td>
<td>0.71056</td>
</tr>
<tr>
<td>Self esteem</td>
<td>Pre</td>
<td>0.9672</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>0.9508</td>
<td>61</td>
<td>0.21804</td>
</tr>
<tr>
<td>Sex role stereotype</td>
<td>Pre</td>
<td>0.2295</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>0.2787</td>
<td>61</td>
<td>0.45207</td>
</tr>
<tr>
<td>Personal invulnerability</td>
<td>Pre</td>
<td>1.3607</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>1.6066</td>
<td>61</td>
<td>0.86176</td>
</tr>
<tr>
<td>Stigma</td>
<td>Pre</td>
<td>1.9836</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>2.1148</td>
<td>61</td>
<td>0.91466</td>
</tr>
<tr>
<td>Non-discrimination of people with H/A</td>
<td>Pre</td>
<td>0.8525</td>
<td>61</td>
</tr>
<tr>
<td>Post</td>
<td>0.8689</td>
<td>61</td>
<td>0.34036</td>
</tr>
</tbody>
</table>
It is evident from the results of the analysis of the pre and posttests (Table 4.11) in the experimental group that the entering characteristics and knowledge of the participants are significantly improved along 11 of the eighteen dimensions. These dimensions focus on areas of HIV and AIDS knowledge (the disease, transmission, statistics); attitudes (discriminatory behaviour and stigma attached to being HIV positive, gender and sex role stereotypes, cultural and traditional construction of HIV and AIDS and personal invulnerability).

An analysis of relevant HIV and AIDS skills for pre adolescent girls and the impact of the intervention on the participants in the experimental and control group are reflected
in the pre and post test paired samples in Table 4.13. The results indicate that the impact of the HIV and AIDS prevention intervention programme on the area of skills in the experimental group is significant at the 95% level in the areas of assertiveness training and being open about talking about HIV and AIDS; in the girls taking more personal responsibility for their health and well being; and in seeking more information to ensure health promotion (see Table 4.13). The control group reflects no significant change in these variables in the pre and posttest. It is evident that the intervention has a positive impact on the acquisition of skills to promote healthy behaviour.

**Table 4.13 Paired Samples Test for HIV and AIDS Skills Reflected in the Pre and Post Tests (Experimental and Control Groups)**

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre Test vs Post Test</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being open/assertiveness</td>
<td>3.339</td>
<td>39</td>
<td></td>
<td>0.002*</td>
</tr>
<tr>
<td>Sex role stereotype</td>
<td>0.352</td>
<td>38</td>
<td></td>
<td>0.727</td>
</tr>
<tr>
<td>Personal responsibility for well being</td>
<td>2.755</td>
<td>38</td>
<td></td>
<td>0.009*</td>
</tr>
<tr>
<td>Influence of peer pressure</td>
<td>0.719</td>
<td>39</td>
<td></td>
<td>0.477</td>
</tr>
<tr>
<td>A need for more information to promote well being</td>
<td>-2.975</td>
<td>39</td>
<td></td>
<td>0.005*</td>
</tr>
<tr>
<td><strong>Control</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being open/assertiveness</td>
<td>0.442</td>
<td>61</td>
<td></td>
<td>0.660</td>
</tr>
<tr>
<td>Sex role stereotype</td>
<td>1.162</td>
<td>58</td>
<td></td>
<td>0.250</td>
</tr>
<tr>
<td>Personal responsibility for well being</td>
<td>0.725</td>
<td>60</td>
<td></td>
<td>0.471</td>
</tr>
<tr>
<td>Influence of peer pressure</td>
<td>0.680</td>
<td>60</td>
<td></td>
<td>0.499</td>
</tr>
<tr>
<td>A need for more information to promote well being</td>
<td>-1.393</td>
<td>60</td>
<td></td>
<td>0.169</td>
</tr>
</tbody>
</table>

*Significant difference at 0.05 levels*
4.5.1. Graphical Representation of HIV and AIDS Knowledge, Attitudes and Skills in the Pre and Post Test Questionnaire

The eighteen items in the pre and post test questionnaire are grouped under twelve areas of HIV and AIDS knowledge, attitudes and skills that are necessary and appropriate for the pre adolescent girl to possess so as to improve health promotion. These items are then graphically represented to show changes in these dimensions in the pre and post tests of the experimental and control groups. The following is the key to interpret the types of HIV and AIDS information analysed.

Table 4.14. Key to the Details of HIV and AIDS Information represented in Figure 4.1; 4.2; 4.3 and 4.4.

<table>
<thead>
<tr>
<th>HIV and AIDS Knowledge</th>
<th>1. What is HIV and AIDS?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Methods of Transmission</td>
</tr>
<tr>
<td></td>
<td>3. HIV and AIDS Statistics</td>
</tr>
<tr>
<td></td>
<td>4. Seriousness of the Epidemic</td>
</tr>
<tr>
<td></td>
<td>5. Testing Procedures</td>
</tr>
<tr>
<td></td>
<td>6. Awareness of Misinformation</td>
</tr>
<tr>
<td>Attitudes</td>
<td>7. Impact of Culture and Belief Systems</td>
</tr>
<tr>
<td></td>
<td>8. Emotional Support of People with AIDS</td>
</tr>
<tr>
<td></td>
<td>9. Impact of Gender/Assertiveness</td>
</tr>
<tr>
<td></td>
<td>10. Uncomfortable Talking about Sex</td>
</tr>
<tr>
<td>Skills</td>
<td>11. Need for information</td>
</tr>
<tr>
<td></td>
<td>12. Need for Self Protection</td>
</tr>
</tbody>
</table>
An analysis of the results of the pre test with the experimental and control groups (Figure 4.1) reflect that the control group has a relatively higher level of pre-existing HIV and AIDS information on all dimensions. Figure 4.2 reflects the results of the posttests that were administered to the experimental and control groups. The experimental group now has an increase in eight of the twelve dimensions of HIV and AIDS information.

Figure 4.2
Figure 4.3 reflects that the HIV and AIDS prevention intervention programme has a significantly positive impact on the experimental group’s level of HIV and AIDS information in the post test (see Table 4.12). Furthermore, after the intervention, the experimental group has higher levels of HIV and AIDS information on all the dimensions of HIV and AIDS information.

Figure 4.4
Figure 4.4 reflects that the levels of HIV and AIDS information in the pre and posttest for the control group are not statistically significantly different (see Table 4.10). There is, however, an improvement in the results, on all dimensions, in the experimental groups response in the pre and posttest (Figure 4.3). When a comparison study is made of the pre-existing knowledge and characteristics of the experimental and control groups (Figure 4.1), it is evident that the control group has a higher entering level of HIV and AIDS information on all dimensions. In a comparison study of the post tests results of the experimental and control groups (Figure 4.2) it is evident that the intervention programme significantly changed the level of information for the experimental group on eight of the twelve dimensions.

4.6. Analysis and Discussion of the Participants' Evaluation of the HIV and AIDS Prevention Intervention Programme

The goals and objectives of the programme formulate the evaluation of a programme, which needs to be focused and goal-driven. The evaluation of the three individual sessions with the girls is analysed according to their respective objectives and whether they are met. The general overall evaluation is analysed according to the research questions that shape this research.

4.6.1. Analysis of Individual Sessions

Session one: The objectives of this session are to address issues around HIV and AIDS and to impart information on HIV and AIDS, methods of transmission, sex and sexuality. In the evaluation 90% of the girls rated this session as excellent; 7.5% as
Table 4.15 lists new information that the participants have attained in session one. Twenty seven and a half percent of the participants list facts about sex, sexuality, reproduction and menstruation as being new information; 20% list information on the methods of transmission of HIV and AIDS and 17.5% on general knowledge about HIV and AIDS. It is evident that the objectives of this session are met as all of the girls had listed information linked to HIV and AIDS.

Table 4.15. New Information Learnt in Session One

<table>
<thead>
<tr>
<th>Areas of New Information</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not indicated</td>
<td>4</td>
<td>10.0</td>
</tr>
<tr>
<td>AIDS Knowledge</td>
<td>7</td>
<td>17.5</td>
</tr>
<tr>
<td>Babies can get infected</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Gender and HIV</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Learnt about Sex/sexuality</td>
<td>11</td>
<td>27.5</td>
</tr>
<tr>
<td>No to sex</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Self-Protection</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>HIV/AIDS Statistics</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Keeping safe</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Transmission</td>
<td>8</td>
<td>20.0</td>
</tr>
<tr>
<td>Taking HIV seriously</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Session two: The objectives of this session are to examine the girls' attitudes towards HIV and AIDS and to assist in the development of non-judgmental attitudes. In the evaluation of this session, 90% of the girls rate it excellent and 10% as good. With regards to new information learnt (Table 4.16), issues relating to sex and sexuality are equally rated with the caring of people with HIV and AIDS (32.5%).
Table 4.16. New information learnt in session two

<table>
<thead>
<tr>
<th>Areas of New Information</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Response</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>AIDS Knowledge</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Reduction in Fear</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Learnt about sex</td>
<td>13</td>
<td>32.5</td>
</tr>
<tr>
<td>Dispelling myths</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>No to sex</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Self-protection</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Caring for people with H/A</td>
<td>13</td>
<td>32.5</td>
</tr>
<tr>
<td>Transmission</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Session three: The objectives of this session are to discuss assertiveness training and the handling of peer pressure; and to explore decision-making skills and problem solving techniques. In this evaluation 90% of the girls rate it excellent, 5% as good and 5% did not respond. The evaluation response lists assertive training (30%); decision-making skills (22.5%) and handling peer pressure (10%) as new information that is learnt and these are key aspects of promoting health and well being (Table 4.17).

Table 4.17. New Information Learnt in Session Three

<table>
<thead>
<tr>
<th>Areas of New Information</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Response</td>
<td>4</td>
<td>10.0</td>
</tr>
<tr>
<td>Assertiveness</td>
<td>12</td>
<td>30.0</td>
</tr>
<tr>
<td>AIDS Knowledge</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Decision making skills</td>
<td>9</td>
<td>22.5</td>
</tr>
<tr>
<td>Handling peer pressure</td>
<td>4</td>
<td>10.0</td>
</tr>
<tr>
<td>Keeping safe</td>
<td>6</td>
<td>15.0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0</td>
</tr>
</tbody>
</table>

4.6.2. Analysis of the Participants’ Evaluation of the Whole Intervention Programme

In the analysis of the overall evaluation, 97.5% of the girls enjoyed the programme. All the girls (100%) state that they learnt something new. Eighty five percent state
that their view of HIV and AIDS has changed. The greatest impact of the programme (Table 4.18) is in the acquisition of HIV and AIDS related knowledge (15%); taking HIV and AIDS seriously and realising their vulnerability (12.5%); learning about ways to keep safe from infection (10%); and realising that there is no cure for AIDS (7.5%).

Table 4.18. Impact of the Programme on the Participants' View of HIV and AIDS

<table>
<thead>
<tr>
<th>How did their view of HIV and AIDS change?</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No response</td>
<td>15</td>
<td>37.5</td>
</tr>
<tr>
<td>AIDS knowledge</td>
<td>6</td>
<td>15.0</td>
</tr>
<tr>
<td>Being healthy</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Dispelling myths</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>How to keep safe</td>
<td>4</td>
<td>10.0</td>
</tr>
<tr>
<td>No cure for H/A</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>Self-protection</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Statistics</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Transmission methods</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Taking H/A seriously</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4.19. Impact of the Programme on the Participants' Self-efficacy for Promoting Healthy Behaviours

<table>
<thead>
<tr>
<th>What information makes the participants feel confident?</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Response</td>
<td>8</td>
<td>20.0</td>
</tr>
<tr>
<td>Being Assertive</td>
<td>4</td>
<td>10.0</td>
</tr>
<tr>
<td>AIDS Knowledge</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Being Healthy</td>
<td>10</td>
<td>25.0</td>
</tr>
<tr>
<td>Reduction in Fear</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Keeping Safe</td>
<td>6</td>
<td>15.0</td>
</tr>
<tr>
<td>Maturity</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Handling peer pressure</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>No to Sex</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Self Protection</td>
<td>4</td>
<td>10.0</td>
</tr>
<tr>
<td>Transmission</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4.19 lists information that makes the participants feel confident about promoting healthy behaviours. Information on how to keep healthy (25%), how to
keep safe (15%) and information on self protection (10%) afford the greatest boost to their confidence levels.

4.7. General HIV and AIDS Information that Creates Initial Dissonance

According to Crosby (1996) the first step in penetrating the adolescent mind is to cast doubt on currently held beliefs and shake the adolescent's complacency. Carl Rogers and Jean Piaget also cite dissonance as a starting point for behaviour change. Creating dissonance works best when emotional aspects precede cognitive issues in exposing adolescents to new realities. The researcher observed that the following information startled the girls:

- There are so many people who are already HIV positive in the world and more especially in South Africa.
- They are shocked at the number of new infections per day in South Africa.
- That girls, as young as eleven years old, are falling pregnant and having babies.
- Babies can contract HIV at birth.
- That menstruation is a sign of womanhood and the onset of the ability to fall pregnant.
- That menstruation lasts well into one's adult life until the onset of menopause.
- That there is no way that the female could get out of menstruating.

4.8. Themes Elicited from the Qualitative and Quantitative Analysis of the Questionnaire and Intervention Programme

4.8.1 Cultural Construction of HIV and AIDS

With regards to the impact of culture on the girl's construction of HIV and AIDS,
Fine (1988) as cited in Moore and Rosenthal (1993) suggest that sexuality develops in a culture replete with mixed messages about its acceptability. Four themes dominate the public and private discourse about sexuality and these provide conflicting messages about how adolescents should conduct their sex lives. The themes revolve around morality and responsibility, desire, danger and victimization. In this research, the girls raised an important aspect of morality and responsibility in the second session when they referred to young girls selling their bodies in exchange for gifts. Saneka et al. (2007) claim that the lure of gifts and money is a powerful motivator to engage in risky behaviour. According to Everatt and Milner (1994, p. 34) the youth don’t take AIDS seriously enough and a possible explanation for this is “... when you are faced with all the ravages of apartheid, with the everyday hardships of hunger, exposure to the elements and violent crime, how can you take seriously an invisible little virus that might have an effect seven years down the road?”

The discourse of desire is Fine’s second theme and is juxtaposed with the discourse of danger. The possibility of pregnancy and social disgrace is more frequently communicated to girls. It was interesting to note that there was no significant change on the item addressing the girl’s ability to say No to a boy they like even though they had attended the intervention programme. Desire could therefore be understood to be a powerful motivator of behaviour.

Inappropriate beliefs or myths about sexuality and AIDS can, in part, explain why young people engage in risky behaviour. One of these we may refer to as the “trusting to love” myth (Moore & Rosenthal, 1993). Trust becomes a significant element in making decisions about health promoting behaviours. There is a statistically significant difference at the 95% level in the girl’s response in the pre test and post
test questionnaire in favour of being more careful to trust (p-level of .000, df 1). In addition the Fisher’s Exact Test was carried out (p= .000). There is an increase from 11.1% to 33.3% in the experimental group. However, we can interpret the results, as 66.7% of the girls still believe in trusting their boyfriends not to give them HIV. The cultural and social concepts of fidelity and trust in a relationship are still powerful even when faced with the HIV and AIDS epidemic.

Other myths surrounding HIV and AIDS that the girls’ had referred to in the session were that they had heard that HIV and AIDS was first contracted when a man slept with a dog. They had heard that “you get it if you do bad things” and “gay people contract it”. They had also heard that eating garlic had cured HIV and AIDS. There is a significant change in this belief in the posttest response (p-level of 0.46, df 1 and Fisher’s Exact Test p= 0.70). The girls’ response in the posttest reflects a significant change at a p-level of .001 (df 1) with regards to whether one can tell if a person has AIDS by looking at them. The Fisher’s Exact Test was also carried out (p= .001).

In the data captured in the pre test questionnaire, 17.3% of the girls in the experimental group and 8.9% in the control group had believed that AIDS is a punishment from God. There is a statistically significant change at the 95% level in the post test result with the experimental group (p- level of .001, df 1). In addition the Fisher’s Exact Test was carried out (p= .001). There is a reduction in this belief from 17.3% to 3.7%. The control group posttest results remain the same.

4.8.2. Gender, Identity and Concept of Well Being

The WHO (2003) states that gender plays an integral role in determining an individual’s risk and vulnerability to HIV infection and to a great extent determines
HIV and AIDS Intervention

how we think, feel and what we believe we can control. The pre adolescent girl is especially vulnerable as age intersects with gender at a critical stage when identity is being developed. Some areas which impact on the development of a girl's identity and self concept are her ability to be assertive; the influence of peer pressure; her acceptance of sex role stereotypes; and her ability to take responsibility for her well being. An analysis of the pre and post test scores (see Table 4.13) reflect a significant change in the girls' responses as a result of the intervention programme. There is a change in their understanding and implementation of being assertive, significant at a p-level .002 (df 39); taking personal responsibility for their health and well being, significant at a p-level .009 (df 38); and needing more information so as to keep infection free, significant at a p-level .005 (df 39). The response of the girls in the control group is not statistically significant on any dimension (see Table 4.13).

The positive change in the posttest scores in the experimental group highlights the literature surveyed on theories of development reviewed in chapter two. Biehler and Hudson (1986) state that Kohlberg's moral development in the preadolescence phase can be accelerated as it is determined by social, cultural and historical factors. Piaget's (1963) concept of adaptation also relates to the inclusion of new information into existing information. Gouws and Kruger (1994) reinforce this by stating that the individual can be assisted by exposure to suitable experiences that are likely to positively influence personality development.
4.8.3. The Dilemma of Talking about Sex

The topic of sex and sexuality created much interest. There were many questions ranging from enquiring about what is sex, periods, to breast development and how babies are born. There was much hilarity when the male and female reproductive organs were discussed. Many girls had for the first time heard the terms ‘penis’ and ‘vagina’ and stated that they had used the terms “sausage” and “polony”. They were interested to know what “deep kissing” was and whether one could contract HIV in this way. Many girls very forcefully stated the concept of ‘not selling your body for money’ and that they had “heard” that this is what some girls do. They also wanted to know about how gay men had sex. It was obvious that they had many questions and were very curious to know the answers. It also reflected to the researcher that they were comfortable with her and were able to ask these questions.

The onset of bodily changes and raging hormones gives rise to confusion especially for the pre adolescent who is trying to develop a clear sense of what it means to be male or female in our society. Concern and curiosity about sex are almost universal, especially among girls. The struggle between wanting to talk about these bodily changes, changes in the perception of the opposite sex and an awareness of sexual pleasure is weighted down by social norms about appropriate female behaviour. In this connection dominant ideologies of femininity promote ignorance, innocence and virginity and dominant versions of masculinity encourage young men to seek sexual experience with a variety of partners (Rivers & Aggleton, 2001). This wanting to talk about sex and denying themselves this want was reflected in the ambiguous results in the posttest questionnaire with the experimental group. Results reflect that there is no significant change in the girls’ response that sex is a personal topic and we shouldn’t
talk about it (p-level of .059). The Fisher’s Exact test is also carried out (p=.076) (df1). There is however a significant difference at the 90% level in the girls’ response that HIV and AIDS should be spoken more freely between parents and children (p-level of .002, df 39). Gupta, Weiss, and Mane (1996) say that talking about sex is a prerequisite for AIDS prevention, and only when people talk about sex can negotiation between partners take place. The researcher observed from the intervention sessions that the girls were very interested to know about sex and sexuality, male and female reproductive organs and pregnancy and childbirth.

4.8.4. Fears around HIV and AIDS

University of Natal academics, Robert Morrell and Lebo Moletsane presented a paper on research at schools at the University of London’s Conference on Gender and the Politics of Education (Goodenough, 2001). They reported that the girls’ knowledge of HIV and AIDS was set in a powerful context of their first-hand experience of rape and sexual assault. Morrel and Moletsane’s report was highlighted in this research (see table 4.6) where being infected with HIV was listed as the girl’s greatest fear (18.1%), followed by crime (17.0%). The girl’s were also afraid of death (7.4%) and rape (7.4%). An example of a few written responses from the girls from both schools as to what their greatest fear was included the following:

‘I am afraid of murder, rape and child abuse.’

‘I will die while I am still small.’

‘I am afraid of AIDS.’

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4.8.5. Asserting your Rights

The ability to assert your rights and decisions is an important skill in promoting health and handling peer pressure. A composite result of the overall evaluation reflects that a total of 77.5% of the girls had rated an increase in knowing how to be more assertive (see Table 4.16). This result could be analysed further to reflect the various components which constitute assertiveness, namely a boost in confidence in asserting their rights (30%); practicing better decision making skills (22.5%); handling peer pressure (10%); and knowing how to keep safe (15%). Table 4.13 which analyses pre and post test HIV and AIDS skills attained, reflects that there is significant difference in assertiveness at a p-level of .002 (df 39); personal responsibility for safety at a p-level of .009 (df 38) and being interested in new information on how to keep safe at a p-level of .005 (df 39).

Observations of the girls’ role-play of passive, aggressive and assertive female behaviour indicated that they had no idea about how to be assertive. They were very interested to learn about body language, eye contact, tone and pitch of voice and the meanings it conveyed to other people.

4.8.6. Personal Projections of their Future in a World of HIV and AIDS

Self-efficacy, which refers to a person’s belief that they can perform a behaviour, is a powerful motivator for the implementation and sustainability of that behaviour. The girls in the experimental group reflect a positive personal view of the future as they list occupations, which require effort and determination to achieve (Table 4.4). Eighty percent report confidence in their ability to handle the HIV and AIDS epidemic (Table 4.19).
While they acknowledge fear and concern about their vulnerability, they also display positive skills about coping with HIV and AIDS on a personal and community level.

4.9. Conclusion

An important aspect to take note of in an overview of the intervention programme is that the girls in the experimental group thoroughly enjoyed the intervention. There was a vibrancy and willingness to participate in the tasks that were required. They were very interested in the biological aspects of the body and the disease, the importance of having a strong mind in order to make the right choices, that while socialising was important it must not be at the expense of their safety and that there were ways of caring for people who have HIV and AIDS. Thus the concept of HIV and AIDS as a biopsychosocial phenomenon was explored. Chapter five presents the findings, limitations, recommendations and conclusions.
Chapter Five

Findings, Limitations, Recommendations and Conclusions

A perusal of the results and discussion in chapter four highlight the following:

- The control group when compared with the experimental group had a higher level of entering knowledge (pre test) on all dimensions of HIV and AIDS information.
- When the control group's pre and posttest results were analysed, the levels of HIV and AIDS information did not significantly change in the posttest.
- The experimental group, when compared with the control group in the posttest, improved their level of HIV and AIDS information on eight of the twelve dimensions assessed.
- When the experimental group's pre and post test results were analysed there was an increase in their HIV and AIDS information on all dimensions.

The objectives of this research were met as the extent and nature of the preadolescent girls knowledge, attitude and skills were assessed. An HIV and AIDS prevention intervention programme was designed and implemented with these girls. An analysis of the results of this intervention indicates that it has had a positive impact on all dimensions of HIV and AIDS information.

5.1. Findings

This study has found that preadolescent girls are already very interested in knowing the facts of life. Their curiosity about their physical and sexual development and
engaging with the opposite sex is at a peak. This to a large extent explained the vibrancy in their participation. Few parents feel comfortable talking about sex and sexuality (White, 1999) and if schools are not going to address it, then the danger is that their curiosity will be satisfied by their peers who may be misinformed. This in itself may not be a calamity, but in a world rampant with HIV and AIDS, misinformation may ring the death knell for these children. This reinforces the importance of early intervention in HIV and AIDS education especially as Lemba (2002) reports that the first sexual contact for girls is as young as eleven years of age.

Peer education is an important tool to be accessed.

It is also evident that while the girls knew that physical relations with boys were dangerous, they had no idea of how to assert themselves. Thus HIV and AIDS programmes must go beyond the disseminating of knowledge and address attitudes and skills that the learners can incorporate into their behavioural repertoire so as to stand by their decisions.

Findings revealed that participants wanted to know more about their physiological changes as a result of puberty. They also wanted more knowledge about sex and yet felt a sense of inappropriateness in talking about it. This may be due to the impact of feminine ideology, which promotes ignorance, innocence, virginity and apathy.

Puberty therefore is a biological event that changes the pre adolescent and adolescents’ functioning on a social level (Miller & Simon, 1980). In addition, the young person may be further confused because the issue of sex and sexuality is emphatically attached to morality. Even though they may endorse the traditional view that premarital sex is wrong, however the youth are motivated to engage in such relationships. They may feel that they are expected to have early sexual experience
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and to develop a high level of competence. HIV and AIDS education needs to be cognizant of these multiple factors that come into play and incorporate biology, psychology and sociology into its broad frame of reference.

5.2. Limitations

- A larger sample size and a study of learners in primary schools in other areas would have yielded richer information.

- The duration of the intervention was too short to deeply address issues, which the girls wanted to explore. Smaller groups and more contact time would address this limitation.

- Learning has the greatest impact when it is reinforced outside of school. Formulating peer support groups and including parents in a similar intervention programme would consolidate HIV and AIDS education in all spheres.

5.3. Recommendations

- The education system must integrate age and development appropriate sexual health and HIV and AIDS education into the curriculum for all educational grades.

- Ensure that every learner is adequately equipped with relevant life skills especially in the fourth ‘R’, that is, relationships with oneself and with others. This should include many aspects of behaviour, attitudes and values.

- An HIV and AIDS intervention programme must be repeated every six months so as to have the greatest impact and to address different issues that may become pertinent to the learners as they mature.
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- The school must identify an educator who is trained in providing counselling and support to the learners, staff and the community that it serves.
- Guidelines for HIV and AIDS intervention programme for pre adolescent girls is presented in chapter six that educators can use in the life skills programme.

5.4. Conclusion

HIV and AIDS is not just a threat facing South Africa; it is alive, well and living amongst us; masquerading under the guise of economic hardships and poverty, gender power play, sexual awakening and experimentation, stigma and prejudice. Just as the children of South Africa raised their fists against the apartheid government in the uprisings in 1976; so too, the children of South Africa need to gather together and unmask this threat which has the power to decimate us. In the onslaught of the current HIV and AIDS crisis in South Africa, educational interventions must look beyond the individual to social and economic conditions, to see health as more than medicine, to understand concepts of well being. HIV and AIDS prevention education needs to incorporate more than ABC messages of the medical model. We need to look deeper, at social constructs of health promotion. We need to unravel the layers of gendered and patriarchal thinking and light the spark of critical thinking and an education for liberation. The battle now is not for political freedom but the freedom to live.

Young people’s sexual behaviour does not follow a rule-governed script but is strongly influenced by the biological, psychological, sociological and cultural contexts. The broad aim of HIV and AIDS education should be to promote more conservative adolescent sexual behaviour. It is hoped that they may return to the days of premarital chastity. Whatever their chosen path, today’s adolescents will have to
live with the danger of HIV and AIDS and their sexual decisions must be guided accordingly. Interventions will certainly stretch creativity and resources, but it is absolutely necessary to rise to the challenge.
6.1. Guidelines for Educators Developing an HIV and AIDS Prevention Intervention Programme for Pre Adolescent Girls

The objective of an HIV and AIDS prevention intervention programme is to help learners acquire knowledge, attitudes and skills to make informed decisions, practice healthy behaviours and create conditions conducive to good health.

The design of the programme must consider the developmental level of your target group; and build on and reinforce previous learning experiences. Special note must be taken of your school’s code of conduct regarding HIV and AIDS. While scientific terms and biological terms/details may be important, for purposes of health education, practical and basic information to avoid infection is more important.

The actual intervention programme should include the following areas:

- **Knowledge** – what is HIV and AIDS, methods of transmission, is there a cure, testing procedures, statistics (national and international), basic sex education and bodily changes during puberty, shared responsibility for HIV prevention and protection.

- **Attitudes** – stigma attached to being HIV positive, fears around transmission of infection, myths, how traditional belief systems and cultural beliefs colour our perception of illness, discrimination of people with AIDS, development of empathy, acceptance and tolerance.
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• Skills – practical and positive methods of handling emotions, developing healthy communication skills including assertiveness training, building a personal value system, saying no to abuse, developing positive self esteem and general well being, impact of gender roles, caring for people with HIV and AIDS, keeping healthy while being HIV positive.

The method adopted for the dissemination of the above information is vital for the message to be received. The educator must move beyond the didactic mode to a psychological and emotional level so that the learners may firstly feel dissonance and be aware of their vulnerability and then learn to prevent and protect themselves from infection. The following methods may be used to achieve this:

• The group of girls must number not more than twenty as working groups can be easily created and controlled and attention can be given to individual learners.

• Group rules regarding conduct, with special reference to confidentiality, must be ascertained from the girls and reinforced timeously. This creates an accepting environment.

• The educator must be knowledgeable in the area of HIV and AIDS and must feel comfortable to communicate with the learners on sensitive issues.

• Different teaching techniques must be used ranging from answering questions in groups, role playing scenarios, art and graffiti boards reflecting ideas, open discussion time and a group quizz which creates healthy competition.

• The programme must be divided into approximately eight weekly sessions of one-hour duration each and must be reinforced at six-month intervals. This is to accommodate new situations that learners may be exposed to and change due to maturation.
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- Evaluation of the programme is vital, as it would reflect if objectives have been achieved and would highlight areas that may need to be included, reinforced again or addressed differently.

- To facilitate meaningful learning, a programme empowering parents with knowledge and skills to talk to their children about responsible sexual behaviour can be implemented.

- Peer education is a powerful tool. A few pupils can be groomed to lead this programme. Note: It must be their programme and the educator can oversee the logistical needs and provide guidance.

- Relevant sources of HIV and AIDS support, together with contact details, must be made accessible.

The educator must be cognizant of the fact that there may be learners in their group who are already HIV positive or may have loved ones who are infected. This fact must run through the entire programme as while it is very important to prevent new infections, learners must also be given hope that HIV positive people can lead a healthier lifestyle provided they take special care of their health, nutritional needs and have the necessary medical support.
References


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UNAIDS. (2001). *Children and young people in a world of AIDS.*
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Ethiopia % 20HIV factsheet.pdf


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Appendix 1


According to the UNAIDS (1999) World Health Organisation Information Series on School Health (document six), the following information was recommended to be included into Health promoting programmes.

With regards to knowledge, young children will learn that:

1. HIV is a virus some people have acquired.

2. HIV is difficult to contract and cannot be transmitted by casual contact, such as shaking hands, hugging or even eating with the same utensils.

3. People can be HIV-infected for years without showing symptoms of this infection.

4. Many people are working diligently to find a cure for AIDS and to stop people from contracting HIV infection.

With regards to attitudes/beliefs/values, young children will learn that:

1. Acceptance, not fear, of people with HIV and AIDS.

2. Respect for themselves.

3. Respect between adolescent males and females.

4. Tolerance of differences in attitude, values and beliefs.

5. Understanding of gender roles and sexual differences.

6. Belief in a positive future.

7. Empathy with others.

8. Understanding of duty with regards to self and others.

9. Willingness to explore attitudes, values and beliefs.
10. Recognition of behaviour that is deemed appropriate within the context of social and cultural norms.


With regards to skills students and others will be able to:

1. Acquire practical and positive methods for dealing with emotions and stress.

2. Develop fundamental skills for healthy interpersonal communication.

With regards to knowledge related to HIV transmission, pre adolescent children will learn:

1. Bodily changes that occur during puberty are natural and healthy events in the lives of young persons, and they should not be considered embarrassing or shameful.

2. The relevance of social, cultural, and familial values, attitudes and beliefs to health, development and the prevention of HIV infection.

3. What a virus is.

4. How viruses are transmitted.

5. The difference between AIDS and HIV.

6. How HIV is and is not transmitted.

With regards to attitudes/beliefs/values preadolescent students will demonstrate:

1. Commitment to setting ethical, moral and behavioural standards for oneself.

2. Positive self-image by defining positive personal qualities and accepting positively the bodily changes that occur during puberty.

3. Confidence to change unhealthy habits.

4. Willingness to take responsibility for behaviour.

5. A desire to learn and practice the skills for everyday living.
6. An understanding of their own values and standards.

7. An understanding of how their family values support behaviours or beliefs that can prevent HIV infection.

8. Concern for social issues and their relevance to social, cultural, familial and personal ideals.

9. A sense of care and social support for those in their community or nation who need assistance, including persons infected with and affected by HIV.

10. Honour for the knowledge, attitudes, beliefs and values of their society, culture, family and peers.

With regards to skills preadolescent students will be able to:

1. Communicate messages about HIV prevention to families, peers and members of the community.

2. Actively seek out information and services related to sexuality, health services or substance use that are relevant to their health and well-being.

3. Build a personal value system independent of peer influence.

4. Communicate about sexuality with peers and adults.

5. Use critical thinking skills to analyse complex situations that require decisions from a variety of alternatives.

6. Use problem-solving skills to identify a range of decisions and their consequences in relation to health issues that are experienced by young persons.

7. Discuss sexual behaviour and other personal issues with confidence and positive self esteem.

8. Communicate clearly and effectively a desire to delay initiation of intercourse (e.g., negotiation, assertiveness).

9. Express empathy toward persons who may be infected with HIV.
Dear Learner,

The aim of this questionnaire is to obtain information on how much you know about HIV and AIDS and what attitudes and skills you may have. Your personal details and responses are strictly confidential and will be used for research purposes only. Thank you for your time and effort.

A) Please answer the following questions.

1. Your date of birth:_____________________

2. Area in which you live:__________________

3. How many people live in your home?_____

4. How many people sleep in your bedroom with you?________

5. What work would you like to do/what would you like to be when you grow up?
   _______________________________________________________________________

6. What give you the greatest happiness? __________________________
   _______________________________________________________________________

7. What is your greatest fear? _____________________________________________
   _______________________________________________________________________
8. Do you know of someone close to you who is HIV positive?  YES / NO

9. Do you know of someone in your area that is HIV positive?  YES / NO

B) Are the following statements true or false? Please underline your answer

1. Once you are infected with HIV you are infected for life.
   True / False

2. There is no way you can find out if you are infected with HIV.
   True / False

3. It is dangerous to hug a person with AIDS.
   True / False

4. HIV is only passed through sexual activity.
   True / False

5. South Africa is not as badly affected by HIV and AIDS as other countries in Africa.
   True / False

C) Please circle the answer that you think is correct.

1. What causes AIDS?
   a) a bug
   b) a bacteria
   c) a plant
d) a virus

e) don’t know / unsure

2. How do people get AIDS?
   a) from sharing clothes
   b) from toilet seats
   c) from mosquitos
   d) from sex
   e) don’t know / unsure

3. Can you tell if someone has AIDS by looking at them?
   a) No
   b) Yes
   c) Don’t know / unsure

4. Is there a cure for AIDS?
   a) Yes
   b) No
   c) Don’t know / unsure

5. Will most people with AIDS die from the disease?
   a) Yes
   b) No
   c) Don’t know / unsure

6. Which is one way to avoid HIV?
   a) wipe off toilet seats before use
   b) Don’t touch people with HIV and AIDS
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c) use condoms during sex
d) don’t know/ unsure

7. AIDS is the abbreviation for
   a) An Infectious Disease
   b) Acquired Immune Deficiency Syndrome
   c) Human Deficiency Virus

8. If you are infected with HIV the symptoms will appear
   a) within 2 weeks
   b) within 2 months
   c) within 2 years
   d) Any time from 2 weeks to 10 years or more

9. The first symptoms of HIV infection are often mild, flu-like fever, aches, tiredness and enlarged glands
   a) True
   b) False
   c) Don’t Know/ Unsure

10. Small babies can be born with HIV?
    a) True
    b) False
    c) Don’t know / unsure

11. A person may get HIV by sharing drug needles.
    a) True
    b) False
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c) Don’t know / unsure

12. There is no way you can find out if you are infected with HIV.
   a) True
   b) False
   c) Don’t know / unsure

13. You can be cured of AIDS if you are careful to take the medicines the doctor gives you.
   a) True
   b) False
   c) Don’t Know / unsure

14. People with AIDS die from serious diseases.
   a) True
   b) False
   c) Don’t know / unsure

15. AIDS is caused by HIV.
   a) True
   b) False
   c) Don’t know / unsure

D) Please underline the correct answer.

1. True / False       People with AIDS should stay in hospitals as they may infect others.

2. True / False       Sex is a personal topic and we shouldn’t talk about it.
3. True / False  There is too much information on HIV and AIDS and I am tired of it.

4. True / False  AIDS is a punishment from God.

5. True / False  We must respect our bodies and keep ourselves safe.

6. True / False  Children who are HIV+ should not be allowed to attend schools.

7. True / False  The government should not allow people with HIV to enter the country.

8. True / False  The person with HIV and AIDS should be treated with respect.

9. True / False  We must trust our boyfriends not to give us HIV.

10. True / False  HIV and AIDS can be cured by eating garlic.

E) Please tick the number that describes how you feel about the statement


a) We must talk with our parents and friends about HIV and AIDS.

b) It is difficult to say ‘no’ to a boy I like.
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c) We are responsible for our own bodies.

1 2 3 4 5

d) To fit in with my friends, I sometimes do things that I do not like.

1 2 3 4 5

e) There is so much talk about HIV but I don’t know what I can do to keep safe.

1 2 3 4 5

Thank you for taking part in this questionnaire.
SESSION 1: KNOWLEDGE

TIME: 1 hour

NUMBER OF SUBJECTS: 62 girls

OBJECTIVES: To address issues around HIV and AIDS
To impart information on HIV and AIDS, methods of transmission, sex and Sexuality.

REQUIREMENTS: Newsprint, Kokis, Prestik, Blank paper, relevant diagrams, evaluation Sheets

WELCOME: Educator to introduce herself.

ICEBREAKER: Children will introduce themselves by giving their name and an adjective that starts with the first letter of their name, that best describes them. (5 mins)

GROUP CONTRACT: A contract affords a safe environment so everyone can share information and ask questions. Elicit from the group and include the following:
Confidentiality, respect, no laughing at others, allow each person time to share, being open and honest, no one to answer questions they are uncomfortable with. (5 mins)

Group rules to be written on newsprint; to be displayed at every session.

EXERCISE 1: The girls will be divided into 5 groups. Each group will be given a question or questions to brainstorm and answer. A spokesperson may be chosen to present the answer.

**Group 1**
What are the main physical differences between the male and female body? What is sex? What is sexuality?

**Group 2**
What is HIV? What is AIDS? Are they related?

**Group 3**
Name the ways in which HIV and AIDS are spread?

**Group 4**
How can we protect ourselves from being infected with HIV?

**Group 5**
About how many people in South Africa are HIV infected or positive? Can children get HIV? How do we treat HIV? (10 mins)

While feedback is in progress, the educator will elicit information from all the girls and will cover the following areas:

**Group 1 feedback:** Physical differences between male and female; Basic sex education; male and female reproductive systems; what are periods; how can you fall pregnant; being attracted to the opposite sex is part of sexuality

**Group 2 feedback:** Correct terminology, differences and the relationship between HIV and AIDS, what does the virus look like, how does it attack the body, how is it different from other viruses.
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**Group 3 feedback:** Methods of transmission (mother to child, blood, sex) and non-transmission (toilet seats, holding hands, swimming pools etc.), fragility of the HIV virus outside of the human body.

**Group 4 feedback:** Protection, prevention, how to avoid infection, high risk behaviour, abstain, be faithful, condomise, Sources of help (clinics), Testing to know your status.

Treatment.

**Group 5 feedback:** South African situation and statistics especially among the youth, How does HIV and AIDS affect the youth. Touch on teenage pregnancy. (25 mins)

**EVALUATION**

1. Rate today’s session: circle your answer
   - excellent
   - good
   - average
   - satisfactory
   - didn’t enjoy it

2. Write down one new thing that you learnt from today’s session.

---

**SESSION 2: ATTITUDES**

**TIME:** 1 hour

**OBJECTIVES:** To examine the learners attitudes towards HIV and AIDS

To assist in the development of non judgmental attitudes

**REQUIREMENTS:** Newsprint, kokis and prestik

Review group contract (3 mins)
EXERCISE 1  "Graffiti Board"

- Learners will be asked to form 4 groups and they will be given kokis, newsprint and prestik
- Each group must write and draw graffiti expressing how they feel about a particular topic

Topics:

1. Your doctor has just told you that you are HIV positive. How do you feel? What are your biggest fears?
2. A member of your family is HIV positive. How does the rest of the family and the community treat them? List good and bad ways that they are treated.
3. HIV and AIDS is a sign of evil and a curse. List points that show how people agree and disagree with this statement.
4. As young people, how can we keep ourselves safe and free from infection?

    (Preparation time: 5 mins)

- Learners have 10 minutes to fill in the graffiti board
- Ask each group to brainstorm first before they start drawing
- All members of the group must engage in the activity
- They can use the table or wall to display their newsprint
- There are no wrong or right graffiti

    (10 mins)

The whole group will review each group’s work. Comments about the following will be asked:

- The process itself
- The feelings that were expressed
- How did they feel while doing the exercise
- Ask learners to explain some of the drawings
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- Each topic will be “unpacked” and attitudes, perceptions and myths will be discussed. This will be as follows:
  
  Topic 1. Common feelings and attitudes of people living with HIV and AIDS (denial, shock, shame, anger, sorrow, guilt, loneliness, self-consciousness, bargaining, depression and acceptance).
  
  (8 mins)

  Topic 2. Families may react by trying to hide the truth. Rumours and gossip may be rife. Some families may feel shame. Some families may reject the person with HIV and AIDS. Explore discriminatory behaviours. Explore the need for developing empathy, care and compassion.
  
  (8 mins)

  Topic 3. Explore why some people may believe that HIV and AIDS is a punishment from God. Explore other popular beliefs and myths and where they come from. De-stigmatise AIDS. Emphasise that it is a disease.
  
  (8 mins)

  Topic 4. The youth must be aware of peer pressure and how to handle it. Don’t think that it can’t happen to you. Emphasise self-care and self-confidence.
  
  (8 mins)

CONCLUSION: What have we learnt today?

Why do people discriminate? (They learn from their parents, adults and peers; Lack of accurate information; Fear; dislike of anyone who is different)

Why is it important not to discriminate? (It hurts other people; it isn’t fair; we wouldn’t want to be treated that way; equality is a fundamental human right)

What could you do if you hear discriminating remarks about a person with HIV or AIDS from someone in your community? (Inform the person that they are wrong and tell them why; explain why it is important to be compassionate and supportive of someone who has HIV or AIDS)
SESSION 3: SKILLS

TIME: 1 hour

OBJECTIVES: To discuss assertiveness training and the of handling peer pressure

To explore decision making skills and problem solving techniques

REQUIREMENTS Paper and pencils

Review of group contract (2 mins)

Introduction

The essence of the last two sessions will be reviewed. We looked at what HIV and AIDS was and how we can and can’t be infected. Today we will look at how to handle difficult situations and how to say NO.

EXERCISE 1. The group will be divided into 3 smaller groups and they will each be asked to role play a scene between Tom and Tammy who are classmates. Tom has a habit of touching Tammy in ways that she doesn’t like (on her hair, her back, her hands and her chest). He sits too close to her and Tammy is uncomfortable.

Group 1. to role play Tammy as a weak person who doesn’t know how to express her feelings

Group 2. to role play Tammy as an aggressive, loud and noisy person who doesn’t really get her message across. Tom laughs at her aggression and doesn’t take her seriously.
Group 3. to role play Tammy as a serious, mature person who handles the situation very well and lets Tom know that she does not like what he’s doing. (preparation time: 10 mins)

GROUPS TO ENACT THE ROLE PLAY (15 mins)

DISCUSS ASSERTIVENESS TRAINING

Am I assertive?

You are assertive when you stand up for your personal rights without putting down the rights of others. You can do this when you will be able to:

1. Say “no” without feeling guilty

2. Disagree without becoming angry

3. Ask for help when you need it.

As a result you will feel better about yourself and have more honest friends and relationships.

PASSIVE

- Take no action to assert your own rights
- Put others first at your expense
- Give in to what others want
- Remain silent when something bothers you
- Apologise a lot

AGGRESSIVE

- Stand up for your own rights with no thought about the other person
- Put yourself first at the expense of others
HIV and AIDS Intervention

- Overpower others

- Get your own goals but at the expense of others

ASSERTIVE

- Stand up for your own rights without putting down the rights of others

- Respect yourself as well as the other person

- Listen and talk

- Express positive and negative feelings

- Be confident, but not “pushy”.

REVIEW ROLE PLAY HIGHLIGHTING ASSERTIVE BEHAVIOUR (10 mins)

EXERCISE 2. The 3 groups will be given one scenario each, which they will have to brainstorm, and feedback to the class.

SCENARIO 1: Jane and Maggie are 10-year-old girls. Jane is very popular and has many friends (both boys and girls). Maggie wants to be like her. She therefore does whatever Jane does. Jane asks Maggie to bunk school and go to the movies with some boys! What do you think Maggie should do? Why? Look at what may happen if she agrees and what may happen if she disagrees.

SCENARIO 2: A little girl has an uncle James who touches her in ways that she does not like. He threatens her, tells her that it’s a secret, that she’s a naughty girl and that she must tell noone. What can the little girl do? You may give her a name. Look at both sides of the story i.e. If she doesn’t tell someone, what will happen and if she tells, what will happen.

SCENARIO 3: As you have learnt HIV and AIDS is a big/major disease in our country. It is also affecting the young people. What advice can you give to a person with HIV and AIDS which will
help them live a healthy life.

(prep time: 5 mins)

FEEDBACK AND DISCUSSION FOCUSING ON:

Scenario 1. self esteem, decision making skills, problem solving skills, how an innocent act may have serious results.

Scenario 2: abuse, good touch, bad touch, our rights and privileges, it is not your fault that someone behaves badly.

Scenario 3: Medical help, nutritious foods, good hygiene, rest and relaxation, keeping busy, avoid smoking and alcohol, be aware of reinfection. (15 mins)

EVALUATION

Rate today's session. Circle your answer.

Excellent  good  average  satisfactory  didn't enjoy it

List one new thing that you learnt today. (3 mins)

SESSION 4: REVIEW / REINFORCEMENT

TIME: 1 HOUR

REQUIREMENTS: newsprint, kokis, prestik.

OBJECTIVES: To reinforce HIV and AIDS knowledge, attitudes and skills.

To allow learners to ask questions about HIV and AIDS in a non-threatening and non-
judgemental environment.

REVIEW OF GROUP CONTRACT

EXERCISE 1. Class Quizz

The class will be divided into 3 groups. Each group will be given 5 questions that they must work out the answer to and they will pose these questions to another group.

QUESTIONS

1. What causes AIDS?
   a virus

2. How do people get AIDS?
   from unprotected sex, body fluids, MTC, infected bloods

3. Can you tell if someone has AIDS by looking at them?
   No

4. Is there a cure for AIDS?
   No

5. Will most people with AIDS die from the disease?
   Yes

6. List the ways in which one can avoid HIV?
   Abstain, be faithful, use condoms during sex

7. AIDS is the abbreviation for
   Acquired Immune Deficiency Syndrome

8. If you are infected with HIV the symptoms will appear
   Any time from 2 weeks to 10 years or more

9. The first symptoms of HIV infection are often mild, flu-like fever, aches, tiredness and enlarged glands
   True

10. Small babies can be born with HIV?
HIV and AIDS Intervention

True
11. A person may get HIV by sharing drug needles.
True
12. There is no way you can find out if you are infected with HIV.
False
13. You can be cured of AIDS if you are careful to take the medicines the doctor gives you.
False
14. People with AIDS die from serious diseases.
True
15. AIDS is caused by HIV.
True

(15 mins)

EXERCISE 2. Open Time – students may ask questions on HIV and AIDS and related issues. A group discussion will ensue. Issues that may be covered: growing up, friends, general fears and concerns.

(10 mins)

EXERCISE 2. Divide the learners into 5 groups. Each group will create a graffiti board focusing on positive things about themselves and others in their group. There will be a walk-around and discussion by all. Focus on the process itself. Was it easy or difficult? Explore issues of accepting praise and self-confidence.

(20 mins)

Evaluation of the whole programme

1. Did you enjoy the whole programme? YES / NO

2a. Did you learn anything new about HIV and AIDS? YES / NO

b. If Yes, list 2 things that you have learnt.
c. If No, where did you hear this information before?

3a. Has your view of HIV and AIDS changed? YES / NO

b. In what way has it changed?

4a. Do you feel confident about looking after your health? YES / NO

b. Why?

5. Do you feel assertive enough to say NO to someone who is making you feel uncomfortable?

YES / NO

(13 mins)
Appendix 4

A Copy of the Experimental School’s AIDS Policy

1. Introduction

HIV is a virus. It causes AIDS. To date there is no cure for it. The virus spreads through four types of body fluids: blood, semen, vaginal fluids and infected breast milk.

2. Rights as an infected person

2.1. AIDS sufferers have the same human rights as any other person, the right to be heard and seen without fear of discrimination, rejection or intimidation.

2.2. Informed consent before testing: No one can force the learner or educator to take the HIV test.

2.3. Confidentiality: The result of an HIV test is confidential. Only an infected learner has a right to tell others about their status.

2.4. Treatment: No health care workers may turn an individual with AIDS away. The infected individual has the same right to medical care as other patients.

2.5. Employment: An AIDS sufferer may not be refused employment or dismissed from their job because of their HIV status.

2.6. Education: Learners with HIV have the right to attend school. A respectful climate must prevail at school. Verbal or physical harassment should not be allowed. Prejudice and discrimination of learners or educators with HIV is not allowed.
3. Admission

3.1. School, Governing bodies and school management teams should not discriminate against learners and educators on the basis of HIV.

3.2. Everyone should be regarded as potentially infected.

3.3. Disclosure of HIV and AIDS status is not required as the individuals are protected by the right to privacy.

3.4. All stakeholders undertake to protect all individuals' basic human rights and dignity which must be respected and protected.

3.5. Phase and grade appropriate education will be provided.

4. Role of Educators

4.1. Educators should set an example of responsible sexual behaviour.

4.2. Educators and learners should be treated as potentially infected. This demands never touching blood or body fluids without gloves or protection.

4.3. Educators are responsible for referring learners with sores, open wounds etc. to the office for referral to the local clinic.

4.4. Educators must share correct information on HIV and AIDS and its effects.

4.5. It is the responsibility of the educator to educate parents on the effects of HIV and AIDS.

4.6. No educator has the right to have sex or demand sex from learners or colleagues.

4.7. A responsible individual will educate children never to handle blood and body fluids but must call an educator.

4.8. Contact sports which have risk elements must be conducted under strict supervision.

4.9. Invite guests, NGO's to deliver talks to learners on HIV and AIDS and STDS.
4.10. Enlist a care and support group of individuals who are HIV positive.

5. Infection Control Procedures

5.1. If an individual injures himself/herself, all skin and other parts of the body exposed to blood must be washed with soap and running water.

5.2. Add antiseptic to water and use gloves.

5.3. All contaminated materials must be put into plastic bags and burnt.

5.4. Call parent/caregiver

5.5. If parent/caregiver not available call for state ambulance to remove injured child to hospital.

6. First Aid Kit

6.1. School management teams must ensure that the following items are in the first aid kit at all times.

- Latex gloves
- Materials to cover wounds, cuts or grazes
- Waterproof plasters
- Disinfectant
- A pair of scissors
- Cottonwool

6.2. Management must ensure that a first aid kit must always be available in the sports ground, field trips and excursions.

6.3. Management or a responsible officer must not allow anyone to participate in any sport if he/she has an open wound. Anyone injured and bleeding must be removed from the playground immediately and treated appropriately.
7. Contacts: Help

7.1. Lovelife: 0800 121 900

7.2. AIDS Helpline: 08000 12322

7.3. Sinikithemba Christian Care Centre: 031 2086110

7.5. Childline: 0800055555

7.6. Life line: 031 3122323

7.7. SANCA: 031 2022241
AN ESTIMATED 45 000 South African teachers are infected with HIV, the virus which causes AIDS.

According to the Department of Education's education policy on HIV/AIDS, an estimated "one in eight of the country's sexually active population — those over the age of 14 — is now infected."

Experts warn it will worsen the projected shortage of teachers, affect their ability to teach, increase infection rates among pupils, change enrolment patterns and generally disrupt schooling because of erratic attendance rates as teachers and pupils take time to care for family members with AIDS.

Mary Crewe, head of the AIDS Unit at the University of Pretoria, said experience in other African countries showed a high infection rate among teachers.

She estimates teachers' infection rate at 12 percent — in line with the 1998 South Africa Human Development Report, which stated that up to 15 percent of the civil service was HIV-positive.

Crewe said that at colleges in some African countries 25 percent more teachers were being trained than were needed. This was because by the time the training was finished, a significant number of the student teachers would be too ill to work, would have died, or would be expected to die in the first five years of teaching.

The new HIV/AIDS policy forbids sex between teachers and pupils, as this could increase the infection rate.

"Many teachers have recognised their risk of HIV infection and, as a consequence, are seeking out younger and younger partners," Crewe said.

However, the highest infection rate is among young women aged 16 to 26. At Africa's largest HIV/AIDS conference, held in Zambia last week, Carol Bellamy of Unicef said that one in four adolescent women south of the Sahara did not know even one way of avoiding infection.

At the conference it was suggested that the age of five to 15 provided a "window of hope" within which schools needed to teach children survival skills.

Crewe said HIV/AIDS should become an examinable school subject.

In the HIV/AIDS policy, schools are given the option to distribute condoms — at the discretion of the school community. But experts warn that many schools are too conservative to take such steps.

Crewe said: "We can't tell young people to use condoms if they are sexually active, and then tell them that we cannot provide them."
KZN child sex shock

Kids molest kids

Daily News 2/05/06

RIVONIA NAIDU
and BHAVNA SOOKHA

S HOCKING statistics released by KwaZulu-Natal Childline have revealed that sexual offences among children have dramatically increased.

Childline yesterday told the Daily News that children as young as six are involved in sexual activity which leads them to committing sexual offences.

Director of Childline in KwaZulu-Natal Linda Dabicharan said 65% of children monitored by Childline are found to be committing sexual offences. However these statistics only represent work done through the Childline network.

She said the figures were taken from assessing ongoing programmes like the crisis line, therapeutic service and the sex offender programme, as well as parents, people from within the community and the children themselves.

"There are other avenues and sources from which we obtain our information from."

"We work closely with the police, the criminal justice system, education department, child welfare and social welfare," she said.

Dabicharan added that the high percentage of sexual offences had led to a high number of children contracting the HIV virus. "Due to many of the children not knowing their sexual status, they molest other children and pass the virus on."

Girls

"And girls are more sensitive than boys, so even when there is no actual penetration during sexual intercourse, they can contract HIV as the skin around their vagina ruptures or tears and bodily fluid is exchanged," she said.

Dabicharan said the best way to tackle the problem was to introduce sexual education into prevention and awareness programmes.

"Children have to be taught about sex, condoms and the HIV virus from a young age, because they are in direct contact with it," she said.

Dabicharan added that sexual offences among children is a major concern and that there were influences tying into the issue.

"Sexual abuse is the second biggest problem in the country and not enough has been done to prevent it and curb the problem," she said.

Dabicharan said that the KwaZulu-Natal Childline receives about 24 000 calls a month, with a large percentage of calls being made by children.

Joan Campbell, a social worker who has her master's degree in sex education and child sexuality, said that there was a definite increase in the number of children involved in sexual activity.

She said the ages of the children was getting younger, with some as young as six getting involved in child-on-child sexual molestation.

Pornography

Campbell, who trains probation officers all over the country, said that the officers had also reported seeing an increase in child sexual molestation.

"It is very difficult to say whether there has been an increase, but one of the contributing factors could be the easy access to pornography via cellphones," she said.

"By viewing pornography children normalise inappropriate sexual behaviour and repeat what they have seen," Campbell also said that drug and alcohol abuse, violent behaviour, divorce or dysfunctional families could also contribute to the behaviour.

"These children are trying to satisfy an emotional need as sex becomes a tool to satisfy this need," she said.

Campbell added that another reason for the increase in incidents could be because some professionals were not taking the issue seriously by thinking the behaviour was normal curiosity on the part of the children.

"There is also a lack of sex education and superviso Society is not taking the problem seriously," she said.

"There needs to be professional intervention.

"And the problem is definitely worse. Not all incidents are reported.

"What we are seeing is definitely the tip of the iceberg."

Parents send daughters out to earn money

Young girls from Chatsworth's impoverished "Bangladesh" community are selling their bodies to support their families. Nelandri Pillay reports

Some poverty-stricken parents in Glenover, Chatsworth, who are facing threats of eviction, are sending their teenage daughters out to earn money as prostitutes.

The girls, some as young as 13 and 14, exchange sexual favours for paltry earnings - anything between R5 and R10. Several have become pregnant and some have been diagnosed as HIV positive.

The girls work mainly from outside busy shopping complexes, such as the Chatsworth Centre and Chatsworth Main. They also solicit within their communities.

Police spokesman Captain Vish Naidoo confirmed several complaints about prostitutes in Chatsworth had been received, but police found it difficult to establish the exact facts. Those interviewed often gave incorrect details of their identities.

Chairman of the Westcliff Flat Dwellers' Association, Orelene Naidoo, said her greatest fear was that the baby flesh trade could spiral out of control.

"I work with these girls by trying to counsel and assist them. But the reality is they are selling their bodies to put food on the table. Telling them what they're doing is wrong is futile because they already know that. Their parents probably know that, too. Survival is the name of the game.

Options

"I counsel as many as I can, but they need what I cannot give them - food, clothing and decent homes. The powers that be need to stop condoning and start doing something to help. Give these girls practical options.

"It is really big business. The result is an increase in pregnancies and Aids. We're going to have more babies and fewer people to take care of them. This will further strain stretched resources."

Maya (not her real name), 29, is being helped by Naidoo. A mother of three, she was recently diagnosed as HIV positive. She has stopped being a prostitute, and her children have been taken into foster care. She described her life as "living hell".

"My life went downhill at the age of 14, when my mother died. I thought getting married would solve my problems. It was a disaster and my husband left. I had nothing and took to drinking, and eventually prostitution." "My family did not care about me. But the reality is they are selling the humiliation I endured. I lost my self-respect and dignity. Men demanded I do the most degrading things. I just had to comply - in exchange for a few rand notes."

"I was even raped by one of these men in 1997. I was so disgusted by what I was forced to do that I tried to commit suicide. I was not even successful at that."

"I have Aids now, but I know it is not my fault. I had nobody to turn to. If somebody just loved me enough to take me away from that life, I would have been a healthy person today and been able to take care of my children."

A Chatsworth City Police officer, who did not want to be named, said the problem was serious.

"While on patrol we constantly find these young girls trying to sell their bodies. We chase them away, only to find they've set up business somewhere else. It is a pathetic situation and I don't know how it can be stopped."

South Central Local Council deputy mayor Gona Moopanai said he had experienced the problem first-hand when he was approached by a young woman outside the Chatsworth Centre.

"It was humiliating, but I opened my eyes to what is going on. I've seen parents in their cars sending their girls out and even counting their money. I've raised the matter with the community policing forum. Working together we've even chased men with their pants down, quite literally. I want to involve the welfare services."
SANGOMAS FIGHT AIDS

Sangomas have been included into the fight against AIDS. AIDSCOM, a non-governmental AIDS education organisation, recently held a workshop with 95 Sangomas in the township of Nkowankowa near Tzaneen. Ellen Elmendorp was there to photograph the event.

Aai! The condom is on! What a sight. Sangomas listen as a speaker explains the importance of using condoms and how Sangomas can get the message of AIDS across to their clients.

Getting serious! A Sangoma ready to roll the condom onto the artificial penis.
Alarm over school Aids deaths
Massive drop in enrolment

SHERLISSA PETERS

The HIV/AIDS virus has clawed its way into our province’s schools, ravaging its young victims and leaving teachers and parents in a state of panic.

Educators contacted in schools around Durban and Pietermaritzburg confirmed that more and more pupils are absent from school, developing conditions associated with the virus, like pneumonia and tuberculosis.

"It has become a cause for grave concern," said Paul Pillay, a Clare Estate primary school teacher.

Pillay said that it was becoming more evident that a large number of pupils had fallen victim to the killer disease. He said that these children were “practically disappearing before our eyes”, drastically losing weight over a short period of time, and are also prone to skin rashes, fevers and nagging coughs.

Simphiwe Dladla, a principal at a Phoenix secondary school, said that all classes, from Grade 8 to Grade 12, were dwindling in numbers.

“Our class numbers have been cut in half since last year,” Dladla said, adding that a number of pupils have passed away.

“Schools in the district are constantly in a state of mourning with more children being infected and succumbing to the disease,” he said.

Principals in the Pietermaritzburg area said that a school’s management is often approached by parents, who are infected themselves, and are afraid that they may have passed the virus on to their children at birth.

While most schools could not confirm how many children were infected.

“No official records are kept at schools regarding the state of health of pupils, but it does not take a rocket scientist to figure out that these children are suffering,” Pillay said.

Several principals indicated to the Daily News that they would be petitioning the education department to make available counselling sessions and medical assistance to those pupils who require it.

A list of questions was sent to the education department a week ago, and several calls made for comment, however no response was received at the time of going to press.

A recent survey in South Africa conducted by the United Nations found that the number of pupils enrolling in the first year of primary and secondary school in 2003 in parts of KwaZulu-Natal, was 30% lower than in 2001.

This was found to be largely because more children were becoming infected and either not living long enough to start school or not surviving their years of schooling.
Young girls’ plight bound by unity and peace

SAMESH MOHANLALL

REPRESENTATIVES of different faiths, cultures, beliefs and customs spoke with one voice on Tuesday against the atrocities suffered by many young girls.

The meeting, which took place at the Temple David in Durban, was hosted by the Durban Progressive Jewish Congregation to coincide with the annual Jewish celebration of Pesach Freedom Seder.

This is when the youngest child of the household stands at the Passover table and asks the family elder, “Why is this night different from all other nights?” The elder then recounts the story of the passing of the ancient Israelites from the bondage of slavery in Egypt to freedom.

“Tonight is different from all other nights because tonight is the first time that we of different faiths and beliefs have found enough commonality and a will of purpose to come together and commit ourselves to promoting freedom.

“Freedom from fear, persecution and prejudice of the most vulnerable member of our society - the girl child,” said Rabbi Hillel Aviden of the Jewish Congregation.

The Rev Dan le Cordeur, representing the Christian faith, made an emotional appeal to the other representatives present to stand together to uphold traditional values of the family in an effort to counter the breakdown of moral society.

“The number of Aids deaths indicates the lapse of family life in the community,” said Le Cordeur who also works as an Aids counsellor.

He reminded those present that the woman of today is free to educate herself, free to work and earn a living but, as a child, was offered no social protection and was vulnerable to rape, child abuse and HIV.

“Silent screams”

“The only protection society offers her is free abortion, condoms and ARVs (anti-retroviral drugs),” he said.

Another speaker, Bongi Zengele, who represented the African-traditional religious view, said no religion could afford to ignore the “silent screams” of abuse victims.

“We hear of the rape of Tamar in the House of David in the Old Testament. She became a desolate woman because of her ordeal.

“This is an unfamiliar text that is not commonly read.

“Most girls’ first sexual encounter is a forced one, we need to be more vocal and talk about it. Women grow up with a disturbed mental history because of the trauma of their childhood and it becomes a lifelong struggle,” she said.

She said these incidents should become “our problem and not theirs. We must help them to forget their childhood”.

Zengele pleaded with the other religions to assist by becoming healing tools in the lives of abused girl children and others.

“If we don’t have peace we cannot have freedom,” she said.

Pupils ‘must see effects of HIV’

CHARMAINE PILAY

HARD-HITTING visual images depicting the effects of the HIV-Aids virus needed to be included in awareness programmes being run at schools, education portfolio committee members told the provincial department of education this week.

The department has declared September 6-10 Schools Aids week - and life skills co-ordinating committee has put together a plan to disseminate the Aids message.

Although committee members praised the department’s plans, they felt that a less soft approach and a proper sex education programme were required to help combat the rapid spread of the disease.

They said a change in sexual behaviour would only come about if the awareness programmes showed the youth what happened to a person who had Aids.

Using Uganda as an example, committee members said that the country managed to get its Aids awareness message across to people only after the public saw victims wasting away in the streets.

According to the department, more than 50% of all new infections were among the 14 to 24 age group, indicating that school pupils were likely to be carrying the HIV virus.

It has committed itself to providing Aids education through cultural activities and awareness campaigns.

The department also recently gazetted a policy on HIV/Aids for schools to ensure that pupils were not deprived of Aids education and that no pupil or member of staff was discriminated against if HIV positive or suffering from Aids.

However, school governing bodies can decide whether they want condoms to be made available to their pupils.
Aids - 10 steps to five-year success

MY VIEW

GLENDA GRAY AND DAVID HARRISON

In unprecedented co-operation, government and civil society have wrestled together with the new five-year national plan to combat HIV/AIDS.

We are confident that it will lead to more decisive action. In terms of impact, the five-year horizon is realistic, as the past decade has taught us just how obtuse the HIV epidemic can be. Yet it is essential that we chart clear paths from the outset.

Here are 10 priorities for the first 100 days of implementation that either hold quick potential gain or open up new frontiers in the national response:

1. Put in place a national treatment literacy programme. Every South African should know that they are entitled to anti-retroviral treatment if they need it; that ART can prolong life but is not a cure; that mother-to-child transmission can be prevented in most cases; and that treatment is most effective combined with a healthy lifestyle and protective sexual behaviour.

2. Initiate an extensive testing campaign led by prominent national and community figures.

Only a third of adults have had an HIV test, yet those who have been tested use condoms more consistently. If that proportion could be doubled within a year, it could trigger a big move to safer sexual behaviour.

3. Scale up behaviour change interventions to achieve face-to-face coverage higher than 70%. Many schools still don’t have adequate lifeskills programmes in place and the combined community-level coverage by campaigns like Soul Budyza, iwe Lunga and Khamanani is still below 50%.

4. Zoom in on the spike in infection of 18 to 21-year-old women. School-leaving heightens the risk of HIV infection, as women look to older men for physical and material security and seek social or personal affirmation in childbearing. This age group needs an intense and comprehensive campaign focused on changing perceptions of opportunity.

5. Zoom in on schools reporting five pregnancies a year or more. Typically, school-going pupils against teen pregnancy and HIV infection, with sexually active schoolgirls twice as likely to use condoms as their out-of-school age counterparts.

But some schools are danger zones with up to 70 teen pregnancies in a year. No national campaign will succeed without eliminating these hot spots associated with gangsterism, endemic violence and substance abuse.

6. Renew the commitment to keep young people at school: One in six 14-year-old pupils drop out before completing Grade 12. They are at highest risk for infection.

7. Reinforce the positive potential of business and mitigate its negative impact on HIV. A vastly scaled-up national learnership and volunteer programme could create massive new opportunities for young people.

8. Establish a national “positive prevention” campaign. Every person living with HIV should know how best to protect themselves and their partner, that repeated reinfection may speed up progression to full-blown AIDS, understand reproductive choices and know why regular check-ups are needed.

9. Focus on key bio-medical interventions that can make a big impact. While public healthcare workers are pretty good at managing sexually transmitted infections, private practitioners aren’t.

A national campaign aimed at both health practitioners and the public should stress the importance of early treatment of STIs.

Given that circumcision has now been shown to reduce HIV transmission, clear communication should show the benefits of circumcision while stressing that circumcised men are still at risk from unprotected sex.

10. Finally the first 100 days should set clear benchmarks of progress. We can’t wait for 2011 to gauge success; neither should we rely solely on overall prevalence statistics. With successful treatment, total prevalence could stay high for several years, even as the rates of new infection decline.

We need to anticipate what changes will happen first and which will come later. For example, if we judge success only by antenatal surveys - a sub-set of the population that has by definition had unprotected sex - we could miss important signs of progress among most teenagers and men.

The very first step is to share a common roadmap of the most critical pathways and markers of progress towards an HIV-free generation.

Glenda Gray is the Executive Director of the Perinatal Health Research Unit. David Harrison is CEO of loveLife.