

**AN INVESTIGATION INTO THE PERCEPTIONS OF ADOLESCENTS IN
KWADLANGEZWA TOWNSHIP TOWARDS HIV AND AIDS**

BY

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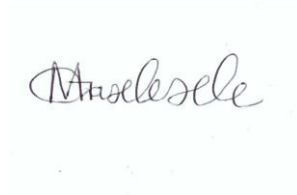
2013

DECLARATION

I Mosiwa Georgina Maselesele declare that this thesis titled:

“An investigation into the perceptions of adolescents in KwaDlangezwa Township towards HIV and AIDS” is my own work and that all sources quoted have been indicated and acknowledged by means of references.

Signed _____

A handwritten signature in cursive script, reading "Maselesele", is centered within a light blue rectangular box. The signature is written in dark ink on a white background.

DEDICATION

This dissertation is dedicated to all young people who are currently living with HIV and AIDS and all those who have already passed on, may their souls rest in peace. It is also dedicated to all those children who lost their parents and everyone who lost their family member because of AIDS. A special dedication goes to my relatives who are currently living with HIV and all those who already passed on due to HIV/AIDS.

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ABSTRACT

Background: AIDS (Acquired Immune Deficiency Syndrome) is caused by HIV (Human Immunodeficiency Virus). The HIV and AIDS epidemic is one of the largest obstacles that are destroying the lives and the livelihoods of millions of South Africans. Adolescents are the most vulnerable population at high risk of contracting HIV. Department of Health (2010) noted that in South Africa, KwaZulu-Natal (KZN) is the province with the highest HIV prevalence.

Aims: To explore the perceptions of adolescents living in a township about HIV/AIDS.

: To explore factors contributing to adolescents' high rate of HIV/AIDS infection.

: To explore the influences of these perceptions on adolescents' sexual behavior.

: To explore adolescents' general knowledge and understanding of HIV/AIDS.

Method: Data collection instrument that was employed is a questionnaire with both open-ended and closed ended questions. Random sampling was employed and 50 participants from Ongoye high school took part in this study with 44% males (n=22) and 56% females (n=28).

Results: Findings of this study revealed that the majority of respondents have enough information in regard to meaning, mode of transmission and preventing methods of HIV/AIDS, however some of the participants listed unrealistic perceptions about HIV/AIDS. When comparing between both genders, females seems to have more misconceptions about HIV and AIDS than males.

Conclusion: Adolescents have misconceptions about HIV and AIDS. More programmes that target adolescents should be implemented in order to address these misconceptions as well as the factors that make them vulnerable to contract HIV/AIDS. More research should also be conducted on issues related to HIV/AIDS among adolescents.

KEY WORDS: HIV, AIDS, Perception, Adolescents

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CHAPTER 1 INTRODUCTION

1. Introduction

The research study is aimed at investigating adolescents' perceptions towards HIV/AIDS in KwaZulu-Natal (KZN) with special reference to the KwaDlangezwa Township. The study's major aim is to explore adolescents' views and understanding of HIV/AIDS, while examining whether adolescents in KwaDlangezwa Township have misconceptions about HIV/AIDS and highlighting these, in order to generate recommendations to assist with providing relevant facts about HIV/AIDS.

Pinsky and Douglas (2009:5) defined AIDS as an illness that damages a person's ability to fight off disease leaving the body vulnerable to attack from ordinarily innocuous infections and certain forms of cancers. According to Kelly (2004), no illness has changed the face of sexuality as much as the appearance of a microscopic virus HIV.

UNICEF (2017) indicated that the turning tight against HIV/AIDS will require more concentration focus on adolescents. According to Agyei-Mensah (2001), HIV/AIDS was first reported in 1981, and has had devastating consequences on all the components of our society while becoming the most fatal, infectious epidemic illness. The disease is seen as a threat to the stability of all nations and regions, affecting the most productive members of society as well as the younger generation including adolescents that are anticipated to change the world. HIV/AIDS has become a global phenomenon. Adolescents are prone to HIV infection as a result of lack of correct health information and engagement in risky sexual behaviors (Chen, 2008).

According to Steinberg (2008), adolescence is a time when puberty takes place, and is when most adolescents initiate sex. It is the time when sexual preference and identity are formed and a period of first-time experiences, risk-taking and experimentation with many things, including alcohol and other substances.

DiClemente Crittenden, Rose, Sales, Wingood, Crosby and Salazar (2008) stated that sexual risk-taking in adolescents often occurs in conjunction with other behaviors such as substance use and delinquency, more common in low-income communities. According to Wargo (2007), adolescence, as every parent and

adolescents' professional knows, is a time of risk-taking. In a longitudinal study of 850 primarily African American high school learners, researchers found that substance use mediated the relationship between psychological distress and sexual risk-taking, including increased sexual activity and decreased condom use (Elkington, Bauermeister & Zimmerman, 2010).

Despite HIV prevention efforts throughout the past decade, adolescents represent one of the fastest growing groups of newly HIV-infected persons. The physiological, psychological and socio-cultural changes that take place during adolescence, place this group of young individuals at higher risk levels of being infected with HIV. These factors contribute to the increase in newly acquired HIV infections seen among adolescents all over the world (Lerner & Steinberg, 2004).

Adolescence is the period when individuals get a chance to explore on their own, and are responsible for making decisions and choices, a gradual process of working towards an integrated notion of self. During this stage, adolescents start interacting with their peers and are influenced by peer pressure (Sadock & Sadock, 2007).

Adolescents grow among adults who have gone through adolescence, and, therefore, these adults always want to guide them in what they should and should not do, as well as how they should do it. Adolescents' period of experimentation and risk-taking, increase their vulnerability to contracting HIV during these years of rapid physical and psychosocial development (Ross & Dick, 2006).

During adolescence, individuals stop believing everything they are told, resort to testing what they are told because of their desire to explore rather than listen to what adults tell them. According to The Foundation for AIDS Research (2010), adolescence is a dynamic developmental phase with significant physiological and psychological changes. It often happens that different people perceive the same stimulus but produce such differing interpretations of it that one may wonder if they are talking about the same thing. It will, therefore, be vital to find out if there are differences in the way adolescents perceive HIV and AIDS. Perception in this study refers to the manner in which adolescents view and comprehend the concepts of HIV and AIDS.

1.1 Background to the study

According to STATS SA (2014), it was estimated that South Africa has the population of 54 million. KwaZulu-Natal (KZN) is the province which the study was conducted at Empangeni in KwaDlangezwa and (KZN) is the province that was rated the second largest with approximately 10.69 million people (19.8%) living in the province. Ansari (2009) delineated that the first HIV infection was reported in 1982, when AIDS was first identified, it was believed to be a disease that was transmitted primarily through homosexual contact.

STATS SA (2014) further estimated overall HIV prevalence rate is approximately 10, 2% of the total South African population. The total number of people living with HIV is estimated at approximately 5.51 million in 2014. For those aged 15-49 years, an estimated 16, 8% of the population is HIV positive. An estimated 5.6 million people were living with HIV and AIDS in South Africa in 2009, more than in any other country (UNAIDS 2008).

Kruger and Ritcher (2003) stated that consequently it has become clear that AIDS is an equal opportunity disease to which everyone is at risk of contracting HIV despite a person's sexual orientation. In recent years, there has been increasing concern about the vulnerability of adolescents to HIV infection and AIDS because of the prevalence of unprotected sexual intercourse. This is contradictory to the statement made by Agyei-Mensah (2001) who stated that HIV/AIDS was first reported in 1981.

2.7 million people acquired the HIV infection in 2010 (US Global health policy, 2011). The perception of HIV/AIDS has changed significantly since it became a well-known disease in South Africa in the early 90s. The past three decades have seen the country's HIV prevalence grow to over 15% with approximately 5.6 million HIV infections (UNAIDS, 2011)

According to Kates and Carbaugh (2006), globally, just half of all people living with HIV are female. Over one-third, (36%) of people living with HIV in Latin America is female. Women and girls represent 57% of all people living with HIV in sub-Saharan Africa, where a striking 76% of young people including adolescents (aged 15-19 years) as well as early adulthood (aged 20-24) living with HIV are females. Brazil accounts for over one-third of 1.7 million people living with HIV in Latin America.

Furthermore, Kates and Carbaugh (2006) mentioned that India and China, the world's most crowded countries, are experiencing rapid growth of HIV in certain sub-populations and geographic areas. Although national rates of infection in these countries are low, owing to the size of their populations, even small increases in infection rates translate into large numbers of people infected with HIV. According to UNAIDS (2012), discrimination is a problem among people with HIV and AIDS. Fear and discrimination due to HIV continue to exact profound human costs, including their worst forms such as abusive treatment and violence. According to data collected through individuals living with the HIV stigma index, more than half (52%) of people living with HIV in Zambia reported having been verbally abused because of their HIV status.

According to Wiwanitkit (2003), adolescents are one group of the population most at risk of the HIV infection. Many adolescents hold serious misconceptions about the disease that could lead to unintentionally risky behaviour.

1.2 Population at higher risk of contracting HIV/AIDS

Research has demonstrated that the population most at risk of contracting HIV/AIDS is that of young women and adolescents.

1.2.1 Young Women

UNAIDS (2012) outlined that HIV continues to profoundly affect women and girls across the region. For example, sub-Saharan Africa, the region most severely affected by HIV/AIDS, women and adolescent girls represent 58% of people living with it. Socio-economic and political status of women and adolescent girls is assigned including fear or experience of violence compound women's and adolescent girls greater physiological vulnerability to HIV. Owing to social and economic power imbalances between men and women as well as the associated limitations in access to services, many women and adolescent girls have little capacity to negotiate sex, insist on condom use or take steps to protect themselves against HIV.

According to Sayles et al. (2006), the prevalence of HIV among South African youth is frighteningly high and disproportionately affects girls and women, with one-quarter

of women aged 20 to 24 infected with HIV compared with one in every 14 men of the same age. Muula (2008) points out that those young women in South Africa are at great risk of being infected with HIV. This is due to poverty, violence against women, cultural limitation that promote intergenerational sex, non-condom use and preference for dry sex, recreational drug use and biological factors such as sexually transmitted diseases.

Many women and adolescent girls in poor communities perceive sexual relationships as a means of income or sustained livelihood, and in many cultures, men are expected to provide material assistance to their wives or girlfriends. If they fail to do so, their girlfriends or wives are justified in having sexual intercourse with a man who will provide them with either money or rewards such as clothing, grocery and other material things in exchange and women's infidelity, which is acceptable for that reason (Booyesen & Summerton, 2002).

Pelser (2002) asserts that the reasons for the susceptibility of adolescent girls and women to HIV include social norms that deny them sexual health, as well as cultural practices that prevent them from controlling their bodies or deciding upon the terms on which they have sex. Women and adolescent girls are still brought up to be subservient to men, especially in sexual relationships.

1.2.2 Adolescents

CDC (2016) points out that sexual risk behaviors place adolescents at risk for HIV infection, other sexually transmitted diseases (STDs), and unintended pregnancy: Young adolescent girls and those in their early adulthood (aged 13-24) accounted for an estimated 22% of all new HIV diagnoses in the United States in 2015. The adolescents and those in their early adulthood (aged 13-24) were diagnosed with HIV in 2015, 81% were gay and bisexual males. Half of the nearly 20 million new STDs reported each year were among adolescents and early adulthood, between the ages of 15 to 24. Nearly 230,000 babies were born to adolescent girls aged 15–19 years in 2015.

CDC (2016) further points out that to reduce to sexual risk behaviors and related health problems among youth, schools and other youth-serving organizations can help adolescents adopt lifelong attitudes and behaviors that support their health and

well-being including behaviors that reduce their risk for HIV, other STDs, and unintended pregnancy.

According to Hartell (2005), throughout South Africa the AIDS epidemic is affecting a large number of adolescents, leading to serious psychological, social, economic and educational problems. Adolescents' number of dropouts at schools increases because of HIV/AIDS.

1.2 Role of HIV/AIDS communication programmes and HIV statistics

According to STATS SA (2017), one of the main HIV statistics for South Africa is that by the middle of 2017, 12.6% of the following population that is 7.06 million people are HIV positive. The increased prevalence of HIV in 2017 is largely due to combined effect of new infections. Looking at the total population, the prevalence among adolescents and those individuals in their early adulthood (aged 15-24 years) is 4.64%.

STATS SA (2008) has shown that several awareness campaigns at national, regional and local community level were, over the past 15 years, launched in South Africa through government initiatives and private non-governmental organizations. Five national level HIV/AIDS communication programmes using media and interactive components have been run over many years in South Africa, including during the period of the survey, by the Department of Health.

These are discussed as follows:

The first project to be discussed, was introduced in 1994, is Soul City that aimed to educate people about HIV/ AIDS through radio, print and television by using drama and soap operas to promote HIV/AIDS messages (Odine, 2015). This is followed by a campaign called Beyond Awareness, which was run between 1998 and 2000, focusing on informing young people about HIV/AIDS through the media (Department of Health, 2008). Another campaign that was run by the AIDS Communication Team (ACT), a group set up by the government in 2001 and called Khomanani, meaning caring together. It aimed to address issues such as sexually transmitted diseases, HIV/AIDS using mass media to broadcast messages on radio and television (Department of Health, 2008). According to UNAIDS (2012), another programme known as Pink Ribbon Red Ribbon was introduced in September 2011. This

project's major aim focused more on HIV/AIDS prevention and other treatment services especially to females including adolescents. Lastly, the most popular prevention projects that targeted people of all age groups adolescents, in integrating HIV/AIDS prevention messages into their culture are Lovelife and Soul Buddyz (Department of Health, 2008).

All these programmes use mass media in combination with interactive approaches, and two of them, Soul Buddyz and LoveLife, have a clear focus on young people. Soul Buddyz is aimed at children, and Love Life is aimed at adolescents.

According to the 2006 National HIV/AIDS Communication Survey, national HIV/AIDS communication programs reached 92.5% of the population. (Kincaid, Parker, Schierhout, Connolly & Pham, 2006)

1.4 Motivation for the study

Owing to the high rates of adolescent infections in South Africa, especially in KwaZulu-Natal as the province with the highest rate of HIV/AIDS infection among the youth, the researcher felt a need to conduct such a study in a semi-rural environment such as KwaDlangezwa Township. The researcher feels that there is also a need for more research to be conducted in order to address the issue of HIV/AIDS.

1.5 Statement of the problem

Adolescents are exposed to sexuality and HIV/AIDS education in schools through Life Orientation, introduced as part of the curriculum. Even though adolescents are exposed to this information, there are still a number of adolescents who contracts HIV. Life Orientation (LO) was introduced in schools as a way of conveying information about HIV/AIDS and how to prevent it, new HIV infections among adolescents are still reported. Therefore, research in this category of the population still needs to be conducted.

1.6 Aims of the study

The aims of the study are as follows:

- To explore the perceptions of adolescents living in a township about HIV/AIDS.
- To explore factors contributing to adolescents' high rate of HIV/AIDS infection.
- To explore the influence of HIV/AIDS on adolescents' sexual behaviour.
- To explore adolescents' general knowledge and understanding of HIV/AIDS.

1.7 Definition of terms

1.7.1 Perception

Perception is the process of organizing and interpreting sensory information to give it a meaning. The purpose of perception is to represent information from the outside world inside (King, 2009).

Morris and Maisto (1999) point out that in perception; we discover how we perceive patterns, distance and movement. In addition, how we are able to recognize an object regardless of changing or even conflicting information. Perception is a response to an unknown event not presented to any known sense. It is a variety of phenomena including awareness of an unknown object or event, knowledge of someone's thought or feelings, and knowledge of future events. It entails that certain events in the real world occur below our level of conscious experience, and it seems some people claim to have an extra power of perception, beyond the normal. This means that when we argue about our understanding of things, it would be due to how we perceive them and the way it makes sense to us.

1.7.2 Adolescence

Adolescence is a transitional period between childhood and adulthood in which peer relationships become stronger, autonomy in decision-making grows, and intellectual pursuits and social belonging are sought. This takes place between the ages of 13 and 19 (Sadock & Sadock, 2007).

1.7.3 HIV/ AIDS

According to Louw and Louw (2007), HIV stands for the human immunodeficiency virus that causes AIDS. This virus is passed from one person to the other through blood-to-blood and sexual contact. In addition, infected pregnant women can pass HIV to their babies during pregnancy or delivery, as well as through breast-feeding. Breast-feeding is discouraged unless the new mother has tested negative for HIV test. People with HIV have what is called HIV infection. Most of these people will develop AIDS because of their HIV infection.

Van Dyk (2008) states that AIDS stand for acquired immunodeficiency syndrome. It is acquired because it is not something that we inherit from our parent, but we acquire it after birth. HI virus that enters the body from the outside causes it. Immuno refers to the body's immune system and this includes all organs and cells that function to fight infections and diseases. People with AIDS have weak immune system, the body becomes slow in responding to the cells that function to fight against infections, and this refers to deficiency. The weak immune system no longer functions the way it should. The syndrome refers to a collection of specific signs and symptoms that occur together, and that are attributes of a particular condition.

1.8 Value of the study

The study that the researcher conducted aimed at assisting in revealing the perceptions of adolescents towards HIV/AIDS and suggested the types of interventions that can be used to further reduce the reported new infections.

1.9 Summary

This chapter has outlined the background and aims of the study as well as the operational definition of terms. The research problem, population sample, and ethical considerations were discussed. HIV and AIDS seem to be a major problem in South Africa, mainly as a while amongst adolescents. This study has focused specifically on the adolescents in KwaDlangezwa Township. The sample population does not represent adolescents of the whole area of KwaZulu-Natal, so the results of this study might be, to some extent compromised or biased.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of the literature. According to Pettifor et al. (2005), adolescents in sub-Saharan Africa are the population at greatest risk of HIV/AIDS infection, predominantly young women and adolescent girls. Based on the 2011 Antenatal survey, HIV prevalence in South African population was estimated at 17.3%. The province that recorded the highest HIV/AIDS prevalence was KwaZulu-Natal with 39.5%.

Harrison, Newell, Imrie and Hoddinott (2010) state that South African adolescents (aged 15 to 19) and early adulthood (aged 20 to 24) experiences amongst the highest HIV/AIDS incidences in the world. The development of effective HIV prevention programmes is thus a high public health and policy precedence. Even though there has been a recent call to increase attention to the high levels of HIV transmission to young women and adolescent girls, predominantly in Southern Africa, small scientific consensus exists about how to best implement prevention of HIV infection among the youth. In countries where HIV/AIDS incidence has dropped, a change in sexual behaviour among adolescents has been referred to as an important contributing factor. Yet questions remain regarding how to achieve and maintain the individual level of behavioural changes needed to lessen HIV/AIDS incidence. Comprehensive sexuality basic education is regarded an important means of addressing adolescent risk behaviour, although slight evidence supports its direct impact on biological measures of prevention success, particularly HIV/AIDS and other sexually transmitted infections (STIs). This chapter presents the literature review that forms the foundation of the following concepts: perception, adolescence and HIV/AIDS.

2.2 Perception

According to Louw and Edwards (1997), perception refers to those processes through which we give meaning to the information our senses receive from the environment. Perception involves selection, organization and interpretation of stimuli. It can be subliminal, which means it is subconsciously acquired through furtive messages transmitted on television or movie screens as a means of influencing the

viewer in various ways. Perception is, therefore, the only part of us that experience experiences the world.

Perception opens one's eyes to many instances where it is possible that our brain is thinking for itself and building its own version of the physical world (Schutz & Lipscomb, 2007). Perception is a necessary property to animate action: without perception action will not be guided, or will just be pointless (Robles-Delatorre & Hayward, 2001). Perception is, therefore, a subjective view of an individual about reality, which may not necessarily be a universal meaning to everyone.

Morris and Maisto (1999) point out that in perception, we discover the way we perceive patterns, distance and movement, as well as the way we identify an object, despite changing or even contradictory information. Perception is a response to an unknown event not presented to any known sense. It may comprise a variety of phenomena including awareness of an unknown object or event, knowledge of someone else's thought or feelings, and knowledge of future events.

According to Sternberg (2004), perception entails that certain events in the real world occur below our level of conscious experience, and it seems that some people claim to have an extra power of perception, beyond normal sense. This means that when we argue about our understanding of things, it will be because of how we perceive them and how they make sense to us. Sternberg (2004) further indicated that, perception begins with some real world object with real world properties. It synthesizes sensations and assigns meaning to them by taking into account our expectations, our previous experiences and sometimes our culture. Each person's perception is influenced by his or her specific frame of reference.

In the researcher's opinion, perception might be realistic or unrealistic. For instance, one person may view HIV as God's way of decreasing the number of human beings on earth, while another may view it as an infection from unprotected intercourse with someone who is infected with HIV. This is a realistic perception as it was proven scientifically, and God's way of decreasing the number of human beings becomes an unrealistic perception because it has never been scientifically proven.

2.2.1 According to Louw and Edwards there are three types of perception:

2.2.1.1 Telepathy: It means perceiving another person's thought directly.

2.2.1.2 Clairvoyance: It means perceiving objects and events outside the reach of the senses, such as the contents of a sealed envelope with HIV test results.

2.2.1.3 Pre-cognition: It means perceiving the future events such as being the first person to find HIV/AIDS cure.

2.2.2 Ecological approach to perception

Robles-Delatorre and Hayward (2001) argued for an ecological approach to perception, claiming that rather than depending on interpretations, inferences and experiences, most of our perceptual experience is due directly to the wealth of information contained in the range of stimuli presented by the environment. The main goal of perception is to support actions that are most important for performing actions. Different experiences seem to affect people's perceptions to the extent that people in different cultures are exposed to significantly different visual environments; where some of their perceptual experiences may be different as well.

2.3 Adolescence

According to Bainbridge (2009), during adolescence, many things can happen for the first time of which some are good and others are bad. Being an adolescent is seen as a time when a person has the best of both worlds, namely the charming wonder of the child and the reassuring independence of an adult. Being an adolescent is also a distinctive opportunity to experiment with the world and other people. This is the period when peer relationships play a very important role. At this stage, peer groups are formed, and individuals start interacting with one another. Romantic relationships also begin during adolescence, and many young people start having intimate partners.

According to Sadock and Sadock (2007), factors impacting sexual behaviour in adolescents include personality traits, gender, and cultural and religious background. Personality traits have been found to be associated with sexual behaviour and sexual risk taking. Higher levels of impulsiveness are associated with a younger age at first experience of sexual intercourse, a higher number of sexual partners, and

sexual intercourse without using a condom. Historically, male adolescents have initiated sexual intercourse at a younger age than female adolescents. The primary reason adolescent girls who have never had intercourse give for abstaining from sex is that having sex would be against moral beliefs their moral beliefs. Another reason is a fear of contracting HIV and other sexually transmitted diseases (STDs).

Bainbridge (2009) stated that as adolescents gradually gain more freedom, they must learn to plan what to do with it. Adolescents who undertake risky behaviour tend to have higher self-esteem and social competence. Adolescence is a time of wonderful mental experiments when many young people decide who they really are and where they are going (Bradshaw, Hibbard & Gillam, 2002).

Hashmi (2013) stated that puberty is the most observable sign that adolescence has begun. Puberty is a sensible place to pursue a quest for the nature and origins of adolescence because it is such an important part of being an adolescent. The bodily changes that puberty causes can seem strange to adolescents, but they gradually make sense of those changes. Puberty is certainly not all bad: by the time it is complete, men and women are pleasantly different in many different ways (Bainbridge, 2009).

2.4 HIV and AIDS

Stages of HIV infection are as follows:

The first stage is called pre-clinical stage: Primary HIV infection. Van Dyk (2008) stated that this stage begins after Seroconversion has taken place. Seroconversion means the point at which a person's HIV status changes from being HIV negative to HIV positive.

The second stage is Clinical stage: The asymptomatic latent stage. According to WHO (2005), this stage lasts for an average of ten years. This is a period in which HIV antibodies are detectable in the blood and antibody tests will show a positive result.

The third stage is Clinical stage 2: The minor symptomatic stage. Van Dyk (2008) stated that in the second stage of infection, slight and early symptoms of the HIV disease usually begin to manifest.

The fourth stage is Clinical stage 3: The major symptomatic stage. Major symptoms and opportunistic diseases begin to appear as the immune system continues to decline. At this point, the CD4 cell count becomes very low i.e. less than 200, while the viral load becomes very high. Signs of more severe HIV-related diseases begin to show.

The final stage is Clinical stage 4: The severe symptomatic stage with AIDS-defining conditions.

According to WHO (2005), as the immune system becomes more and more damaged, the individual may develop increasingly severe opportunistic infections and cancers, leading eventually to an AIDS diagnosis. Van Dyk (2008) stated that it usually takes about 18 months for the major symptomatic stage to develop into AIDS in patients who do not receive antiretroviral therapy. In the final stage of AIDS, the symptoms of HIV disease become more acute. HIV stands for the human immunodeficiency virus that causes AIDS by damaging a person's immune system. The result is that the body has no protection against diseases. At this stage, there is no cure for AIDS.

The only available treatment relieves the symptoms and prolongs life. Without such treatment, AIDS lasts for five to 10 years from infection to death. HIV is spread by having unprotected sex with an infected person, or from an infected mother to her newborn baby, and through contact with infected blood. Playing with an infected person, kissing, or sharing eating utensils do not increase the risk of contracting the disease. AIDS stands for acquired immuno-deficiency syndrome. It weakens a person's immune system, with the result that he or she is more susceptible to a number of illnesses (Louw & Louw, 2007).

Conclusion

This section has attempted to provide the reader with important concepts that are included in the study. These concepts are perception, adolescents and HIV/AIDS. The types of perception in relation to this study were also discussed. Adolescence was also explained and discussed using examples and lastly the stages of HIV/AIDS infection were also discussed and related them to the current study.

2.5 Literature about the perceptions of adolescents towards HIV and AIDS

Nolen (2007), states that international some adolescents perceive HIV/AIDS as a disease that was spread intentionally to thousands of people all over the world. The reason of spreading this disastrous disease was to kill a large number of blacks and homosexual people.

Van Dyk (2008) has found that there are egocentric perspectives that dominate adolescents' perceptions of HIV/AIDS. Their perception of HIV/AIDS as a lethal disease leads them to infer that all people who are seriously ill, such as cancer and tuberculosis (TB) patients, have AIDS. They have the perception that if someone in their community has AIDS, everyone like him/her also has AIDS. They dissociate themselves from groups that they identify as vulnerable to HIV/AIDS.

Hansjorg (2008), on the other hand, indicates that some adolescents have the perception that God as a punishment imposed HIV/AIDS for all those who commit adultery. They also perceive HIV/AIDS as the consequence of good or bad behavior.

Page, Louw and Pakkiri (2006) found that adolescents do not consider themselves as vulnerable of HIV/AIDS. Rather HIV/AIDS is perceived to be a disease of homosexuals and long-distance truck drivers. They also perceive it as a disease of morally corrupt people. Adolescents seem to have different perceptions when compared to adults. Several studies have found that many sexually active adolescents do not perceive themselves to be at risk of HIV/AIDS infection despite knowing about it.

Adolescents believe that an individual will contract AIDS if the body fluids are exposed to each other. They think that anal sexual intercourse is safe because of the dryness of the anus, but they regard oral intercourse as risky because the mouth is wet. They also believe that AIDS can pass through skin, so masturbation is considered by adolescents as far more risky if the semen lands on the skin (Anderson & Maughan-Brown, 2007).

Smith (2004) noted that adolescents claim that AIDS is a bad disease and a punishment from God, who has become tired of fornication and adultery in contemporary society. Less drastic views nevertheless entail elaborate discourses

relating the spread of HIV/AIDS to a present shaped by disorder and immoral behaviour. Smith (2004) further delineated that most strictly religious adolescents perceive AIDS as a metaphor for the ethical breakdown of society, as a symptom of modernity perceived as seriously ill. These discourses focus specifically on young women and adolescent girls who have regular or temporary employment, or who are engaged in small-scale trading activities. These women and adolescent girls, are perceived as behaving like prostitutes, are also seen as responsible for the spread of HIV. In some cases, this is done by questioning a person's religious integrity.

A study conducted by Wekwete and Madzingira (2005) has found that despite adolescents' high awareness and knowledge levels of HIV and AIDS, misconceptions about the illness still exist among some of the girls. Some beliefs are factually inaccurate, and since perception of risk is related to knowledge, girls may subject themselves to infection thinking that they are not vulnerable to acquire HIV/AIDS. For example, 8.1% believe that a man will be cured of HIV and AIDS if he has sexual intercourse with a virgin, and more than a quarter of the girls still believe that HIV can be transmitted through mosquito bites.

Durojaiye (2009) conducted a study that explored youth and adolescents' knowledge, perception and behavior practice and the findings pointed out that their level of HIV/AIDS knowledge was 8.3 out of 10 points. Close to 73.5% did not believe that they were at high risk of contracting HIV/AIDS and, therefore, that resulted in a lack of commitment to behavior change.

Singh and Jain (2009) conducted a study in India about secondary school adolescents' awareness of HIV/AIDS in the District of Gujarat. The sample was comprised of 755 participants from 29 schools. In their findings, over 90% were familiar with the various ways HIV/AIDS is transmitted, 80% were familiar with various ways of guarding against HIV/AIDS infections, and most participants were familiar with the knowledge that there is no cure for HIV/AIDS.

According to the study that was conducted by Mwamwenda (2013), in response to the question of whether participants considered themselves vulnerable to being HIV/AIDS infected, the majority of respondents were more negative, disagreeing with the statement.

2.6 Factors that worsen the rate of HIV and AIDS infection among young people

South Africa remains the region worst affected by the HIV/AIDS epidemic, with the young people as well as adolescents mostly affected (UNAIDS, 2008). This is owing to a number of factors that will be discussed below, namely: sexual abuse (rape), poverty, multiple sexual partners, substance abuse and unsafe sexual intercourse.

2.6.1 Sexual abuse

According to UNAIDS (2010) survey has reported that more than four in 10 South African men have been physically violent to an intimate partner. Over a quarter of men have reportedly raped a woman, with nearly one in 20 committing rape in the previous year. Little difference was found in the HIV prevalence of men who had raped a woman or adolescent girl compared to those who had not. However, the generally high HIV prevalence among all men surveyed means there is a good chance that a man who has committed rape has HIV. Women and adolescent girls who are unable to negotiate safer sex and the use of condoms will inevitably be at a greater risk of HIV.

Violence against women and adolescent girls, including sexual violence, is widespread in South Africa. A 2008 survey found that twelve per cent high school age girls and five per cent of high school age boys reported an experience of sexual abuse while the other research discovered that adolescent and early adulthood females aged 16-24 are at greatest risk of physical and sexual victimization (The Foundation for AIDS Research, 2010).

Research has found that those women and adolescent girls who have been physically and sexually assaulted by their partners, as well as those who are in relationships with men who have a greater degree of control over them, are at a higher risk of HIV infection. This is because these women and adolescents are afraid of their partners and, therefore, do not have the courage to negotiate protected sexual intercourse (UNAIDS, 2010).

According to Caldwell (2000), physical violence, a threat of violence and fear of abandonment act as significant barriers for vulnerable groups such as young people

and adolescents because they have nowhere to go or do not know whom to consult when perpetrators continue to inflict pain, injury and insecurity on them. This type of abuse is most likely to affect young people as well as adolescents. They are not safe as this abuse can happen anywhere and anytime, and this poses a problem because young people and adolescents are unable to defend themselves. Sexual abuse can take place in schools, homes and any other social environment, and can be committed by individuals who are respected and with whom young people are expected to feel comfortable and safe, such as a father, brother, uncle or a teacher at the school. Rape is definitely a contributing cause of increased HIV infection among adolescents and young people.

Violence against women, and particularly rape, are major problems in South Africa, where it is estimated that more than one woman is raped each second. The fact that rape is unsolicited and is likely to be unprotected (no condom use), makes it a significant contributor of HIV transmission in South Africa. The risk of HIV infection may be reduced by the provision of drug prophylaxis, which may not be readily available, especially in remote rural parts of South Africa (Muula, 2008).

2.6.2 Poverty

Lopman et al. (2007) state that poverty both at the individual and the societal level has been associated with HIV prevalence. Poor neighborhoods do not have the necessary social infrastructure, which may promote HIV spread. Poor individuals, owing to a lack of alternatives for earning a livelihood, may be more likely to engage in sex work or other forms of transactional sex. Transactional sex has consistently been associated with a high risk of sexually transmitted infections and HIV.

According to Muula (2008), transactional sex may be understood as sex work from the Western standpoint, some reports from Africa suggest that exchange of money and material resources may simply be a different cultural practice. Committed sexual partnerships among youth are associated with the expectation that the male will provide material and financial resources to the female partner. The ability of the male partner to provide these resources affects both the duration and the exclusivity of the relationship. Poverty seems to be the agent that contributes towards increasing HIV/AIDS infection among young people. Poor people engage in unsafe sexual

intercourse with people of high socio-economic status in exchange for a financial benefit.

Tladi (2006) argues that low economic status increases the risk of HIV infection since poor people are more likely to have unsafe sex owing to harsh circumstances that force them to resort to it for survival. HIV/AIDS is therefore perceived as a disease of the poor because they are seen as the ones likely to engage in unsafe sex. Any efforts that aim at reducing the HIV infection rate should take poverty into consideration. Poverty and its related circumstances, such as financial dependence on sexual partners, are responsible for the spread of HIV/AIDS. Poor people often sacrifice the future to ensure a better today.

AIDS-affected households are more likely to suffer severe poverty than non-affected households; this is true for countries with low as well as high prevalence. AIDS care-related expenses can absorb one-third of a household's monthly income. Families may have to use their savings, sell assets such as land and livestock, borrow money or seek support from their extended family (UNAIDS, 2004).

2.6.3 Multiple sexual partners

Concurrent sexual partnerships, where sexual relationships overlap in time, are noted to be a major factor contributing to the rapid growth of HIV infection, and qualitative research illustrates that such partnerships are normative in South Africa (Parker, Makhubele, Ntlabathi & Connolly, 2007). A national study of Native American men who have sex with men found 34% HIV prevalence and a cumulative concurrency prevalence of 55%, indicating an alarmingly high risk for HIV transmission (Cassels, Pearson, Walters, Simoni & Morris, 2011).

2.6.4 Substance abuse and unprotected sexual intercourse

Substance abuse (alcohol and drugs) is another cause of adolescents' vulnerability to HIV/AIDS. South Africa is one of the countries that have the highest growing HIV epidemics; alcohol use is known to be a risk factor for HIV (Kalichman, 2007; Mah & Halperin, 2010).

According to CDC (2004), incidents of risky sexual behaviours occur when the individual is under the influence of drugs and alcohol. Therefore, a responsible person who always uses protection when engaging in sexual activities can end up being infected with HIV/AIDS by not practicing protected sexual intercourse owing to impaired judgment of right or wrong at the moment of alcohol or drug influence. This is most likely to happen among adolescents. Adolescent girls are more likely to suffer the consequences of this behaviour by falling pregnant and becoming infected with HIV.

Galvez-Buccolini, DeLea, Herrera, Gilman and Paz-Soldan (2009) have pointed out that risky sexual behaviour of young people has received increasing attention in the last two decades. The most common form of transmission in this group is unprotected sexual intercourse. Young people and adolescents are at highest risk of acquiring sexually transmitted infections such as STIs and HIV because most are sexually active and frequently mix sex with alcohol or drugs.

The incidence of HIV doubles among young people in late adolescence. Cross-sectional studies show that young people and adolescents at school are relatively protected against HIV and that marked changes in sexual outcomes for young girls are associated with school leavers. Many are aimless with little prospect of work or further studies in the near future. In the face of new pressures and special expectations, they tolerate more risk. Young men and adolescents, in particular, consume too much alcohol, increasing their tolerance of and demands unprotected sexual intercourse (LoveLife, 2009).

2.7 HIV and AIDS in South Africa

HIV in South Africa is transmitted predominantly through heterosexual intercourse, with mother-to-child transmission being the other main infection route. The transmission rate of HIV from mother to child is approximately 11% (HSRC, 2009; South African Department of Health, 2010). An estimated 310 000 South Africans in 2009 died of AIDS; more than in any other country (UNAIDS, 2010). According to the HSRC (2009), prevalence is 17.8% among those aged 15 to 49. Almost one in three women aged 25 to 29 and over a quarter of men aged 30 to 34 are living with HIV. The impact of the AIDS epidemic is reflected in the dramatic change in South

Africa's mortality rates. The overall number of deaths increased sharply from 1997, when 316 559 people died, to 2006 when 607,184 607 184 people died (UNAIDS, 2010).

Young people and adolescents in South Africa have the fastest growing infection rates (Casale & Whiteside, 2005; Cogneau & Grimm, 2006). They are expected to delay sexual activity and avoid unplanned pregnancy and sexually transmitted infection to safeguard their sexual health (Collins & Leibbrandt, 2007). Even though a decline in HIV prevalence has been reported in South Africa among South African youth aged 15-24, from 10.3% in 2005 to 8.6% in 2008, the prevalence remains disproportionately high for females overall in comparison to males (Casale & Whiteside, 2005). For instance, young females have three to four times the prevalence of HIV than their male peers (Barnighausen, Hosegood, Timaeus & Newell, 2007). Therefore, it is crucial to take into account the gender differences of HIV prevalence and HIV risk behaviours (Harris, Michael, Christine & Dale, 2006).

2.8 Global status of HIV and AIDS

According to UNAIDS (2012), globally an estimated 34 million i.e. 31.4 million-35.9 million people were living with HIV at the end of 2011. It was also estimated that 0.8% of adults aged 15-49 years worldwide are living with HIV. In countries such as Botswana and Swaziland, adult prevalence is approaching 40%. In many areas, AIDS is erasing decades of progress made in human development as young, productive people die, households fall into poverty, and the costs of the epidemic mount. Average life expectancy in the region has declined from 62 years to 47 and continues to fall. UNAIDS (2010) stated that new indications show a slowing of HIV incidence amid some signs of a shift towards safer sex among young people.

An estimated 900 000 new HIV infections occurred among young people and adolescents in 2008. Among young people and adolescents living with HIV, nearly 80% (four million) live in sub-Saharan Africa. The HIV epidemic has been harsh on the lives of young women, who comprise 66% of infections among young people worldwide. More than half of all sexually transmitted infections (more than 180 million out of a global annual total of 340 million new infections) other than HIV occur

among adolescents and individuals in their early adulthood aged 15 to 24 (UNAIDS, 2008).

There seems to be a diminution of HIV/AIDS contraction in other countries except for sub-Saharan Africa. The most recent statistics indicate that knowledge of how to prevent HIV infection has increased among adolescents and individuals in their early adulthood aged 15 to 24, which is the group that is at high risk of infection. Even though there seems to be a decrease in infection, UNAIDS (2010) plans to build social coalitions to reduce vulnerability to HIV infection to support individuals and strengthen communities. The other plans include investing in health care and social support systems, working to eliminate violence against women and girls and promote gender equality, and working to end stigma and discrimination against people living with HIV.

UNAIDS (2012) Sub-Saharan Africa remains most severely affected with nearly one in every twenty adults (4.9%) living with HIV and accounting for 69% of people living with HIV worldwide. Sub-Saharan Africa is followed by the Caribbean, Eastern Europe and Central Asia, where 1.0% of adults were living with HIV in 2011.

2.9 Decline in new HIV infections

According to Pettifor et al. (2004), the prevalence of HIV among 15 to 24-year-olds has fallen from 10.3% in 2005 to 8.7% in 2008. Although that does not seem like a big drop, it does imply that the rate of new infection has fallen sharply. The prevalence of HIV among 15 to 19-year-old men has been consistently low (about 2.5%) – because adolescent boys tend to have sex with girls their own age. On the other hand, the prevalence of HIV among young women aged 15 to 19 climbed to close to 10% before dropping back to 6.7%.

In 33 countries, the HIV incidence has fallen by more than 25% between 2001 and 2009; 22 of these countries are in sub-Saharan Africa (UNAIDS, 2010). On the other hand, UNAIDS (2012) has revealed that worldwide, the number of people newly infected continues to drop: the number of people (adults and children) acquiring HIV infection in 2011 was 20% (2.5 million) lower than in 2001. The sharpest declines in numbers of people acquiring HIV infection since 2001 have occurred in the Caribbean (42%) and sub-Saharan Africa (25%).

Pettifor et al. (2004) emphasize that the reason for the rise and fall in prevalence in 15 to 19-year-old women over the past few years is that their sexual partners are typically 20 to 24-year-old men, resulting in a time-lag between prevalence changes in men and women of the same age: 20 to 24-year-old men had a high prevalence of HIV six years ago, but it has dropped steadily since then. The consequently lower prevalence among 15 to 19-year-old adolescent girls is now working through into 20 to 24-year-old women. There may also be a lot less new HIV infection among 20 to 24-year-old women although there are uncertainties.

2.10 Preventing new HIV infections

Proven strategies exist to prevent every mode of HIV transmission—sexual, blood borne (including through injecting drug use and in health care settings), and mother-to-child. Recent years have seen the confirmation of medical male circumcision as a potentially valuable technology for HIV risk reduction in men. The supply of free male condoms and later on female condoms also act as preventions of new HIV/AIDS infections among young people and adolescents. Although the most reliable way to prevent new infections is abstinence, adolescents fail to practice it, and so it is crucial that they become encouraged to actually use condoms to protect themselves (UNAIDS, 2008).

2.11 Theoretical framework

Introduction

Theoretical framework plays an important role in the study. Therefore the following theories will be discussed in this section: two major theories of HIV and AIDS namely: AIDS as a centuries-old disease and HIV crossed the species barrier from primates to humans. The Health Belief Model will also be included in this section which comprises of perceived susceptibility, perceived severity, perceived barriers, cues to action and lastly self-efficacy.

According to Schoub (1999), no other disease has ever fired the imagination of the world as much as HIV/AIDS has done. There are two main theories about HIV/AIDS. They are: (1) AIDS is a centuries-old disease of Africa: and (2) HIV crossed the species barrier from primates to humans.

2.11.1 AIDS as a centuries-old disease

According to Schoub (1999), this theory about AIDS suggests that it is not a new disease but has been present for centuries in central Africa. It remained undetected only because of lack of diagnostic facilities. The clinical symptoms of AIDS were ascribed to malaria and TB. The spread of HIV/AIDS was limited because there was little contact with outsiders, and it was introduced to the Western world only when international travel became more common. One of the arguments against this theory is that modern testing of blood samples from Africa rarely shows any signs of HIV infection before the 1980s.

2.11.2 HIV crossed the species barrier from primates to humans

According to (Korber, 2000), this theory about the origin of AIDS is that HIV crossed the species barrier from primates to humans at some time during the twentieth century. HIV is related to a virus called SIV, the simian immunodeficiency virus, which is found in primates. There are a number of SIV strains, and each strain is specific to the monkey species that it infects. Under natural conditions, each strain will infect only its own specific species of monkey, and it will infect humans, but no other animal.

2.11.3 Health Belief Model

According to Boskey (2010), Health Belief Model (HBM) is defined as a realistic tool that scientists use to change health behaviour. It was originally developed in the 1950s and updated in the 1980s. It is based on the theory that a person's willingness to change their behaviour is primarily due to the following factors.

2.11.3.1 Perceived susceptibility

People will not change their health behaviour unless they seem at risk: for example, after a subjective evaluation of the risk of HIV. According to Chen, Fox, Cantrell, Stockdale & Kagawa-Singer (2007), personal risk or susceptibility is one of the most powerful perceptions in prompting people to adopt healthier behaviours.

2.11.3.2 Perceived severity

The probability that people will change their health behaviour to avoid a consequence depends on how serious the person they consider the possible consequence to be: for example, contracting HIV (Boskey, 2010).

2.11.3.3 Perceived barriers

People think that changing their behaviour is going to be hard, physically and socially: for example, it may cause them embarrassment. According to CDC (2008), in order for new behaviours to be adopted, a person needs to believe the benefits of new behavior outweigh the consequences of continuing the old behavior.

2.11.3.4 Cues to action

These occur when an external event prompts a desire to make a health change: for example when a person sees a picture of a condom on a billboard (Boskey, 2010).

2.11.3.5 Self- efficacy

This perception occurs when a person believes he/she has the ability to make a health change without risk. Many research studies show that many adolescents do not perceive themselves as being at high risk of contracting HIV and AIDS. According to Orji, Vassoleva and Mandryk (2012), self-efficacy is a personal belief on one's own ability to enact the desired behaviours.

2.12 Summary

There has been an apparent decline in infections of HIV/AIDS among young people and adolescents who have sexual intercourse with partners of their own age. In situations where male partners, are far older than their female partners there seems to be a very high rate of infections. These infections imply that older men who are in a relationship with adolescents have control over the relationship and this result in a lack of condom use. Female adolescent partners are afraid of negotiating safer sexual intercourse with their older partners, and that is why there is a peak in HIV infection among female adolescents.

The most recent statistics suggest that since adolescents are the people most at risk of contracting HIV, their behaviour makes them more vulnerable to contracting this

disastrous disease. Their behaviour includes having multiple sexual partners with whom they neglect the condom use in most cases. However, the most dangerous behaviour adolescents indulge in is substance abuse involving alcohol and drugs. Eventually they engage in unprotected sexual intercourse, in most cases because their judgment has been impaired under the influence of substances such as alcohol and drugs.

On the other hand, the literature suggests that female adolescents are the ones with a high rate of HIV infection. This is because they get involved with older men, using their bodies in exchange for gifts. Older men who date younger girls are likely married. In situations such as these, it is unlikely that adolescent girls would say no to unprotected sex because that would mean they would not receive gifts. Some older men seem to believe that they can be cured of HIV if they have unprotected sex with a virgin. This leads to older men targeting young, innocent, vulnerable school learners.

This chapter has attempted to provide a reader with a review of literature relevant to the study. It has also provided different theories related to the study. This chapter has outlined how adolescents are at risk of contracting HIV/AIDS and discussed agents that worsen HIV infections among adolescents. Those agents are sexual abuse, poverty, multiple sexual partners, substance abuse and unprotected sexual intercourse.

CHAPTER 3 RESEARCH METHODOLOGY

3.1 Introduction

This chapter is aimed at discussing the methods that were employed in this study. The section provides an overview of target population, study design, research questions, hypothesis, data collection instrument, data analysis and interpretation of findings, validity and reliability, ethical considerations, limitations of the study and a summary. The chapter will also include participants' demographic information as well as the setting within which the research was conducted.

3.2 Demographic characteristics of the participants

3.2.1 Summary of participants' characteristics in terms of their grade

GRADE	NUMBER	PERCENTAGE
8 to 9	19	38%
10 -11	18	36%
12	13	26%
TOTAL	50	100%

3.2.2 Summary of participants' characteristics in terms of their gender

GENDER	NUMBER	PERCENTAGE
Males	22	44%
Females	28	56%
Total	50	100%

3.2.3 Summary of participants' characteristics in terms of their age

AGE	NUMBER	PERCENTAGE
13-14 years	15	30%
15-16 years	22	44%
17-18 years	13	26%
TOTAL	50	100%

3.3 Research hypothesis

According to Kruger and Welman (2002), a hypothesis is an assumption that is expressed as a statement, and it is a premise that can be used as a basis for investigation. Rumsey (2011) has discussed two types of hypothesis namely null and alternative hypothesis. She defined null hypothesis as the population parameter that amount to the claimed value whereas alternative hypothesis is defined as the

population parameter that does not amount to the claimed value. They affirm that hypotheses are advanced from logical chains of inference arising from the evaluation of the interrelationship of data regarding factors thought to be contributing to the problem. The study attempts to investigate the perceptions of adolescents towards HIV and AIDS. The hypothesis of the study is that:

- Adolescents' perceptions of HIV and AIDS are not realistic.
- Adolescents have basic knowledge about HIV and AIDS.

3.4 Research questions

- What perceptions do adolescents in KwaDlangezwa Township have about HIV and AIDS?
- Do adolescents perceive themselves as being at high risk of contracting HIV and AIDS?
- Can adolescents differentiate between HIV and AIDS?
- Do adolescents know ways of protecting themselves from contracting HIV and AIDS?
- Can adolescents differentiate between myths and truths about HIV and AIDS?

3.5 Target population

The participants were selected from community learners who attend at Ongoye High School in KwaDlangezwa Township in KwaZulu-Natal Province. The school has a total population of 250 learners. Although the researcher hoped to target more participants, only 50 participants took part. The target population was 125 participants. The researcher approached all the classes to ensure that every learner in the population of 250 had an equal chance to be selected. Since learners had a right to participate or not, only 50 learners showed interest and signed the consent form to participate in the study. All participants in the study were unmarried adolescent males and females with ages ranging from 13 and to 18. The school was chosen because it was the nearest accessible school with adolescents of both genders. The participants were chosen based on willingness to take part in the

study. The participants were assured that they could withdraw at any time they felt uncomfortable about completing the questionnaire.

3.6 Study design

This study employed descriptive design that incorporated both qualitative and quantitative methods of investigation. The research paradigm of this study is interpretive. According to the research design employed in the study, it was a sample that helped to gain an understanding of the perceptions of adolescents in KwaDlangezwa Township towards HIV and AIDS.

Cozby (1997) has pointed out that surveys use self-report measurement techniques to question people about themselves, their attitudes, behaviours and demographics, i.e. income, race and marital status. Surveys may employ careful sampling techniques to obtain an accurate description of an entire population. The survey method is an important way for researchers to study the relationships among variables and ways that attitudes and behaviour change over time.

3.7 Sampling method

For sampling purposes, a convenience sampling method was employed. According to Domyei (2007), convenience sampling is the type of sampling in which participants are chosen based on their willingness to participate in the study. Therefore nobody should be biased for participation unless the individual shows no interest in participating.

3.8 Data collection instrument

In light of data collection instrument, the perceptions of adolescents in Kwadlangezwa Township towards HIV and AIDS questionnaire were utilized. Data was obtained through a semi-structured questionnaire with both open-ended and closed-ended questions. The reasons for open-ended questions were to allow participants to express themselves without being limited as well as to allow infinite responses about the respondent's understanding of HIV/AIDS. Finally to encourage creative responses and understand the respondents' reasoning and thinking capacities where HIV/AIDS issues are concerned. A questionnaire is defined by McBurney and White (2004) as a group of questions used to gather information from

respondents, and it is regarded as one of the commonest tools for gathering data. Participants were told to raise a hand if they needed clarity on any of the questions, nobody asked for any clarity and the researcher was of the opinion that all the questions asked were making sense.

The researcher restricted the participants to communicate with each other while they fill in the answers and they were restricted to share a desk. Each participant was encouraged to sit alone to discourage them from copying from each other. All participants were given a questionnaire to complete and return after completion. The questionnaire covered questions concerning the perceptions of adolescents about HIV/AIDS. Data collection duration was approximately fifteen minutes, after that time everyone had finished answering the questions and had returned the questionnaires to the researcher. All questionnaires returned were assessed for errors before the participants left. The perception of adolescents in KwaDwlangezwa Township towards HIV and AIDS questionnaire was used and it consisted of the following information:

3.8.1 Section A

This section consisted of biographical information of the participants such as grade, gender, age, home location, date as well as their racial group.

3.8.2 Section B

This section consisted of closed-ended questions assessing the perceptions of adolescents about HIV and AIDS in which they had to choose between true and false. These questions are listed below:

- AIDS can be cured if treated early.
- Most people who get AIDS usually die from this disease.
- A new vaccine has been developed for HIV prevention.
- AIDS is a punishment of good and bad behaviour from God.
- People with AIDS only suffer from this disease; they do not get infected by other diseases.

- Substance abuse and sexual abuse worsen the spread of HIV/AIDS.
- HIV/AIDS is contracted when body fluids come into contact with each other.
- HIV/AIDS was spread deliberately to thousands of people all over the world to wipe out a large number of blacks and homosexual people.

3.8.3 Section C

In this section, HIV/AIDS was assessed using open-ended questions. These questions are listed below:

- What do you understand by the words HIV and AIDS?
- How would you prevent yourself from contracting HIV/AIDS?
- Do you perceive yourself as being at high risk of contracting HIV?
- Do you think HIV/AIDS has an impact on your sexual behaviour and why?
- Do you think people with HIV/AIDS should be kept in isolation? If yes why?
- What are the factors that make HIV/AIDS infections worse?
- The last part of the questionnaire includes the participants' comments of any information about HIV and AIDS that they felt was not covered in the questionnaire and they thought was important.

3.9 Data analysis and interpretation of findings

Data collected from the questionnaires was verified and analysed manually by using descriptive statistical analysis. The information obtained from the participants was coded, categorized and presented in tables and graphs using Excel.

3.10 Validity and reliability

Banks (2007) defined validity as the degree in which the research instrument measures what it supposed to measure. Reliability refers to a degree which the research instrument gives more or less the same results if it is re-administered (Roberts, Priest & Traynor, 2006).

It is the impression of the researcher that the questions posed by the research instrument are valid given that the research instrument covered the questions which the researcher wanted to know and the sample is the accurate representation of the total population.

Reliability is also assumed given that it was administered to participants while they were under supervision to ensure that they did not copy from other participants. It is also the researcher's impression that the research instrument employed was valid and reliable given that it had clear language which was in English, and that promoted understanding. The participants were also encouraged to ask about questions that were not clear to them, and those questions were explained to them in easier terms. The questionnaire was developed to ask specific questions to what was being researched and research instrument covered such questions.

3.11 Ethical considerations

All ethical considerations were adhered to in the study. Permission to conduct a study at Ongoye High School was granted to the researcher by the school Principal. The participants recommended by the teachers had equal rights to agree or disagree to participate in the study. No learner was forced into participation; they all took a decision to do so in their own free will. No learners were allowed to participate in the study without a written consent form from the parent or guardian especially those who were under the age of 18 years. Parents or guardians were informed about the study as well as its aims prior giving permission for their children to partake in the study. This was done by giving learners the letters explaining the process to follow and asking permission as well as consent forms. Therefore parents or guardians gave consent by signing the forms and learners gave them to the researcher before taking part in the study. Learners who were already 18 years and older gave assent to participate by signing the consent forms and they were informed that their participation in the study was voluntary, and that they should not participate unless they felt completely comfortable. Both consent forms signed by parents or guardians as well as learners who were 18 years older were translated into isiZulu as well.

The forms also explained that there would be no rewards for participating. The participants were allowed to withdraw from the study at any time, and they would not

be questioned about their withdrawing. The form explained that their information would remain confidential and their responses would remain completely anonymous. The participants were not deceived about the purpose of the research project because they were informed that it was conducted as part of a university research programme.

3.12 Limitation of the study

The researcher intended to target more participants in this study but few participants showed interest to take part. It was difficult to have all participants at the same time when collecting data because some of the participants did not return their signed consent forms the day the researcher was administering a questionnaire. Other participants did not come to complete a questionnaire the same day the researcher was administering it. The researcher had to make other arrangements to administer a questionnaire to the remaining participants. The researcher was also limited when it comes to religious afflictions of respondents as the questionnaire did not include it. It would have been better to find out the perceptions of HIV/AIDS in terms of adolescent's religious believes because that would have depicted the findings of adolescents from different religious beliefs. The researcher only thought about it after data was collected. Due to relocation constraints debriefing were not done as well as free counselling, therefore it was pivotal for adolescents to receive free counselling as HIV and AIDS are sensitive issues.

3.13 Summary

This chapter has provided a description of research design and methods that were employed in the study. It also provided the methods used to collect data and the descriptions of the setting in which the research was conducted. Validity and reliability of research instrument were also explored.

CHAPTER 4 RESEARCH FINDINGS

4.1 Introduction

This chapter deals with the presentation of results obtained in the study in terms of the participants' gender and age. These results are represented in the form of tables and percentages as indicated below:

4.2 Perceptions of HIV and AIDS

This section is comprised of closed-ended questions in which the participants were required to choose between true or false where applicable.

4.2.1 Table 1 – AIDS can be cured if treated early

True or False	Males	Females	Percentage
TRUE	10	8	36%
FALSE	12	20	64%
Total	22	28	100%

The respondents consisted of thirty-six per cent (36%) (n=18) who answered true and sixty-four per cent (64%) (n=32) who answered false. Literature reveals that there is no cure for HIV/AIDS infections (Schololey and Mellors, 2007).

True or False	13-14 years	15-16 years	17-18 years	Percentage
TRUE	12	16	4	64%
FALSE	3	6	9	36%
Total	15	22	13	100%

The respondents consisted of twenty-four per cent (24%) (n=12) aged between 13 and 14 years who answered true and six per cent (6%) (n=3) who answered no. Those aged between 15 and 16, they consisted of thirty-two per cent (32%) (n=16) who answered true and twelve per cent (12%) (n=6) who answered false. The respondents aged between 17 and 18 consisted of eight per cent (8%) (n=4) who answered false and eighteen per cent (18%) (n=9) who answered false.

AIDS Policy Project (2010) stated that, although antiretroviral treatment can suppress HIV, i.e. the virus that causes AIDS, and can delay illness for many years, it cannot clear the virus completely. Unproven cures for HIV have been around since the syndrome emerged in the early 1980s (Amon, 2008). In most cases they only

served to worsen the suffering. The promotion of fake HIV cures undermines HIV prevention (AIDS Policy Project, 2010). Adolescents who believe in cure if AIDS is detected early are less likely to fear becoming infected with HIV and AIDS, and hence less likely to take precautions.

4.2.2 Table 2 – Most people who get AIDS usually die from this disease

True or False	Males	Females	Percentage
TRUE	20	22	84%
FALSE	2	6	16%
Total	22	28	100%

The respondents consisted of eighty-four per cent (84%) (n=42) who answered true and sixteen per cent (16%) (n=8) who answered false.

True or False	13-14 years	15-16 years	17-18 years	Percentage
TRUE	7	10	3	40%
FALSE	8	12	10	60%
Total	15	22	13	100%

The respondents consisted of fourteen per cent (14%) (n=7) of those aged between 13 and 14 years who answered true and sixteen per cent (16%) (n=8) who answered false. Those aged between 15 and 16, they consisted of twenty per cent (20%) (n=10) who answered true and twenty-four per cent (24%) (n=12) who answered false. The respondents aged between 17 and 18 consisted of six per cent (6%) (n=3) who answered true and twenty per cent (20%) (n= (10) who answered false.

Literature reveals that for people with HIV, the virus may seem to be under control for a while with antiretroviral treatment. But after the virus has been living in someone's body for some time, he/she will become sick. People with HIV/AIDS die from AIDS exacerbated by infections, Tuberculosis and cancer, pneumonia, digestive problems and infections caused by bacteria, virus or fungus because the body becomes weaker and can no longer fight these infections (Nettina, 2009).

4.2.3 Table 3 – A new vaccine has been developed for HIV prevention

True or false	Males	Females	Percentage
TRUE	11	14	50%
FALSE	11	14	50%
Total	22	28	100%

The respondents consisted of fifty per cent (50%) (n=25) who answered true and fifty per cent (50%) (n=25) who answered false.

True or False	13-14 years	15-16 years	17-18 years	Percentage
TRUE	10	9	2	42%
FALSE	5	13	11	58%
Total	15	22	13	100%

The respondents consisted of twenty per cent (20%) (n=10) of those aged between 13 and 14 years who answered true and ten per cent (10%) (n=5) who answered false. Those aged between 15 and 16, they consisted of eighteen per cent (18%) (n=9) who answered true and twenty-six per cent (26%) (n=13) who answered false. The respondents aged between 17 and 18 consisted of four per cent (4%) (n=2) who answered true and twenty-two per cent (22%) (n= (11) who answered false.

Literature reveals that currently in South Africa there is no vaccine to prevent HIV/AIDS infections. There is only antiretroviral treatment which helps to manage the disease. People with HIV/AIDS live longer with this treatment as there is still no cure for HIV/AIDS (CDC, 2010).

4.2.4 Table 4 – AIDS is a punishment of good and bad behaviour from God

True or false	Males	Females	Percentage
TRUE	7	12	38%
FALSE	15	16	62%
Total	22	28	100%

The respondents consisted of thirty-eight per cent (38%) (n=19) who answered true and sixty-two per cent (62%) (n=31) who answered false.

True or False	13-14 years	15-16 years	17-18 years	Percentage
TRUE	7	15	5	54%
FALSE	8	17	8	46%
Total	15	22	13	100%

The respondents consisted of fourteen per cent (14%) (n=7) of those aged between 13 and 14 years who answered true and sixteen per cent (16%) (n=8) who answered false. Those aged between 15 and 16, they consisted of thirty per cent (30%) (n=15) who answered true and thirty-four per cent (34%) (n=17) who answered false. The respondents aged between 17 and 18 consisted of ten per cent (10%) (n=5) who answered true and sixteen per cent (16%) (n= 8) who answered false.

According to a study conducted in Tanzania in 2004-2005, 65% of participants agreed with at least one of four stigmatizing lame and judgemental statements including that HIV and AIDS are a punishment for bad behaviour (HIV/AIDS stigma, 2006).

4.2.5 Table 5 – People with AIDS only suffer from this disease; they do not get infected by other diseases

True or false	Males	Females	Percentage
TRUE	1	26	54%
FALSE	21	2	46%
Total	22	28	100%

The respondents consisted of fifty-four per cent (54%) (n=27) who answered true and forty-six per cent (46%) (n=23) who answered false.

True or False	13-14 years	15-16 years	17-18 years	Percentage
TRUE	10	16	4	60%
FALSE	5	6	9	40%
Total	15	22	13	100%

The respondents consisted of twenty per cent (20%) (n=10) of those aged between 13 and 14 years who answered true and ten per cent (10%) (n=5) who answered false. Those aged between 15 and 16, they consisted of thirty-two per cent (32%) (n=16) who answered true and twelve per cent (12%) (n=6) who answered false. The

respondents aged between 17 and 18 consisted of eight per cent (8%) (n=4) who answered true and eighteen per cent (18%) (n= 9) who answered false.

Literature reveals that people with HIV may seem to be well for a while, but after the virus has been in the body for some time, they usually become sick with other infections such as tuberculosis (TB), cancer and pneumonia. These infections kill people with HIV/AIDS as they weaken their immune system. Furthermore, HIV-infected people get these infections because HIV stops the body from protecting itself against infections. These infections take the opportunity to attack a weak body that is no longer able to fight back. They are called opportunistic infections (Berman, Snyder, Kozier & Erb, 2010).

4.2.6 Table 6 – Substance abuse and sexual abuse worsen the spread of HIV/AIDS

True or false	Males	Females	Percentage
TRUE	21	26	94%
FALSE	1	2	6%
Total	22	28	100%

The respondents consisted of ninety-four per cent (94%) (n=47) who answered true and six per cent (6%) (n=3) who answered false.

True or False	13-14 years	15-16 years	17-18 years	Percentage
TRUE	11	18	12	82%
FALSE	4	4	1	18%
Total	15	22	13	100%

The respondents consisted of twenty-two per cent (22%) (n=11) of those aged between 13 and 14 years who answered true and eight per cent (8%) (n=4) who answered false. Those aged between 15 and 16, they consisted of thirty-six per cent (36%) (n=18) who answered true and eight per cent (8%) (n=4) who answered false. The respondents aged between 17 and 18 consisted of twenty-four per cent (24%) (n=12) who answered true and two per cent (2%) (n= 1) who answered false.

CDC (2016) reveals that the risk for getting or transmitting HIV is very high if an HIV-negative person uses injection equipment that someone with HIV has used. This

high risk is because the drug materials may have blood in them, and blood can carry HIV.

As a person becomes more intoxicated, alcohol's physiological effects results in decreased ability to process information and make judgements, as a result alcohol consumption impair cognitive abilities such as decision-making such as engaging in sexual intercourse (Noris, 2008).

Pelser (2002) has indicated that rape and violence are associated with an increased likelihood of HIV/AIDS transmission. A national survey of HIV and Sexual behaviour among young South Africans from 15 to 24 years old has revealed that among sexually experienced young people six per cent (6%) reported having been forced to have sex.

4.2.7 Table 7 – HIV is contracted when body fluids come into contact with each other

True or false	Males	Females	Percentage
TRUE	16	12	56%
FALSE	6	16	44%
Total	22	28	100%

The respondents consisted of fifty-six per cent (56%) (n=28) who answered true and forty-four per cent (44%) (n=22) answered false.

True or False	13-14 years	15-16 years	17-18 years	Percentage
TRUE	12	15	9	72%
FALSE	3	7	4	28%
Total	15	22	13	100%

The respondents consisted of twenty-four per cent (24%) (n=12) of those aged between 13 and 14 years who answered true and six per cent (6%) (n=3) who answered false. Those aged between 15 and 16, they consisted of thirty per cent (30%) (n=15) who answered true and fourteen per cent (14%) (n=7) who answered false. The respondents aged between 17 and 18 consisted of eighteen per cent (18%) (n=9) who answered true and eight per cent (8%) (n= (4) who answered false.

CDC (2010) reveals that HIV can be transmitted if body fluids come into contact with each other. The following body fluids have been shown to contain high concentrations of HIV:

- Blood
- Semen
- Vaginal fluid
- Breast milk
- Fluid surrounding the brain and the spinal cord
- Fluid surrounding bone joints
- Fluid surrounding an unborn baby

4.2.8 Table 8 – HIV was spread deliberately to thousands of people all over the world to wipe out large number of blacks and homosexuals

True or false	Males	Females	Percentage
TRUE	9	20	58%
FALSE	13	8	42%
Total	22	28	100%

The respondents consisted of fifty-eight per cent (58%) (n=29) who answered true and forty-two per cent (42%) (n=21) who answered false.

True or False	13-14 years	15-16 years	17-18 years	Percentage
TRUE	14	10	3	54%
FALSE	1	12	10	46%
Total	15	22	13	100%

The respondents consisted of twenty-eight per cent (28%) (n=14) of those aged between 13 and 14 years who answered true and two per cent (2%) (n=1) who answered false. Those aged between 15 and 16, they consisted of twenty per cent (20%) (n=10) who answered true and twenty-four per cent (24%) (n=12) who answered false. The respondents aged between 17 and 18 consisted of six per cent (6%) (n=3) who answered true and twenty per cent (20%) (n= (10) who answered false. There is no research that has proved that HIV was spread deliberately to thousands of people all over the world to wipe out large numbers of blacks and homosexuals.

SECTION C

4.4 General understanding of HIV/AIDS

4.4.1 Table 9 – The understanding of the words HIV and AIDS

	Males	Females	Percentage
Dangerous	3	4	14%
Incurable and it kills	3	4	14%
Infectious, communicable and transmitted	4	7	22%
AIDS is a disease and HIV is a virus	10	6	32%
Bad disease	1	3	8%
You take ARVs when you have HIV and AIDS.	1	4	10%
Total	22	28	100%

The respondents consisted of fourteen per cent (14%) (n=7) who said HIV and AIDS are dangerous diseases, fourteen per cent (14%) (n=7) who said that HIV and AIDS are incurable diseases that kill people, twenty-two per cent (22%) (n=11) who said that HIV and AIDS are infectious diseases that affect people, thirty-two per cent (32%) (n=16) who said that AIDS is a disease and HIV is a virus, eight per cent (8%) (n=4) who said that HIV and AIDS are words that people talk about, ten per cent (10%) (n=5) who said that HIV and AIDS are bad diseases, and six per cent (6 %) who said that someone who has HIV and AIDS should take treatment (ARVs).

	13-14 years	15-16 years	17-18 years	Percentage
Dangerous	2	3	1	12
Incurable and it kills	5	2	1	16
Infectious, communicable and transmitted	1	6	7	28
AIDS is a disease and HIV is a virus	2	5	2	18
Bad disease	3	3	1	14
You take ARVs when you have HIV and AIDS.	2	3	1	12
Total	15	22	13	100%

These findings show that adolescents have a clear understanding of HIV/AIDS in terms of how they perceive it, although the acronyms were not explained in detail.

4.4.2 Table 10 – Prevention from contracting HIV/AIDS

	Males	Females	Percentage
Wearing gloves	10	6	32%
Abstinence	5	9	28%
Being faithful	1	1	4%
Condomizing	4	8	24%
One sexual partner	1	2	6%
Knowing more about HIV	1	2	6%
Total	22	28	100%

The respondents consisted of thirty-two per cent (32%) (n=16) learners who said they would prevent themselves from contracting HIV/AIDS by wearing gloves when helping an injured person, twenty-eight per cent (28%) (n=14) who said they would practice abstinence, four per cent (4%) (n=2) who said they would be faithful, twenty-four per cent (24%) (n=12) who said they would condomize, six per cent (6%) (n=3), who said they would have one partner, and six per cent (6%) (n=3) who said it was necessary to know more about HIV/AIDS.

	13-15 years	15-16 years	17-18 years	Percentage
Wearing gloves	5	3	1	18%
Abstinence	2	2	4	16%
Being faithful	3	3	2	16%
Condomizing	1	5	2	16%
One sexual partner	2	4	2	16%
Knowing more about HIV	2	5	2	18%
Total	15	22	13	100%

According to Dowshen-Atanda (2012), prevention of HIV remains of worldwide importance. HIV infection can be prevented by never sharing needles and abstaining from oral, vaginal and anal sex. Since most people will eventually become sexually active at some point in their lives, always using condoms for all types of sexual intercourse can drastically reduce the risk of getting HIV.

4.4.3 Table 11 – Perception of oneself as being at high risk of contracting HIV

Yes or No	Males	Females	Percentage
YES	10	11	42%
NO	12	17	58%
Total	22	28	100%

The respondents consisted of forty-two per cent (42%) (n=21) learners who said yes, and fifty-eight per cent (58%) (n=29) respondents said no.

Yes or No	13-14 years	15-16 years	17-18 years	Percentage
YES	5	15	11	62%
NO	10	7	2	38%
Total	15	22	13	100%

The research that was conducted by Fernandez et al. (2008) found that many adolescents do not perceive themselves as being at high risk of contracting HIV/AIDS. Studies suggest that adolescents who perceive themselves as being at high risk tend to engage in less risky sexual behaviour than those who do not.

4.4.4 Table 12 – HIV/AIDS has impact on your sexual behaviour

	Males	Females	Percentages
Yes, because HIV/AIDS makes me scared and it does not have treatment.	2	1	6%
Yes, because HIV positive people do not want to die alone so they spread it.	2	6	16%
Yes, because it makes you careful and refrain from sexual behavior	8	5	26%
Yes, because I have unprotected sex and have multiple sexual partners.	1	4	10%
Yes, because you cannot tell if someone is HIV positive.	2	4	12%
No, because I am not in a sexual relationship and I am not sexually active.	3	6	18%
No, because I always have protected sex.	3	1	8%
No, because I have only one sexual partner.	1	1	4%
Total	22	28	100%

The respondents consisted of six per cent (6%) (n=3) learners who said HIV has an impact on their sexual behaviour because HIV/AIDS makes them scared because it does not have treatment, sixteen per cent (16%) (n=8) who said yes because HIV positive people spread HIV, and there is a high possibility of contracting it, twenty-six per cent (26%) (n=13) who said yes because it makes you more careful and refrain from unprotected sexual behaviour, ten per cent (10%) (n=5) who said yes because they have unprotected sex and have multiple sexual partners, and twelve per cent (12%) (n=6) who said yes because you cannot tell if someone is HIV positive. Eight per cent (8%) (n=4) said no because they were not in a sexual relationship and were not sexually active, eight per cent (8%) (n=4) said no because they always had protected sex, and four per cent (4%) (n=5) said no because they only had one sexual partner.

	13-14 years	15-16 years	17-18 years	Percentage
Yes, because HIV/AIDS makes me scared and it does not have treatment.	1	2	1	8%
Yes, because HIV positive people do not want to die alone so they spread it.	2	1	1	8%
Yes, because it makes you careful and refrain from sexual behaviour	3	2	2	14%
Yes, because I have unprotected sex and have multiple sexual partners.	2	2	0	8%
Yes, because you cannot tell if someone is HIV positive.	1	4	1	12%
No, because I am not in a sexual relationship and I am not sexually active.	4	3	1	16%
No, because I always have protected sex.	1	6	4	22%
No, because I have only one sexual partner.	1	2	3	12%
Total	15	22	13	100%

According to Sadock and Sadock (2007), factors impacting sexual behaviour in adolescents include personality traits, gender, and cultural and religious background.

Personality traits have been found to be associated with sexual behaviour and sexual risk taking. Higher levels of impulsiveness are associated with a younger age at first experience of sexual intercourse, a higher number of sexual partners, and sexual intercourse without using a condom. Historically, male adolescents have initiated sexual intercourse at a younger age than female adolescents. The primary reason adolescent girls who have never had intercourse give for abstaining from sex is that having sex would be against moral beliefs their moral beliefs. Another reason is fear of contracting HIV and other sexually transmitted diseases (STDs).

4.4.5 Table 13 – People with HIV should be kept in isolation

	Males	Females	Percentages
Yes, because they will infect others and we will not feel safe.	4	2	12%
Yes, because they will be scared when they are with people.	1	1	4%
Yes, because we will be safe from contracting HIV.	0	1	2%
Yes, because HIV infections will drop.	2	1	6%
No, because they are the same as we are, they have emotions and need love, care and support from us.	4	8	24%
No, because I have relatives who are HIV positive.	3	0	6%
No, because they have to be looked after to make sure they take treatment.	1	1	4%
NO	7	11	36%
YES	0	3	6%
Total	22	28	100%

The respondents consisted of twelve per cent (12%) (n=6) learners who said people with HIV should be kept in isolation because they would infect others and they (the learners) would not feel safe when they are with them, four per cent (4%) (n=2) who said yes because HIV positive people might feel scared and discriminated against when they are with other people, two per cent (2%) (n=1) who said yes because people would feel safe and relaxed knowing they are not at risk of contracting HIV, and six per cent (6%) (n=3) who said yes because HIV infections would drop. Twenty-four per cent (24%) (n=12) of respondents said no because HIV positive people are the same as they are, have emotions and need love, care and support, six per cent (6%) (n=3) said no because they have relatives who are HIV positive,

four per cent (4%) (n=2) said no because they have to be looked after to make sure that they take treatment properly, thirty-six per cent (36%) (n=18) said no without explanation, and six per cent (6%) (n=3) said yes without explanation.

	13-14 years	15-16 years	17-18 years	Percentage
Yes, because they will infect others and we will not feel safe.	2	3	1	12%
Yes, because they will be scared when they are with people.	3	2	1	12%
Yes, because we will be safe from contracting HIV.	3	1	0	8%
Yes, because HIV infections will drop.	1	2	1	8%
No, because they are the same as we are, they have emotions and need love, care and support from us.	1	3	2	12%
No, because I have relatives who are HIV positive.	2	3	2	14%
No, because they have to be looked after to make sure they take treatment.	1	3	3	14%
NO	1	3	2	12%
YES	1	2	1	8%
Total	15	22	13	100%

According to a study by Al-Ghanin (2005), findings indicated that more than a quarter of respondents said that people with HIV/AIDS should be kept in isolation. These findings suggest that these adolescents have a great fear of contracting HIV/AIDS from people who are already infected. It was the same with the findings of this study; adolescents who asserted that infected people should be kept in isolation, as they were mostly concerned that they would infect them with the disease.

4.4.6 Table 14 – The factors that make the spread of HIV/AIDS worse

	Males	Females	Percentages
Unprotected sex, helping injured people without gloves and not taking treatment (ARVs).	15	15	60%
Sharing needles when doing drugs, rape and multiple sexual partners.	0	3	6%
Prostitution, substance abuse and fear of taking an HIV test.	2	5	14%
Lack of discipline, unfaithful partner, poverty and misconceptions.	3	1	8%
Peer pressure, media and HIV positive mother breastfeeding a child.	1	2	6%
Unhealthy diet, sharing tooth- brush and thinking that HIV is a death sentence.	1	2	6%
Total	22	28	100%

The respondents consisted of sixty per cent (60%) (n=30) who said factors that make HIV/AIDS worse are unprotected sex, helping injured people without gloves and not taking treatment (ARVs), six per cent (6%) (n=3) who said sharing needles when doing drugs, rape and multiple sexual partners, fourteen per cent (14%) (n=7) who said prostitution, substance abuse and being scared to take an HIV test, eight per cent (8%) (n=4) who said lack of discipline, an unfaithful partner, poverty and misconceptions, six per cent (6%) (n=3) who said peer pressure, media and an HIV positive mother breastfeeding a child, and six per cent (6%) (n=3) who said an unhealthy diet, sharing a toothbrush, and thinking that HIV is a death sentence.

	13-14 years	15-16 years	17-18 years	Percentage
Unprotected sex, helping injured people without gloves and not taking treatment (ARVs).	5	6	4	30%
Sharing needles when doing drugs, rape and multiple sexual partners.	1	2	2	10%
Prostitution, substance abuse and fear of taking an HIV test.	3	4	2	18%
Lack of discipline, unfaithful partner, poverty and misconceptions.	2	3	3	16%

Peer pressure, media and HIV positive mother breastfeeding a child.	2	4	1	14%
Unhealthy diet, sharing tooth- brush and thinking that HIV is a death sentence.	2	3	1	12%
Total	15	22	13	100%

A Health 24 article (2009) revealed that South Africa is considered to be one of the countries worst affected by HIV/AIDS. The reasons for this are complex, but certain factors have been identified as responsible for the rapid spread of HIV/AIDS. These include:

- i. Gender inequality and male dominance
- ii. Physical and sexual violence
- iii. Political transition and the legacy of apartheid
- iv. Stigma and discrimination
- v. Poverty
- vi. Commercialization of sex
- vii. Lack of knowledge and misconceptions of HIV/AIDS

4.5 Discussion of the results

The focus of this study is to investigate the perceptions of adolescents in KwaDlangezwa Township towards HIV and AIDS. The results indicate that majority of adolescents specifically from KwaDlangezwa Township have realistic and average perceptions about HIV and AIDS, their perceptions are generally adequate. They seem to have more information and are more knowledgeable. Discussion of the results is outlined below and it will incorporate the Health Belief model theory.

The results show that more males than females have unrealistic perception about HIV and AIDS cure. When compared to the total participants respondents, only minority (36%) agreed to this statement. This shows to be a problem area that contribute to new HIV infections even though majority had true perception about the cure of HIV and AIDS. These results correspond with a study that was conducted by Bhagavathula et al (2015) that revealed 80.2 % of participants perceived AIDS as a curable disease, whether detected early or late it will still be cured. Perceived susceptibility of the Health Belief Model plays an important role in the sense that if

adolescents believe there is cure, they will not view themselves as being at risk therefore it is unlikely that they will adopt healthier behaviours such as following the ABC rule (abstain, be faithful and condomise)..

More females than males believe that most people who get AIDS usually die from this disease and the total participants who agree with it make 16%. This shows that we are getting somewhere about educating adolescents regarding the issue of HIV and AIDS.

50% of the participants believe that there is a new vaccine that prevents HIV infection. This perception is inaccurate and it actually makes adolescents even more vulnerable to contract HIV. This shows that attention is needed in providing adolescents with necessary and accurate information that will help combat misconceptions that increases HIV infections among adolescents.

38% of participants believe that AIDS is a punishment from God. These findings correspond with a study that was conducted in Tanzania in 2004-2005 where majority of participants agreed with this statement (65%) (HIV/AIDS Stigma, 2006). The finding of this current study shows that 62% of participants disagree with this statement. This is accurate information and it need to be extended to the few participants of this current study.

94% of participants agree with the fact that substance abuse and sexual abuse worsen the spread of HIV and AIDS. These findings are impressive in the sense that they are accurate and a very high percentage of participants have true perception about factors that makes the spread of HIV and AIDS worse. Other factors that are said to make the spread of HIV and AIDS worse are unprotected sex, rape, sharing needles when doing drugs, multiple sexual partners, prostitution. Misconceptions were also evident as some participants stated that other factors that makes the spread of HIV and AIDS worse are unhealthy diet, sharing tooth brush, lack of discipline and peer pressure. It is pivotal that these misconceptions be addressed especially from a younger age and ensures that the correct information is emphasize among adolescents.

The results of another study revealed that HIV can be transmitted from mosquito bite, sharing food with a person with AIDS and by witchcraft and supernatural (Ogden and Nyblade, 2005). In other studies conducted in Zambia, Vietnam, Tanzania and Ethiopia there were misconceptions that HIV can be transmitted by eating food prepared by HIV positive person, breathing infected air and using objects such as utensils and clothes that were touched by HIV positive person (Mondal et al., 2016). These misconceptions need to be addressed, as they are evident not only in South Africa but also in other countries. The researcher is of the opinion that if these could be addressed the rate of HIV infections among adolescents might drop drastically.

56% of the participants agree with the statement that HIV is contracted when body fluids come into contact with each other. This is an accurate perception and 44% of participants disagreed with the statement. A study conducted by Ferries et al (2010) found that HIV can be transmitted through exposure to blood, semen, vaginal fluid and breast milk, therefore any activity that directly exposes a person to any of these body fluids is at high risk of contracting HIV.

According to the findings of this current study, adolescents have sufficient information and they proved to have better understanding about HIV and AIDS. They perceived HIV and AIDS as dangerous, incurable, infectious, communicable, and transmitted and they are perceived as bad. They furthermore explained that AIDS is a disease, HIV is a virus, and a person takes ARVs when they are diagnosed with HIV. This information proves the adequacy of knowledge they have pertaining HIV and AIDS. Perceived severity of the Health Belief Model plays an important role in that adolescents takes HIV and AIDS serious and they consider the possibility of contracting HIV. This correspond with the study conducted by Mathias (2009) who found similar results that prove that adolescents have adequate knowledge about HIV and AIDS that they may have gained from television, radio and magazines.

Participants also shown to have information regarding the preventative measures from contracting HIV/AIDS. They stated that the ABC (Abstain, Be faithful and Condomize) plays an important role in preventing HIV. They furthermore mentioned that sticking to one sexual partner and having more knowledge about HIV can actually reduce the spread of HIV. These are facts regarding HIV and AIDS.

According to Weller and Davis (2002), it was found that reduction of risk of HIV transmission during unprotected vaginal and anal sex is associated with three factors that are appropriate usage of condoms, male circumcision and lower amounts of HIV in blood of infected person.

A 2002 systematic and meta-analysis found out that when condoms are used consistently for sexual intercourse, they reduce HIV transmission by estimated 80% on average but this does not mean that 80% of people using condoms are protected from HIV and 20% will get infected. It simply means that condoms prevent 80% of transmission that would have occurred if a condom was not used (CDC, 2010).

58% of participants in this current study do not perceive themselves as being at high risk of contracting HIV. According to Tenkorang et al (2011), an individual's perception of oneself being at risk of contracting HIV is a determinant of a sexual behavior. The researcher is of opinion that those who believe that they are at risk of contracting HIV are less likely to engage in risky sexual behaviours than those who do not perceive themselves as being at high risk. The findings of this current study indicate that more females than males do not perceive themselves as being at high risk. These findings contradict with the findings of the study by Osingada et al (2016) who found that more males than females perceive themselves as being at high risk of contracting HIV. This could be explained by using self-efficacy of the Health Belief model because this is their personal belief in their abilities to change their behaviours that makes them vulnerable to contract HIV.

30% of participants stated that people with HIV/AIDS should be kept in isolation and not be among them and the reasons provided were as follows:

- They will infect others with HIV and we will not feel safe
- They will be scared when they are among other people
- We will be safe from contracting HIV and HIV infections will drop

These reflect minority of responses and their responses are also unrealistic. Therefore adolescents with these perceptions need to be educated that keeping HIV positive people in isolation will not solve the health issue. However, it would stigmatize and discriminate them as a result. These results correspond with a study that was conducted by Raheel (2016) in Saudi Arabia that found that more

males than female respondents supported that people with HIV should be kept in isolation, be removed from schools as well as their houses.

The null hypothesis of the study is the adolescents' perceptions of HIV and AIDS are not realistic and the alternative hypothesis of the study is that adolescents have basic knowledge about HIV and AIDS. According to the findings of this study, indicate that majority of adolescents have basic knowledge about HIV and AIDS and only minority still have misconceptions about HIV and AIDS. Therefore, null hypothesis was rejected and alternative hypothesis is accepted.

Based on the findings of the current study according to age of the participants it is noted that those in their early adolescence demonstrated misconceptions when compared to those who are mid and late adolescence. This could be attributed to by their development from concrete to formal operational thinking. At this stage their critical thinking is developing in which they learn how to think for future consequences. Unlike mid and late adolescence, this has already developed and therefore their thinking enable them to plan ahead and identify the possible future consequences (Louw & Louw, 2007).

4.7 Summary

This chapter has depicted the responses of participants as they derived from the completed data-gathering instrument. The responses of the participants have been captured in the tables above. Discussion of the results was also included in this chapter and it incorporated the Health Belief Model relating this theory to the findings of the study.

The findings indicated that the majority of participants have realistic perceptions regarding HIV and AIDs. Even though this was the case, there were misconceptions noted that need to be addressed in order to combat HIV infection among adolescents. One of the aims of the study is to explore adolescents' general knowledge and understanding of HIV/AIDs, therefore addressing these misconceptions play an important role.

CHAPTER 5 CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

5.1 Conclusion

HIV infection in South Africa, as in the rest of sub-Saharan Africa, has become a source of national concern. After many prevention campaigns and educational programmes, the virus continues to spread at an alarming rate (Ackermann & De Klerk, 2002). The result of this study provides evidence that most respondents correctly identified realistic perceptions of HIV/AIDS. However, some respondents have reported misconceptions about HIV/AIDS. The findings of this study have revealed that respondents have adequate information about the meaning, mode of transmission and preventive methods of HIV/AIDS.

This is consistent with previous research in Ghana, which revealed that adolescents have adequate information about HIV/AIDS. At the same time, they still engage in activities that make them more likely to contract HIV. This might be because they still want to explore sexual activities. They thus engage in risky sexual behaviour that makes them more vulnerable to contracting HIV/AIDS.

It was surprising to find that 58% of the participants believed that HIV was spread deliberately to thousands of people all over the world to wipe out large numbers of blacks and homosexuals. This was because the study revealed that some adolescents' perceptions about HIV/AIDS were realistic, meaning that they were able to identify ways in which HIV/AIDS is transmitted and factors that fuel the spread of HIV/AIDS among adolescents. Based on these findings, one would have expected most adolescents to disagree with that statement.

There have been new developments regarding the HIV vaccine in South Africa. According to the National Institutes of Health (2016), the people of South Africa are making history by conducting and participating in the first HIV vaccine efficacy study. This gives South Africa hope because if it becomes successful, it will put an end to HIV/AIDS pandemic that hit African countries badly.

5.2 Limitations of the study

The limitations of the study are discussed as follows:

- i. The study consisted of one racial group only owing to location constraints; therefore only Zulu-speaking participants were included in the study.
- ii. Debriefing was not done due to relocation and financial constraints.
- iii. The research had no representation of the religious denominations of the participants because it was the thought that came after data was collected.
- iv. The participants of this study were taken from one school at KwaDlangezwa Township in KwaZulu-Natal Province. The findings of this study do not represent all adolescents in South Africa. Therefore, the results of this study might to some extent be biased.

5.3 Recommendations

The recommendations proposed are as follows:

- i. It is recommended that education in schools addresses misconceptions about HIV/AIDS among adolescents because they seem to play a major role in putting adolescents at higher risk of contracting HIV/AIDS.
- ii. Debriefing was not done due to financial and relocation constraints. It is therefore recommended that with future HIV/AIDS studies, debriefing sessions should be done because HIV/AIDS is a sensitive topic and some participants might be affected by the questions the answer about HIV/AIDS.
- iii. HIV/AIDS awareness in South Africa is adequate, though it reaches mostly formal rather than informal settlements. It is therefore recommended that HIV/AIDS campaigns should target both formal and informal settlements as the participants were found from informal settlements.
- iv. A new HIV vaccine could be a way to combating the HIV/AIDS pandemic in South Africa. Therefore it is recommended that more research be done to test the effectiveness of the vaccine because the success of this new HIV drug could help our government put the struggles of fighting this pandemic behind us.
- v. Adolescents spend most of their times at school. Therefore, it is recommended that the school teachers create a platform at schools to discuss

issues related to HIV and AIDS with adolescents, especially during debate competitions and also provide them with pamphlets that would be a constant reminder of the dangerous behaviours that makes them vulnerable to contract HIV.

- vi. Some adolescents do not perceive themselves as being at high risk of contracting HIV/AIDS. Therefore it is recommended that this issue should be addressed, as anyone can be at risk.
- vii. Adolescents are still the group with HIV/AIDS infections despite the information they get about HIV/AIDS. Therefore it is recommended that this information be conveyed in their home language because in the researcher's opinion, English might hinder understanding, especially for adolescents in the informal settlements.
- viii. Education is the most powerful tool that can help decrease the spread of HIV among adolescents. Therefore it is recommended that adolescents form HIV lesson groups (support groups) at the public clinics in order to exchange ideas about what they know about HIV, how it can be transmitted and how it can be prevented – in the presence of a counsellor to help address their misconceptions and give them relevant information about HIV.
- ix. Adolescents have access to printing media such as newspapers and magazines. Therefore it is recommended that every newspaper and magazine include articles to help eradicate adolescents' false perceptions about HIV/AIDS.
- x. The researcher was unable to obtain permission from the department of Education due to relocation constraints for conducting research at Ongoye High school; however she managed to obtain permission from the school principal. Therefore, it is recommended that for future research, researchers need to ask permission from the Department of Education prior conducting the study at any school as well.

- xi. Most adolescents have televisions and radios in their homes. Therefore it is recommended that both radio and TV productions focus more on covering topics related to realistic facts about HIV on daily basis.

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9. What do you understand by the words HIV and AIDS?

10. How would you prevent yourself from contracting HIV/AIDS?

11. Do you perceive yourself as being at high risk of contracting HIV?

12. Do you think HIV/AIDS has an impact on your sexual behaviour and why?

13. Do you think people with HIV/AIDS should be kept in isolation? If yes, why?

14. What are the factors that fuel HIV/AIDS infections?

COMMENTS

Please comment on any information about HIV and AIDS that was not covered in the questionnaire and you think is important.

Thank you for your Participation

APPENDIX B LETTER REQUESTING TO CONDUCT A STUDY

University of Zululand

KwaDlangezwa

3886

12 August 2011

The Principal
Ongoye High School
KwaDlangezwa

Dear Sir/Madam

REQUEST TO COLLECT RESEARCH DATA AT YOUR INSTITUTION

I am a Master's student in Counselling Psychology at University of Zululand. I am expected to conduct a research project as a requirement to complete my degree. I would like to ask for your permission to collect data at your institution. My area of focus is: "An investigation into the perceptions of adolescents in KwaDlangezwa Township towards HIV/AIDS." The following are the aims of the study:

- To explore the perceptions of adolescents living in the township about HIV/AIDS.
- To explore factors contributing to adolescents' high rate of HIV/AIDS infection.
- To explore the influences of these perceptions on adolescents' sexual behaviour.
- To explore adolescents' general knowledge and understanding of HIV/AIDS.

The targeted participants are learners in grade eight to twelve of both genders between 13 and 18 years of age. This school was identified as a result of the suitability in relation to the current study. The participation will be in the form of completing a semi-structured questionnaire with open-ended and closed-ended questions that will cover different themes with relation to HIV and AIDS. Participation will also take approximately 15 minutes. This process is expected to take place towards the end of September 2012.

Your assistance in this regard is would be highly appreciated

Yours faithfully

Miss M.G. Maselesele

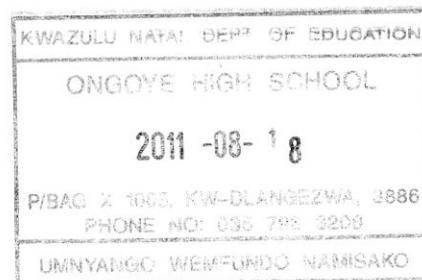
APPENDIX C PERMISSION GIVEN TO CONDUCT RESEARCH AT ONGOYE HIGH SCHOOL

Ongoye High School
P/Bag X 1005
KWADLANGEZWA
3886
18 August 2011

Psychology Department
UNIVERSITY OF ZULULAND
KWADLANGEZWA
3886

TO WHOM IT MAY CONCERN
Miss M.G. Maselesele has been granted a
permission to conduct a research utilizing
our learners.

Thank you
S.J. MLENZANA
DEPUTY PRINCIPAL



APPENDIX D CONSENT FORM FOR UNDER 18 YEARS OLD LEARNERS (ENGLISH)

I Mr/Ms/Mrs ----- grant my son/daughter permission to participate in the research and the topic is: “An investigation into the perceptions of adolescents in KwaDlangezwa Township towards HIV/AIDS.”

- I understand that my child’s participation in this study is voluntary and that my child may withdraw at any stage should he/she feel uncomfortable and I understand that this study will contribute to scientific knowledge that will be used to help others.
- I understand that all information collected will be confidential and I understand that my child’s responses will remain anonymous.
- I understand that collection of data will be in the form of completing a semi-structured questionnaire with closed-ended and open-ended questions that will take approximately 15 minutes that will cover different themes of HIV/AIDS.
- I understand that the following are the aims of the study conducted by the researcher:
 - To explore the perceptions of adolescents living in a township about HIV/AIDS.
 - To explore factors contributing to adolescents’ high rate of HIV/AIDS infection.
 - To explore the influences of these perceptions on adolescents’ sexual behaviour.
 - To explore adolescents’ general knowledge and understanding of HIV/AIDS
- I understand that data collected will be analysed by using descriptive analysis.
- I understand that my child will not get any reward for participating in this study.

Parent’s signature

Date

**APPENDIX D CONSENT FORM FOR UNDER 18 YEARS OLD LEARNERS
(ISIZULU)**

Isicelo semvumo (Umzali/Umbheki)

Mina Mnu./Nks./Nksz ----- nginika imvume indodana/indodakazi yami ukuthi ibambe iqhaza kucwaningo olunzulu “Uphenyo mayelana nendlela intsha yaKwaDlangezwa ebuka ngayo isandulela ngculazi kanye nengculazi uqobolwayo.” Ngियाqonda ukuthi ukubamba iqhaza komntwana wami kulolucwaningo uzobe engakhokhelwa kodwa uzobe ezinikela futhi angahoxa noma inini uma ngingasathandi ukuqhubeka. Ngियाqonda futhi ukuthi ukubamba kwakhe iqhaza kungasiza kakhulu olwazini oluzoqongelelwa ekusizeni ngalo umphakathi. Ngियाqonda ukuthi lonke ulwazi oluyoqoqwa igama lomntwana wami angeke lidalulwe.

Isayini yomzali

Usuku

APPENDIX E CONSENT FORM (PARTICIPANTS) (ENGLISH)

I, Mosiwa G. Maselesele, am a Master's student in Counselling Psychology at the University of Zululand. You are being requested to participate in my research with the topic: "An investigation into the perceptions of adolescents in KwaDlangezwa Township towards HIV/AIDS."

The aims of the study are as follows:

- To explore the perceptions of adolescents living in a township about HIV/AIDS.
- To explore factors contributing to adolescents' high rate of HIV/AIDS infection.
- To explore the influences of these perceptions on adolescents' sexual behaviour.
- To explore adolescents' general knowledge and understanding of HIV/AIDS.

This research is a requirement for my Master's programme. If you agree to participate in this study, please take note of the following before giving your consent (by signing this form):

- I understand that the participation will be in the form of completing a semi-structured questionnaire with closed-ended and open-ended questions that covers different aspects of HIV and AIDS.
- I understand that participation will take approximately 15 minutes.
- I understand that my participation in this study is voluntary, and that I may withdraw at any stage should I feel uncomfortable.
- I understand that this study will contribute to scientific knowledge that will be used to help others.
- I understand that all information collected will be confidential.
- I understand that my responses will remain anonymous.
- I understand that there is no reward for my participation in this study.
- I understand that data collected will be analysed by using descriptive analysis.

I have read the above information and give my full consent to participate in this study, and also agree that I shall complete this questionnaire and hand it over to the researcher after completion.

Signature of the participant.....

Date.....

APPENDIX E CONSENT FORM (PARTICIPANTS) (ISIZULU)

Isicelosemvume (Ozobambaiqhaza)

Mina Mosiwa G. Maselesele ngingumfundi owenza izifundo zokululeka ngokwengqondo eNyuvesi yaseZululand. Uyacelwa ukuba ubambe iqhaza kulolucwaningo olusihloko esithi “Uphenyo mayelana nendlela intsha yaKwaDlangezwa ebheka ngayo isandulela ngculazi kanye nengculazi” Lolucwaningo lungezinye lwezimfuno ezidingekayo ukuthi ngizenze ezifundweni zami zakulo nyaka.Uma uvuma ukubamba iqhaza kulolu cwaningo ngicela uqonde lemigomo kuqala

- Ngiyaqonda ukuthi ngiyazinikela kulolucwaningo futhi ngingahoxa noma inini uma ngingasathandi ukuqhubeka.
- Ngiyaqonda ukuthi ulwazi lwami luyosiza ukwandisa olunye ulwazi oluyosiza umphakathi.
- Ngiyaqonda ukuthi imininingwane yami iyoba imfihlo.
- Ngiyaqonda ukuthi konke engiyokuphawula igama lami angeke lidalulwe.

Ngiyifundile yonke iminingwane futhi ngiyavuma ukubamba iqhaza kulolucwaningo futhi ngiyavuma ukuthi ngizoyiphendula yonke imibuzo bese ngiyayibuyisela kumcwaningi uma sengiqedile.

Isayini yobambe iqhaza

Usuku