

**THE IMPACT OF HIV/AIDS PEER EDUCATION PROGRAM ON
CONDOM USE OF FULLTIME STUDENTS AT THE
UNIVERSITY OF ZULULAND MAIN CAMPUS**

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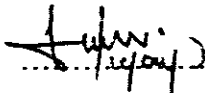
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DECLARATION

I hereby declare that this is my own work and all the sources used have been indicated and acknowledged by means of complete references.


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ABSTRACT

The study investigated the impact of the HIV/AIDS peer education program on behaviour change of students at the University of Zululand main campus. The sample (N = 40) consisted of male (N = 20) and female (N = 20) students whose ages ranged between 21 – 40 years.

Findings indicated a significant change in behavioural practices of the participants post exposure to the program. Based on these findings it is indicated that the program is effective in providing necessary information about HIV/AIDS and to change students sexual behavioural patterns towards HIV/AIDS prevention.

CHAPTER 1

INTRODUCTION

1.1. Introduction

As a country Africa has the highest number of people affected by HIV/AIDS (Nattrass, 2004). Seventy percent (70%) of all infected people and eighty percent (80%) of all infected children live in Africa ([http://www.childhunger.org/aids – general.htm](http://www.childhunger.org/aids-general.htm)). Referring to this fact Kauffman (2004) and Nattrass (2004) state that Africa the poorest region in the world has the highest HIV/AIDS rate. Evidence from literature indicates that HIV/AIDS has become the most serious health problem facing Sub – Saharan Africa (Zulu, Dodoo & Ezeh, 2004).

Indeed over the past few years, the previously largely silent epidemic of HIV in South Africa has shifted to a visible AIDS (<http://www.hst.org.za/sahr/2000/chapter16.htm>). AIDS is a frightening and devastating disease that leads to vulnerability to a variety of debilitating infections (Oskamp & Thomson, 1996). AIDS has had economic and social impact on Southern Africa (Nattrass, 2004; Lewis, 2004). As pointed out by Perloff (2001), there is no medical cure for HIV/AIDS, hence Kauffman (2004) refers to as a virus of mass destruction. In support of this notion UNAIDS records ([http://www.childhunger.org/aids - general.htm](http://www.childhunger.org/aids-general.htm)) indicate that in Sub - Saharan Africa AIDS is deadlier than a war; since in 1998, 200 000 people died in the war; but more than 2,000,000 died of AIDS. The whole world is in the war against the spread of HIV/AIDS.

1.2. Statement of the problem

AIDS currently ranks as one devastating cause of death in the world (Abdool Karim & Abdool Karim, 2005) and has had a severe impact in Southern Africa (Nattrass, 2004). It has wiped out much of the modest demographic, economic and social gains of the past and has decreased expectations of the future (Lewis, 2004; Nattrass, 2004).

AIDS strikes hardest at the productive population. The resulting loss of income produces disastrous consequences on households, even giving rise to the emergence of a generation of AIDS orphans whose upbringing strains families, informal and formal networks (Lewis, 2004). AIDS affects organizations through its impact on costs, on productivity and demand for products (Nattrass, 2004; Lewis, 2004). Organizations/companies are obliged to increase worker related expenses for health benefits or insurances that are utilized more as a result of the epidemic.

The government also is affected by the AIDS pandemic (Lewis, 2004). Most directly, government takes much responsibility for the cost of additional AIDS related spending aimed at combating the spread of the disease (e.g. public awareness and educational campaigns, condom distribution initiations) as well as the cost of care for those population groups who are already infected and are dependent on the public health care system as a result of HIV/AIDS pandemic. Failure to discover a medical cure for HIV/AIDS has resulted in a number of prevention strategies being implemented in an attempt to combat the spread of this pandemic in South Africa. These strategies include: mother - to - child transmission prevention programmes; voluntary counselling and testing (VCT) programmes (Nattrass 2004); use of condoms (Oskamp & Thomson, 1996); and HIV/AIDS education programmes, all of which are aimed at addressing the pandemic by achieving behavioural change (Hak - su, 2004; Deutch & Swartz, 1996).

1.3. Motivation for the study

It has become clear that knowledge alone about the use of condoms in combating the spread of HIV/AIDS is insufficient since it does not bring about a remarkable change in behaviour (Van der Schaaf, 2004). Supporting this notion, Hak – su (2004) indicates that although condoms are an important protective measure used when addressing the HIV/AIDS pandemic, certainly they are not sufficient. The main challenge here would be to achieve behavioural change and that can be attained through behavioural and educational programmes such as HIV/AIDS peer education (Hak – su, 2004).

As noted by Volks (2004), students are at an experimental and developmental stage of

life, a factor that can make them to be highly exposed to HIV/AIDS infection. Some come from homes that have strict rules with regards to sexual relationships and once on campus, they may get involved in sexual interactions in an attempt to prove their maturity, to be inline with peers and to explore love.

As stipulated by Deutch & Swartz (1996) HIV/AIDS peer education and promotion of condom use are part of the total health care approach to fight the war against the spread of the devastating and expensive disease of mass destruction known as HIV/AIDS. Thus, educational programmes to change behaviour toward condom use are necessary to encourage students take preventive action against HIV/AIDS. As a former HIV/AIDS peer educator the researcher was motivated to undertake this study on the impact of HIV/AIDS peer education program on students behavioural change at the University of Zululand main campus.

1.4. Objective of the study

The main objective of the study was to determine whether or not HIV/AIDS peer education program is effective in changing students behaviour towards safer sexual practices (condom use).

1.5. The study's hypotheses

- 1.5.1. HIV/AIDS peer education programs lead to behaviour change (condom use) among students at the University of Zululand main campus.
- 1.5.2. There is a significant difference in behaviour (condom use) among students before and after exposure to HIV/AIDS peer education program.

1.6. Definition of terms

1.6.1. HIV

Human immunodeficiency virus (HIV) is a specific virus that attacks the immune system

and decreases its ability to defend against opportunistic infections (Fisher, 1991). It is a virus known to be the cause of AIDS (Irwin, Millen & Fallows, 2003). Once it has entered the body, HIV attacks the person's immune system, which is normally the body's defense mechanism. It causes this system to be deficient and to malfunction; hence the term immunodeficiency is used to refer to it. It is called 'human' because it can only be found in humans and also because it needs something from the human cells for its replication.

It falls under the family of retroviruses because it is capable of changing its genetic material, ribonucleic acid (RNA), to deoxyribonucleic acid (DNA). Such viruses are difficult to control, hence the difficulty of finding the cure for HIV (Stine, 2005).

1.6.2. AIDS

Acquired immunodeficiency syndrome (AIDS) is the medical designation for a set of symptoms, opportunistic infections (Irwin, Millen & Fallows, 2003). "Acquired" means the transmission of disease from one person to another. "Immunodeficiency" means a disease state that weakens and then destroys the body ability to fight off infectious organisms. "Syndrome" refers to a particular pattern of illnesses associated with this disease (Irwin, Millen & Fallows, 2003).

1.6.3. Peer education program

Peer education involves training and supporting members of a given group to effect change among members of the same group (Walker, Reid & Cornell, 2004). Peer education is often used to effect changes in knowledge, attitudes, beliefs, and behaviours at the individual level.

However, peer education may also bring about change at a society level by modifying norms and stimulating collective action that contribute to changes in policies and programmes. Worldwide, peer education is one of the most widely used strategies to address the HIV/AIDS pandemic (Walker, Reid & Cornell, 2004).

1.6.4. Condom

A condom is a thin sheath made of latex, lambskin or polyurethane which provides protection against sexually transmitted diseases (Irwin, Millen & Fallows, 2003).

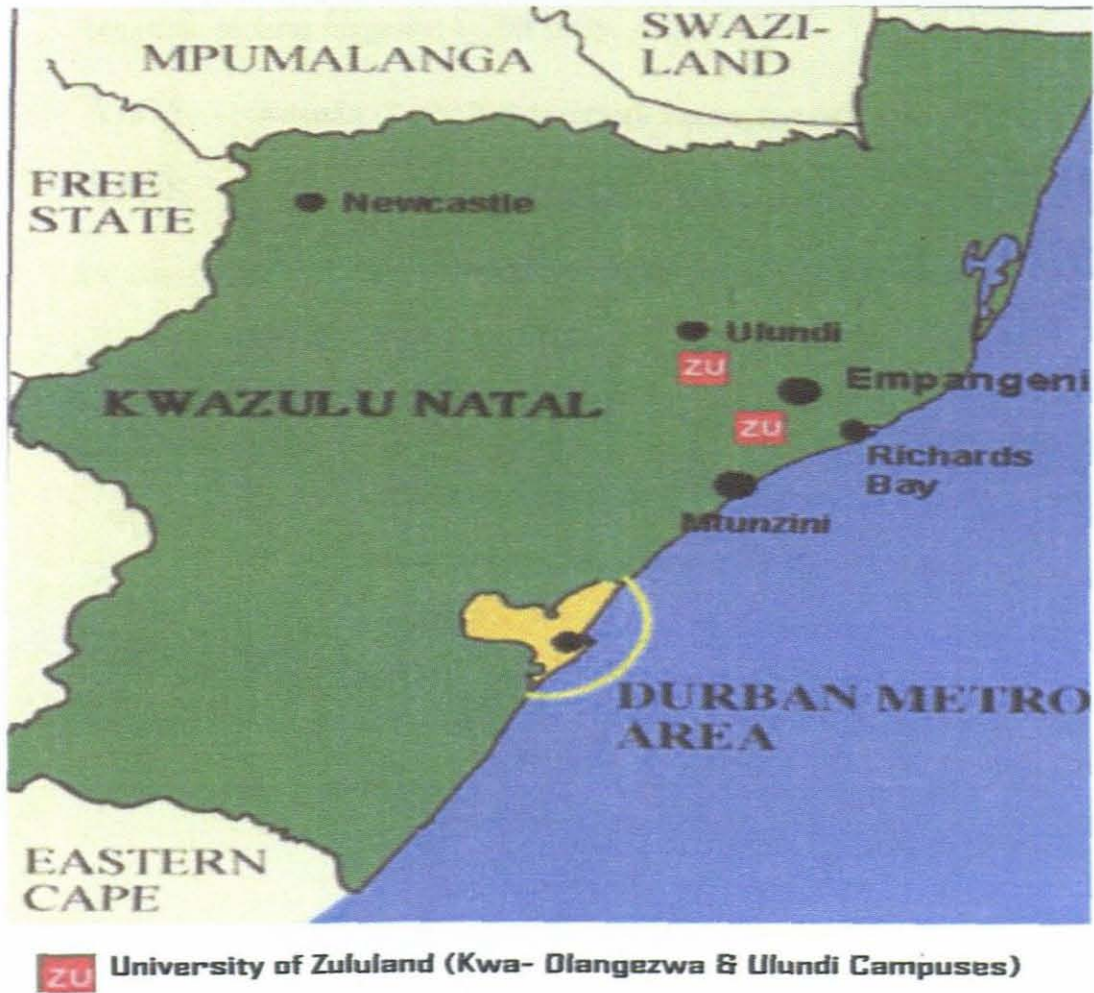
1.6.5. Full – time students

Full – time students are people registered with the university and studying on a full – time bases.

1.6.6. University of Zululand main campus

The University of Zululand main campus is located at KwaDlangezwa in the province of KwaZulu Natal, South Africa, twenty kilometers (20km) South of Empangeni and thirty five kilometers (35km) South of Richards Bay. It was established in 1960 as a college academically affiliated to the University of South Africa. Since then the University of Zululand has dramatically evolved from a so called ‘bush college’ to a fully – fledged University equal to any centre of higher learning in South Africa. The main campus is the only university north of UThukela River. The University experiences an increased intake of students from other parts of Africa, especially from Namibia, Nigeria, Kenya, Zimbabwe, Lesotho, and Swaziland (see Figure 1).

Figure 1: Map indicating the Location of the University of Zululand



1.7. Delimitation of the study

This study will focus on fulltime students of the University of Zululand main campus. This will make it easy for the researcher to control the participants of the study.

1.8. Value of the study

- This study will bring to light whether or not HIV/AIDS peer education is effective in changing students sexual behavioural patterns
- Program facilitators and students will benefit from the results of this study and

- It is hoped that the rate of HIV infection will decrease as a result of students' behaviour patterns suggested by this study.

CHAPTER 2

LITERATURE REVIEW

2.1. HIV/AIDS Threat

HIV/AIDS poses a health threat in the whole world and has become a leading cause of death (Kelly, 2001). Devastation caused by HIV/AIDS on the continent is so acute that it has become one of the main obstacles to development itself (Essex, Mboup, Kanki, Marlink & Tlou, 2002). AIDS threatens societies, communities, and economies. As expressed by Pratt (2003) as well as Essex, Mboup, Kanki, Marlink and Tlou (2002) HIV/AIDS is not only taking away Africa's present but is also taking away Africa's future.

HIV is a pandemic whose impact on societies is highly felt. There is no segment of society that can claim to have escaped its effects. It is affecting families, communities, overwhelming health care services and depleting schools of both students and educators (Tlou, 2002). Organizations have suffered and continue to suffer losses of personnel productivity and profits, economic growth is being threatened and scarce resources have to be acquired to deal with the consequences of the epidemic (Nattrass, 2004).

2.2. Management of HIV/AIDS threat

Currently there is no known cure for HIV/AIDS (Perloff, 2001) and work on the development of a vaccine is proceeding (Stine, 2005). Drugs that prolong the life-span of those infected with HIV are available. Reliance on controlling the epidemic through the provision of antiretroviral therapy for infected individuals faces massive annual increases, since new infected members are added each year to the rank of those whose lives are prolonged by drug therapy that must be maintained throughout life (Perloff, 2001). In this set of circumstances, the most effective way to slow down the spread of HIV/AIDS would be to reduce the rate of transmission from infected to uninfected individuals (Department of Education, 2004). Perloff (2001) succinctly states that preventing further transmission of

HIV must be the principal strategy.

2.3. HIV/AIDS transmission

According to Evian (2003) there are four major sources of HIV infection:

- Sexual transmission
- Transfusion of blood
- transmission from mother to child during pregnancy, labour, or following birth through breast feeding and
- Using piercing instruments or injecting equipment that is contaminated with HIV.

2.3.1. Sexual transmission of HIV

HIV infection has been isolated from a variety of body fluids, including blood, semen, vaginal secretions, breast milk, urine, saliva, and tears (Pratt, 2003). The vast majority of HIV infections are the result of sexual transmission (Barnett & Whiteside, 2002).

Globally, unprotected heterosexual contact with an HIV infected partner is the most common means by which the vast majority of people become infected with HIV. Unprotected sexual contact means not using or not correctly using an intact latex condom (Pratt, 2003).

In Africa the sexual transmission of HIV has remained overwhelmingly predominant. It is the most common way for HIV to move from person infected to another previously uninfected (Perloff, 2001; McKeganey & Barnard, 1992). As noted by Mathews (2005) sexual behaviour is the main driver of the South African epidemic. It is (sexual contact) the means by which HIV spread through individuals, groups, communities and nations. Any one who is sexually active can get AIDS through sexual contact because it is a dominant mode of transmission of HIV/AIDS.

Sexual transmission of HIV/AIDS causes seventy five percent (75%) to eighty five percent (85%) of HIV infections worldwide (UNAIDS, 2000; Kristensen, Sinkala & Vermund,

2002). The heterosexual component of the global burden of HIV infection was shown by UNAIDS estimates at the end of 2003, of the estimated 37.8 million prevalent infections, about eighty-seven percent (87%) were acquired through heterosexual transmission.

Further more, it was estimated that of the 4.8 million AIDS deaths, over eighty five percent (85%) are people who acquired HIV infection heterosexually (UNAIDS, 2000). In all parts of the world the pandemic of HIV/AIDS is related to ignorance of individuals with regard to sexual practices.

2.3.2. Blood transfusion

Blood transfusion is another mode of HIV transmission in Africa (Piot & Bartos, 2002). It is the fastest way of transmitting the virus as it introduces the virus directly into the bloodstream (Barnett & Whiteside, 2002). There are ninety to ninety five percent (90 – 95%) chances that someone receiving blood from an infected donor will become infected with HIV (Pratt, 2003). Although millions of lives are saved each year through blood transfusions, however, recipients of blood have an increased risk of HIV infection. This risk can virtually be prevented by a safe blood supply and by using blood transfusions appropriately (Pratt, 2003).

2.3.3. Mother to child transmission

Another cause of HIV infection is mother to child transmission (Barnett & Whiteside, 2002). The pregnant mother, who is infected with HIV, can pass the virus on to the infant (Evian, 2003). The child can be infected with HIV prenatally, at the time of delivery, or post nately through breastfeeding. Infection at delivery is the most common mode of transmission (Evian, 2003; Barnett & Whiteside, 2002). A number of factors, including the viral load and CD4 count of the mother, influence the risk of infection. Over ninety percent (90%) of children who are living with HIV/AIDS in South Africa acquired infection from their mothers (Piot & Bartos, 2002).

2.3.4. Needle and syringe sharing

The sharing of needles and syringes has been identified as one of the highest risk practices in the spread of HIV infection. The spread of HIV through infected razors and knives is associated with traditional practices that involve making incision on any part of the body resulting in bleeding and then using the same instrument on another person (Oskamp & Thompson 1996). Syringes and needles used to inject drugs may make individuals prone to HIV infection if they are shared without being sterilized (Stine, 2005).

2.4. Theories on risky behaviour change

According to Mathews (2005), theories on risky behaviour change are conceptual frameworks within which we seek to explain why people behave in ways that put their health at risk or why they adopt healthy and protective behaviour. These theories point to key constructs; key processes; and key mechanisms that hypothetically influence healthy behaviour.

Supporting this notion, Perloff (2001) states that a social, psychological and communication approach on unsafe sex education can not influence people unless they understand the cognitive traps that impede people's efforts to change. As indicated by Mathews (2005), effective prevention of health risk (including HIV/AIDS) requires systematic planning. Instead of jumping from a perceived problem to an intervention it is essential to carefully investigate the issues concerned as well as assess the nature and quality of available options before deciding to implement particular interventions.

There are numerous theories on which interventions aimed at behaviour change may be built. A multi level manifestation of risky behaviour suggests that a number of available theories on behaviour change should be considered in the development of intervention. It may be beneficial at this point to consider some of these theories on risky behaviour change.

2.4.1. Theory of planned behaviour.

When people perceive that they can not control a particular behaviour they are less capable of transmitting intentions into action (Ajzen, 1991). Safer sex seems to be one such behaviour over which individuals do not always have volitional control (Perloff, 2001). There are reasons why people may perceive that they have little control over safer sex. One reason is that heterosexuals are concerned about the issue that their partner will get angry when suggesting using a condom, believing there is little they can do to cooperation.

One person once said "AIDS was associated with sex over which we have little control". Believing that safer sexual behaviours are beyond their control, individuals may not always be capable of changing these attitudes to effect appropriate behaviour. The theory of planned behaviour assist us handle this problem. The more control people believe they have over condom use the more likely they are to use them and to translate intentions into condom use behaviour (Ajzen, 1991). Conversely the less people perceived control over condom use the less likely they are to translate safer sex intentions into actions.

2.4.2. Social Cognitive Theory

This theory puts emphasis on self efficacy which is the belief that one can influence things that happen in every day life (Bandura, 1994). Perceived self efficacy is an individual's conviction that he or she can successfully perform behaviours necessary for desired outcomes. As noted by Perloff (2001), individuals who have low self esteem or self efficacy are not apt to insist on safer sex or discuss condom use with partners.

Social cognitive theory assumes that people learn to influence events through observation of role models, verbal persuasion (education), success and failure, experiences and interpretation of these outcomes. It places considerable emphasis on confidence, that is, believing one can master difficult tasks (Bandura, 1994).

According to the cognitive theory, people with a strong sense of personal efficacy take on difficult tasks, become involved in challenging activities, recover from defeat and persist

in the face of failure. Those with low sense of efficacy are more apt to avoid challenging tasks, they focus on personal shortcomings rather than how to master difficult situations and they surrender quickly in the face of failure (Bandura, 1995).

Applied to HIV prevention, social cognitive theory suggests that the more efficacious people feel about talking to partners about safer sex or exerting control over sexual activities, the more likely they are to undertake the challenge of bringing up the subject of safer sex, persist in the face of partner objections and translate safer sexual intentions into behaviours.

By contrast those with low perceived self efficacy may yield when a partner resists their appeal to use protective measures, become depressed after unsuccessful attempts to negotiate condom use and fail to practice safer sex even if they harbour positive intentions (Bandura, 1994; Kebaabetswe & Norr, 2002). AIDS and other sexually transmitted diseases are unlike many other communicable diseases in that their incidence is largely determined by behavioural choice.

Application of this theory to HIV/AIDS prevention may help in the development of more effective programs that may help people protect themselves against HIV infection (Perloff, 2001). Understanding behaviours that place individuals at risk of HIV infection and identifying ways to change these behaviours are some of the strategies that may help to combat the spread of HIV in the country (Kebaabetswe & Norr, 2002).

Communication education (Bandura, 1994) can increase self efficacy. Education strives to impart accurate information thus increasing awareness about health risk, it teaches social and management skills through modelling, offers extensive practice in these skills to increase the odds that people will perform them in real life situations, and provides social support to maintain behavioural change. According to Bandura (1994), being self efficient is an important individual's strength.

2.4.3. Health belief model

This model focuses on behaviours under an individual's control and presumes that people act in order to maximize net benefits of their actions (Perloff, 2001). In making health decisions, individuals consider health related (for example, social or economic) consequences of their actions. Concern with the immediate or short term benefits of certain behaviours may lead people to disregard the negative long term consequences of those behaviours. For example, an individual's concern about possible sexual transmission of HIV may be obscured by immediate needs for sexual release, social approval from a romantic partner, or money received for prostitution (Ostrow, 1990).

According to the health belief model (Ostrow, 1990; Perloff, 2001), some of the factors that operate to either promote or retard desired behaviour change are:

- Knowledge of health risk and health promoting behaviour
- Perception of oneself as being at risk and relating risk to one's actions
- Perceived effectiveness of behaviour change and response efficacy and
- Belief in the power of technological cures or preventions (for example, faith that a vaccine to prevent HIV infection will soon be discovered).

2.4.3.1. Knowledge

Knowledge of what constitutes risk is an essential prerequisite for promoting healthy behaviour change. Knowledge about AIDS has been seen to play a role in motivating initial behavioural change, particularly in persons who see themselves as being at risk and are initially less informed about the disease and the routes of HIV transmission (Ostrow, 1990).

2.4.3.2. Perception of sexual risk

Perception of personal risk appears to be more important in motivating behavioural change. It has been noted (Perloff, 2001) that individuals tend to underestimate their own vulnerability, operating under an 'optimistic bias' regarding their health. Teenagers, for

example, may have difficulty applying biological knowledge of sex and pregnancy to their behaviour, believing that pregnancy won't happen to them. As noted by Worth (1990), if people at risk of HIV infection do not perceive their risk, it is difficult for them to take precautions. For sexually transmitted diseases, risk perception may be related to individuals' views of their partners.

2.4.3.3. Perceived effectiveness of change and response efficacy

Individuals who are knowledgeable about behavioural risk and who feel they are personally at risk must also feel that they are capable of making recommended behavioural changes (response efficacy) and that those changes will actually make a difference for them (perceived effectiveness). It has been recognized (Ostrow, 1990) that the behaviours important in HIV transmission may be marked by low changeability, because of their centrality to the self identity and daily functioning of at risk individuals who have engaged in high risk activities over many years may, in the belief that they are either already exposed or immune, see little point in changing their behaviour now.

This may suggest that high risk individuals recognize behaviour change to be an effective means of risk reduction for others but perceive it to be 'too late' in their own cases. Because of the potentially long period of time between infection and development of disease and the lack of proof that life style change will reduce chances of becoming ill, individuals at high risk may not believe that behaviour alterations will actually make a difference for them.

2.4.3.4. Faith in medical technology

Because of advances in modern medicine over recent years, many individuals have come to expect that medicine will be there to take care of whatever health problems arise. Premature reports of vaccine or chemotherapy breakthroughs may contribute to an unrealistic expectation that a forth coming cure will make bothersome behaviour change unnecessary. This overconfidence in technological solutions to the control of AIDS and HIV transmission may reflect incorrect knowledge or be a form of denial of individuals

at risk. Indeed the belief that science will provide a cure in the near future has been found to be directly correlated with a continuing large number of sexual partners and the persistence of high risk sexual practices (Johnson, Ostrow & Joseph, 1990).

2.4.4. Theory of reasoned action

This theory is a well specialized and well tested model of the psychological determinants of volitional social behaviour. As such, it has considerable relevance for understanding and promoting HIV risk reduction behaviour change. According to the theory of reasoned action, an individual's HIV preventive behaviour is a function of his or her intention to perform a given preventive act. Behavioural interventions to perform an HIV preventive act in turn are a function of two factors: the individual's attitude towards performance of the preventive act and the individual's subjective norm or perception of relevant support for performance of the preventive act (DiClemente & Peterson, 2000).

This theory asserts that it is critical to elicit salient beliefs about the consequences of preventive acts and categories of referents for preventive acts that are important for specific target populations and preventive behaviours as opposed to attempting to identify such beliefs and referents intuitively.

Theory of reasoned action states that preventive behaviour will be likely occurring among individuals who have formed intentions to practice such behaviour. Intentions in turn will be formed by individuals who have positive attitudes towards the personal performance of preventive acts. With respect to understanding HIV preventive behaviour, the theory of reasoned action directs our attention to the basic psychological underpinnings of the attitudinal and normative determinants of behaviour (DiClemente & Peterson, 2000).

2.5. Factors contributing to the spread of HIV infection

2.5.1. Culture

Edwards (1999) refers to culture as everything humanly created. Culture is a set of guidelines which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in relation to other people (Helman, 1990).

Cultural prescriptions of masculinity and femininity control and determine what men and women know, how they communicate with each other, and how they behave within their relationships and these significantly affect men's and women's sexual behaviour and attitudes (Webb, 1997). These norms are enforced by societal institutions, such as schools, work places, communities and health systems (Webb, 1997). For example, in most societies women are cast in a subordinate, dependent, and passive role where the ideal virtues include virginity, motherhood, obedience, and ignorance particularly about their bodies.

In contrast masculinity is cast in terms of aggression, dominance, independence and irresponsibility, where the key virtues are strength, courage and virility (Webb, 1997). Traditional notions of masculinity are strongly associated with risk taking behaviours such as increased alcohol consumption, intravenous drug use, unsafe sex with multiple sexual partners and violence, and all these contribute to the spread of HIV infection (Walker, Reid & Cornell, 2004). This diversity and dynamism implies that there is space in most societies for modifications of harmful dominant ideologies of masculinity and femininity (Webb, 1997).

Cultures comprise the age specific and collectively developed beliefs, expectations and rules for sexual conducts that govern the sort of activities defined as legitimate and how sexual encounters are to be staged (Nattrass, 2004). For example, the culture in some parts of KwaZulu- Natal is underpinned by meanings which associate sex with gifts, and manliness with the ability to attract and maintain multiple sexual partners. Such a culture

clearly contributes to the spread of HIV/AIDS and needs to be addressed as part of any intervention to promote behaviour change. Cultures are socially constructed and they reflect unequal gender relations in the broader society.

Walker, Reid and Cornell (2004) state that our views of sexuality reality are not necessarily individual choices, since the environment in which we live influences the extent to which we are able to control these choices. The Zulu culture is characterized by gender inequality, traditional sex, the sociocultural 'isoka' idea of multiple partners, lack of discussion on matters of sexuality in the home and between the sexual partners, the conditioning of both men and women to accept sexual violence as normal masculine behaviour along with the right of men to control sexual encounters and the existence of increasingly discordant and contested gender scripts.

Sex is about power, who initiates sex, who makes decisions, whether or not to wear a condom (Walker, Reid & Cornell, 2004). These decisions are contested because relationships between men and women are unequal. Norms and values regarding status and power in sexual and social relationships often condition the ability of individuals to change traditional patterns of sexual relations and also restrict an introduction of innovative behaviours into sexual relationships that may reduce the risk of HIV infection (Webb, 1997).

It is difficult for women, especially those that are poor and of minority status to insist on adopting self productive majors in the face of emotional and economic dependence, coercive threat, and sub cultural prescription of compliant roles for women (Bandura, 1994). In this set of circumstances, it is clear that in order to make sense of the AIDS epidemic we need to look at the social context and power dynamics that inform sexual behaviour and understand sexual relationships and gender inequalities between men and women. In support of this notion, Walker, Reid and Cornell (2004) believe that understanding sex and sexuality in their social context has direct implications for development of HIV/AIDS prevention programmes.

Women's inequality (Perloff, 2001) with respect to income, social status, and

interpersonal power places them at a serious disadvantage in communicating about safer sex and taking precautions against HIV infection. It is these factors, together with social pressure to prove fertility, which make behaviour change a difficult task. Sexual cultures characterized by high risk behaviour pose challenges for behavioural interventions.

Culture interacts with sexual power in a dynamic way (Perloff, 2001). Women are taught to play a passive role in sexual relationships, bear children and respect the male partner, who traditionally believes that only unprotected sex constitutes real sex (Webb, 1997). Interventions have encouraged men to wear condoms and women to insist that they do, but this is impossible.

For some men and women the exchange of fluids during sexual contact is linked to strong cultural beliefs about maintaining good health. If condom use is taboo, then a program that promotes only condoms is unlikely to succeed (Walker, Reid & Cornell, 2004). A good woman in most societies is expected to be ignorant about sex and passive in sexual interactions (Webb, 1997).

In many cultures women gain respect in kinship units or clans based on the number of children they bear (Perloff, 2001). Children define a woman's social identity and they guarantee her status in her community and in some instances also her very survival through financial support from the child's father (Webb, 1997). Based on these cultural beliefs, many women are eager to bear children for their male partners to cement the relationship or encourage marriage. Condoms do not feature in such relationships, thus increasing the risk of HIV infection (Tlou, 2002).

Women are also expected to be dependent on men to make decisions and access resources, men are socialized to be self-reliant, which makes it difficult for the control of epidemic. The expectation of invulnerability associated with being a man encourages denial of risk from HIV risk-taking behaviours such as lack of condom use and multiple partner relationships and it influences health-risking behaviours.

The key reason for the women not acting or being able to act on their knowledge and perception of HIV risk is that most of them do not believe they have a right to refuse sex or to insist on condom use, this behaviour is present whether the partner is a husband or a boy friend. Additionally, most women think that their male partner has a right to have multiple partners. Further more, women do not perceive abstinence or non penetrative alternatives such as thong sex or masturbation as viable options.

Referring to this fact, Summerton (2001) states that taking into consideration the role of cultural norms in shaping behaviour is particularly important to interventions that strive to change high risk behaviours, such as high risk HIV/AIDS sexual practices, because cultural norms are at the root of many women failure to incorporate the effective, cognitive and behavioural components of their attitudes so as to produce consistency between their sexual attitudes regarding safer sex, and their actual sexual behaviour.

Only a male condom is perceived as a potential protective option, but use is limited too because it requires that man approves its use. Educating people as couples can facilitate a critical discussion about the particular sexual culture they are part of, and help bring about behaviour change (Nattrass, 2004).

2.5.2. Gender

Gender is a societal construct that compasses widely shared expectations, norms, customs, beliefs, and practices within a particular society (Makhaye, 2005). Gender is about roles and responsibilities as determined by different societies. Society expects men and women to behave in a particular manner based on prevalent beliefs, practices, and norms of the society. The expectations are learnt in families, work place, school and other institutions. Gender defines appropriate but different behaviour for both men and women. Men are expected to be more powerful than women in all respects and are expected to be providers by bringing food, money, and other commodities for their families (Makhaye, 2005).

Gender inequality has contributed to the spread of HIV in many ways (Prince, Kleintjies,

Cloete & Davids, 2005; Perloff, 2001). It is women who are disproportionately affected by HIV/AIDS and bear a burden of responsibility for HIV/AIDS by persuading their partners to practice safer sex, to care for HIV positive and terminally ill family members and for orphans. Perloff (2001) argues that we can not understand or prevent HIV infection without considering culture, ethnicity, and gender. African women's relative lack of power over their bodies and their sexual lives (Tlou, 2002), a situation that is enforced by social and economic inequality, makes them more vulnerable to HIV infection and the consequences of the epidemic.

Social and economic inequality, traditional gender roles, attitudes toward fertility, lack of access to information about sexual and productivity health, traditional practices and beliefs about HIV and AIDS, and gender based violence are among some of the culturally and socioeconomically constructed gender bound factors that increase women and men's vulnerability to HIV infection and AIDS (Tlou, 2002).

Cultural norms of many African countries reinforce gender inequality by giving men control over productive resources such as land. For example, marriage customs that subordinate wives to their husbands and inheritance customs that make males beneficiaries of family property. Such restrictions have far reaching consequences for the transmission and rapid spread of HIV (Webb, 1997).

Economic dependence on men limits women's sexual negotiating power and makes it difficult for them to refuse unsafe sex even when they know that their male partners are involved in risky sexual behaviours that could predispose them to HIV infection (Tlou, 2002). Prevention programs have traditionally neglected the role that heterosexual African men play in the transmission of HIV. Until recently, men have been almost invisible as part of the solution to the HIV epidemic even though it has been obvious that their socialization and reluctant behaviours often determine when, how, and to whom the virus is transmitted.

Dominant ideologies of masculinity encourage men to be aggressive and to demonstrate their sexual prowess by having multiple partners and by consuming alcohol and other

substances that predispose them to sexual violent behaviour and sexual risk taking. The current trends of HIV transmission and prevalence clearly reflect that the epidemic is also fuelled by gender based vulnerabilities (Prince, Kleintjies, Cloete & Davids, 2005).

2.5.3. Drug use

Unwanted pregnancies, sexually transmitted diseases and unprotected sexual contacts have all been linked with the disinhibiting effect of alcohol and other drugs (Evian, 2003). As noted by Pratt (2003), there is a clear connection between the use of alcohol and illicit drugs during sexual activity and failure to comply with 'safer sex' guidelines intended to minimize HIV/AIDS infection risk. High risk sexual activities are frequently associated with heavy alcohol and drug use (Johnson, Ostrow & Joseph, 1990). Alcohol and other substances predispose individuals to sexual risk taking behaviour (Tlou, 2002).

Alcohol and other forms of drug use are related to sexual behaviour and AIDS risk in two important ways: first, the use of such substances due to their relaxing or disinhibiting effect, they may be the prospect of high risk sexual activity. Second, people who have a predilection for indulging in some risky activities are also predisposed to indulge in others. Drugs are the major contributor to HIV infection and most of them increase the likelihood of entering into more high risk sexual encounters (Nattrass, 2004).

2.5.4. Socio – economic factors

HIV is also a product of social and economic factors upon which the virus has found fertile grounds. As noted by Lurie (2005) the spread of the disease in communities is shaped, in part, by the social and economic forces in which people live. These forces play a critical role in promoting the spread of HIV and have been largely overlooked in favour of factors that operate at the individual level.

The epidemiology of HIV in developing countries reflects these powerful social and economic factors. Failure to consider all aspects of HIV transmission inhibits the ability

to reduce the spread of HIV infection. It may be beneficial at this point to consider some of the socio – economic factors that have had an impact in the spread of HIV infection.

2.5.4.1. Labour migration

A key factor that places many men and women at increased risk to HIV infection is the phenomenon of labour migration (Irwin, Millen & Fallows, 2003) because it increases the extent of sexual networking and thus facilitates the fast spread of the HIV/AIDS pandemic (Gow & Desmond, 2002). According to Lurie (2005), Population movement in South Africa takes many forms. Each type of migration may carry with it different levels of risk for the acquisition and spread of HIV and other sexually transmitted diseases.

Labour migration brings about long periods of separation from spouse and family life; increased opportunities to establish multiple sexual liaison or to frequent prostitutes; and forms escapism such as binge use of alcohol and drugs (Irwin, Millen & Fallows, 2003). In Sub – Saharan Africa, where migration is fundamental to the way in which society is ordered; migration has been an important determinant of the spread of infections, including HIV and has contributed to the extraordinary rapid spread of the pandemic (Lurie, 2005).

It is generally assumed that when men or women live their families in search of employment in other parts of the country, where the pandemic has been particularly severe, engage in sexual activities with women or men at high risk and they are themselves at high risk of infection. When they return to their homes, they may carry a virus with them and infect their partners (Gow & Desmond, 2002).

2.5.4.2. Poverty

Mathews (2005) points out that poverty is a pervasive factor in the lives of the majority of South Africans, exerting a powerful influence on sexual behaviour. It is responsible for many of the social pressures that lead to high risk sexual behaviours (Gow &

Desmond, 2002). Mathews (2005) further states that no explanation of HIV risk behaviour will be adequate without referring to poverty. He believes that there are three main explanations for the association between poverty and increased sexual activity among individuals: the exchange of material and financial resources for sex plays a more important role in sexual decision making in poorer communities; there is a marked breakdown of parental authority in poor areas with one or both parents being migrant labourers; and there are few youth recreational facilities. According to Nattrass (2004) as well as Gow and Desmond, (2002), there is evidence that for some young woman sexuality is conceptualized as a resource that can be drawn upon for material or economic advantage.

Nattrass (2004) explains that sex can be used to secure the job or to acquire material benefits of various kinds from men and that the sexual economy operates on a continuum or scale of benefits. This ranges from the trading by women of sexual favours in order to secure basic needs to the use of sex for obtaining expensive fashion accessories (e.g. clothes), prestigious outings (e.g. invitations to dine at restaurants and attend cinemas). Escalating poverty forces women into commercial sex work to survive and males to initiate drug use which exposes them to HIV infection.

2.6. Myths about HIV/AIDS

Another way in which HIV infection is spreading has to do with myths about curing AIDS (Nattrass, 2004) and peer pressure (Plant & McFeely, 2004). In the absence of HIV/AIDS cure, it is possible that more people will latch onto myths about AIDS cures. Some of these myths are harmless, such as 'the African potato cures AIDS', but others, particularly the myth that 'having sex with a virgin cures AIDS', contribute to the spread of HIV infection. The myth that sex with a virgin can help 'clean the blood' is common in most parts of Africa. This myth has been linked to a reported increase in rape and increase in HIV infection among young girls.

According to the study of truck drivers (Marcus, 2001, cited in Nattrass, 2004), thirty five percent (35%) thought that sex with the virgin will protect them from or cure them

of AIDS. Truck drivers' adherence to this myth is particularly shocking since they are a group at high risk of contracting HIV.

2.7. HIV/AIDS education

In spite of its lethality, currently HIV infections are preventable if individuals are assisted to make behaviour change, to lessen or to control viral transmission (Elioke, 2005). It is widely assumed that if people are adequately educated about the AIDS threat, they will take appropriate self directed actions (Bandura, 1994). As noted by Whiteside and Sunter (2000), an adequate response to the threat of HIV/AIDS requires productive health education development in order to effect behaviour change. Efforts to change high risk behaviours remain the only available means to prevent HIV infection (DiClemente & Peterson, 2000). In support of this notion Zulu, Dodoo and Ezeh (2004) state that behavioural change provides the best opportunity to combat the viral transmission.

Although for many illnesses behaviour change is a desirable or necessary condition for disease prevention, it is not a sufficient condition for avoiding the disease. For example, non smoking can prevent lung cancer, but it can not guarantee the prevention of the disease. Similarly, a low fat diet, stress reduction and regular exercise can contribute to, but do not guarantee health. For HIV/AIDS, however, there is a direct relationship between behaviour and the disease, with behaviour change being a necessary and sufficient condition for prevention. Psychological and social risk behaviour change interventions (Kelly & Lawrence, 1991), whether at the level of individual, groups, or entire communities, can play a significant role in HIV/AIDS prevention. Behaviour rather than personal identity characteristics (Kelly, 2001), is responsible for determining the level of risk of HIV infection.

DiClemente & Peterson (2000) state that the risk behaviours responsible for HIV/AIDS infection however occur in the context of people's interpersonal relationships and pose many social, psychological, and cultural obstacles to prevent the epidemic. While sexual abstinence is the most obvious method of preventing sexual transmission of HIV/AIDS.

however, a substantial proportion of adults and adolescents fail to adopt this strategy (DiClemente & Peterson, 2000). The expectation that most sexually active people will routinely adopt sexual abstinence as HIV prevention strategy is unrealistic.

The South African government has responded to the need for prevention of HIV/AIDS by implementing educational programmes aimed at combating the spread of HIV/AIDS in the country. A real commitment to halting the spread of the epidemic requires that much and more money be spent on health education. HIV/AIDS in educational institutions is therefore vital and must include discussion on sexuality in the broadest sense. *HIV/AIDS education is essential not only as a form of disease prevention, but also as a means of combating the fear and ignorance surrounding the disease.*

In one study done in Zambia (Kebaabetswe & Norr, 2002), AIDS education was found to be successful in informing and altering sexual behaviour. In the absence of cure (DiClemente & Peterson, 2000), the only protection against HIV/AIDS that is available is education. Providing education about HIV/AIDS infection (Kelly & Lawrence, 1991) constitutes the first component of prevention to reduce HIV/AIDS infections.

HIV/AIDS education, according to Kelly and Lawrence (1991), has a number of advantages including the following: it provides an opportunity for the listeners to ask questions and have those questions clarified; and motivational empowerment to put information provided into practice. Formal and non - formal education about HIV/AIDS offer a window of hope for escaping the grip of HIV/AIDS. HIV education has been shown (Kelly, 2001) to be related to the reduction of HIV prevalence rates among young people. It has the potential to transmit significantly important HIV prevention and other AIDS related messages to persons.

2.8. HIV/AIDS peer education

Initial attempts to introduce life skills training through schools failed. Peer education through non governmental organizations (NGOs) networks was then introduced. It was seen as a solution to getting safer sex messages across to the most vulnerable sector of

the population that is sexually active youth (Summerton, 2001) and to prevent HIV transmission (Walker, Reid & Cornell, 2004).

According to Walker, Reid and Cornell (2004); the idea of peer education is that young people are more likely to trust their peers and talk about sexually related issues with them than with parents or elders. In support of this notion, Plant and McFeely (2004) state that young people prefer learning from and with their peers. In a peer education program a group of young people is trained and equipped with knowledge about sexual behaviour, sexually transmitted disease, safer sex practices and contraception: information that they share with their peers (Walker, Reid & Cornell, 2004).

Elioke (2005) believes that the involvement of peers in HIV prevention education programmes is of greatest importance to combat the fast spread of HIV/AIDS among young people. He assumes that young people listen more readily to one another in a language and words that adults do not use. He further states that every effort should be made to capitalize on it for the purposes of HIV prevention. Peer education has important practical advantages as a component in a comprehensive HIV/AIDS strategy.

Properly structured, it is proactive and flexible in delivering stimulating and memorable education to youth in a wide variety of setting. It is often more feasible to train, motivate, prepare and to establish personal linkages with clinics and other services so that young people who need HIV testing can be recognized and successfully referred.

According to Sooknannan (2005), a peer education program can be implemented to meet the following objectives:

- to provide correct and appropriate HIV/AIDS information,
- to facilitate the exploration of existing attitudes and beliefs regarding HIV/AIDS in an open and non-judgmental environment
- to encourage reflection on existing negative attitudes and behavioural practices/intentions regarding HIV/AIDS
- to raise the level of understanding of HIV/AIDS throughout the University and thereby

- to reduce the transmission of HIV through the provision of education and information
- to encourage and facilitate voluntary counseling and testing
- to actively promote good health and positive living on campus
- to equip staff and students to be able to live and work in societies with increasing rates of HIV infection.

2.9. Condom use

Male and female condoms are available in South Africa through three general sources: free of charge through the public sector; through social marketing programmes operated by non governmental organizations; and through commercial distributors (Myer, 2005).

Condoms remain an effective way to prevent pregnancy and the transmission of sexually transmitted infections including HIV/AIDS (Myer, 2005; Pratt, 2003). Despite some recent advances in other areas of HIV prevention, including behavioral interventions, microbicides and vaccines, condoms remain a pivotal part of the fight against HIV/AIDS (Green, 2003). Female condoms are as effective in preventing the spread of the disease as male condoms. Increased condom use is associated with a substantially reduced risk of HIV transmission.

A number of factors are frequently linked to a lack of condom use among individuals (Myer, 2005). As a result of the whole range of beliefs that exist about condoms in many different parts of the world and the influence of various cultural, religious or aesthetic values, many men and women do not like using condoms (Pratt, 2003).

The theoretical efficacy of latex condoms (Green, 2003) for preventing HIV transmission is 100%. Tests have confirmed that latex condoms do not leak HIV in the laboratory setting. Latex condoms may also prevent HIV infections by decreasing the incidence of other sexually transmitted diseases (STDs) that may facilitate HIV transmission. Proper and consistent condom use has a proven record of effectiveness in the prevention of transmission of Human immunodeficiency virus in Africa.

It appears (Green, 2003) that condom adoption is a form of behaviour change because it involves a new behaviour. Condoms are really a risk reduction solution for people who do not change their high risk sexual behaviour. Effectiveness of condom promotion and health education among prostitutes studies in Africa have demonstrated up to ninety percent (90%) reduction in HIV transmission among serodiscordant couples who reported consistent condom use (De Vincenzi, 1994).

Rates of condom use remain low throughout Africa. The low use efficacy on condoms is due primarily to non use rather than incorrect use. There are significant barriers to male condom use in many parts of the world. Such barriers include lack of female control over condom use, fear or embarrassment associated with using condoms, lack of knowledge about the effectiveness of condoms, lack of knowledge about HIV, perceived lack of HIV risk, culturally specific stigmas associated with condom use (UNAIDS, 2000).

In heterosexual driven epidemic, it is males who typically determine whether or not condoms are used and there are varying degrees of male dominance in all societies. Along with women's social and economic disempowerment in many South African communities, these factors render many women unlikely to be able to negotiate condom use with their partners and many men are unlikely to want to use condoms and yet it is men after all who must wear condoms (Lachman, 2000).

In many sexual relationships, condoms are associated with infidelity, lack of trust and the possibility of infection. As a result, attempts to introduce condom use into a sexual relationship can bring confusion, awkwardness, and miss understanding. Many men and women complain that wearing male condoms makes sexual contact less pleasurable – leading to popular analogies such as taking a shower while wearing a rain coat or eating a sweet with a wrapper on.

Due to a great deal of males and some females resistance to using male condom, there has been a great interest in some other methods of protection against HIV/AIDS and

sexually transmitted infections, including female condom. A female condom was introduced in 1997 by Chicago – based female health company. By 2001 female condom was available in over sixty developing countries (Lachman, 2000).

2.10. Voluntary counselling and testing

One of the most challenging features of the AIDS epidemic in Africa is that the majority of people infected with HIV do not know their HIV status. As a result of the lack of HIV testing and counselling facilities, persons living with HIV are less likely to adopt behaviours which would prevent further transmission of HIV and they are unable to access care and services in the early stages of HIV disease (Marum, Campbell, Msowoya, Barnabas & Dillon, 2002; Abdool Karim & Abdool Karim, 2005).

Voluntary counseling and HIV testing (VCT) programmes are designed to provide easy access to HIV testing for persons who wish to know their serostatus, through an approach that emphasizes the informed consent (Marum, Campbell, Msowoya, Barnabas & Dillon, 2002). These programmes enable individuals and couples to learn their test result voluntarily in a setting in which confidentiality is strictly maintained and they strive to empower persons to use their test results to make informed decisions about important life events such as partner selection, marriage, and pregnancy and family finances and to help individuals reduce risk of HIV transmission (Marum, Campbell, Msowoya, Barnabas & Dillon, 2002).

Voluntary counselling and testing services are encouraged and supported in South Africa largely because knowledge of serostatus is believed to help reduce risk of HIV transmission (Hiltzik, 1991). In Kenya and Tanzania the efficacy of voluntary counselling and testing was studied (Mann & Tarantola, 1991) using a randomized controlled trial that compared voluntary counseling and testing to a health information session. This study found that among those in the voluntary counselling and testing part, that enrolled as individuals rather than as couples, men reported a thirty five percent (35%) reduction in unprotected sex with non primary partners, compared to thirteen percent (13%) reduction for those who received only health education.

This study (Mann & Tarantola, 1991) also found that individual men and women who learned they were HIV positive were more likely to practice protected sexual contact than were individuals who learned that they were not infected. Those who received voluntary counselling and testing as couples were likely to reduce unprotected sex with that partner than with sexual partners who did not participate in the study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1. Introduction

This chapter outlines the research design used by the researcher to collect data. Huysamen (2001) refers to a research design as the plan according to which data are collected to investigate the research hypothesis or question in the most economical manner. The chapter indicates how data were collected and considers methods, procedures and instruments used in the study.

3.2. The study

3.2.1. Aim of the study

The major aim of this study was to find out whether or not peer education is an effective tool in changing students behaviour when combating the spread of HIV infection and promoting preventative action against HIV/AIDS.

3.2.2. Research technique

A quantitative research method was used in this study. According to Sarantakos (2002), in quantitative research, the emphasis is on collecting data that lead to dependable answers to important questions, reported in sufficient detail that it has a meaning to the reader. Quantitative data are data that can be sorted, classified, measured in a strictly objective way, which then makes their interpretation unambiguous and independent of individual judgments. The advantage of a quantitative method, according to Sarantakos (2002), is that it is objective, easy to replicate and so has a high reliability; results can be reduced to a few numerical statistics and be measured so that comparisons can be made.

3.2.3. Participants

A total of forty (40) students participated in this study. Fifty percent (50%) of the participants were females and another fifty percent (50%) were males. Thirty one (31) participants had ages ranging between 21 and 30 years and nine (9) of the participants had ages ranging between 31 and 40 years.

3.2.4. Sample

The sample was drawn from a population of students registered at the University of Zululand main campus. Purposive and accidental sampling methods were used in this study. In the present study only those individuals who met the purpose of the study were chosen (Sarantakos, 2002). Huysamen (2001) points out that purposive sampling is useful in reaching a target population quickly. Students that were going to be trained to be HIV/AIDS peer educators for 2006/2007 were used as an experimental group. An accidental sampling method was used to select participants that were used as a control group for the study. An accidental sample, according to Huysamen (2001), is the most convenient collection of subjects that are available for research purposes.

3.2.5. Measuring instrument

A questionnaire was used to collect data from participants. Kumar (1996) defines a questionnaire as a written list of questions, the answers to which are recorded by the respondents. It is a method of gathering information from a number of individuals (a sample) in order to learn something about the larger population from which the sample is drawn (May, 1993).

According to Clarke (1999), instruments like this can be administered before and after the implementation of the programme to determine if a planned intervention has had an effect on individuals. Sarantakos (2002) points out that questionnaires are cost effective; produce quick results; offer a great assurance of anonymity and less opportunity for bias; and can be completed at the respondents convenience.

The questionnaire used in this study was in English and consisted of four sections, which included sections on demographic information; knowledge about HIV/AIDS; attitudes towards people infected with HIV/AIDS and disclosing HIV status; and behavioral practices respectively. It was adopted from the questionnaire that was previously used in the research study that was undertaken at the University of Zululand (Sooknannan, 2005).

3.2.6. Procedure

The permission to conduct the study was requested and obtained from the directors and facilitators of the HIV/AIDS peer education programme at the University of Zululand main campus. A good relationship was established with the program facilitators to help with the organization of sessions and to meet with the participants.

Participants in the experimental group were provided with information on HIV/AIDS in workshop training sessions that took about two weeks. In the workshop sessions participants were familiarized with activities and skills that they will need to use in their own practical situations.

Workshop 1

The focus of this workshop was on AIDS information, attitudes, and beliefs as well as misconceptions with regard to HIV/AIDS.

Workshop 2

This session encouraged participants to develop healthy responsible relationships and encouraged:

- Starting a relationship with oneself
- Developing positive relationship strategies
- Realization of the importance of knowing ones status.

Workshop 3

This workshop encouraged participants to reflect on benefits and challenges of knowing their HIV status. It encouraged participants to:

- Address fears which prevent them from coping effectively with an HIV infection
- Find support and coping structures for living with HIV.

Workshop 4

This workshop developed and understanding of the responsibilities of living positively with HIV/AIDS, which included:

- Maintaining a healthy HIV status whether positive or not
- Accessing supporting resources and environments for living with HIV/AIDS.

Workshop 5

This workshop informed participants about their rights and responsibilities and encouraged them to demonstrate care and support for people living with HIV/AIDS by exploring:

- Discrimination and stigma
- Environmental support structures on campus, which participants can reinforce by developing appropriate behaviours and HIV/AIDS policy.

The pre – test questionnaire was administered prior the first session of the workshop training and the post – test questionnaire, which was the same as the pre – test questionnaire, was administered a month post the last session of the workshop training on HIV/AIDS. The questionnaire was distributed to participants and participants were given time to feel it in the presence of the researcher to ensure clarity and understanding.

3.2.7. informed consent; confidentiality and anonymity

The full explanation and the purpose of this study were provided to respondents so they could give their consent to participate in the study and to foster full cooperation of participants. The right to withdraw was also given to respondents. Ethical commitment with regard to informed consent, confidentiality, and anonymity throughout the process was maintained. The names of respondents were not used in the study. The participants were informed that the findings will only be used for the study and consideration towards setting up the peer education programs.

3.2.8. Scoring

Data collected was scored by researcher. Information on scoring is reported in chapter 4.

3.2.9. Data analysis

To make sense of data collected frequencies of responses were tabulated for the total sample. The statistical package for the social sciences (SPSS) was used to analyze the data. According to Rose and Sullivan (1996) SPSS provides a range of facilities including tabulation and multivariate analysis. The cross tabulations were run to get the chi square test results. Multivariate analysis of variance and general linear model was also run to obtain means of participants responses for each item in each group. Results are presented in table form to assist the reader to clearly understand the findings of this study.

CHAPTER 4

ANALYSIS AND INTERPRETATION OF DATA

4.1. Introduction

This chapter presents the analysis and interpretation of data obtained from respondents of this study. According to Sarantakos (2002), analysis of data allows the researcher to manipulate the information collected during the study in order to assess and evaluate findings and arrive at conclusions.

4.2. Control group demographics

Of the twenty (20) participants in the control group ten (10) were males and ten (10) were females with ages between twenty one (21) and forty (40) years. Sixty five percent (65%) of the participants were aged between twenty one (21) and thirty (30) and thirty five percent (35%) were between thirty one (31) to forty (40) as shown in Table 1.

Table 1: Distribution of participants by gender and age (N = 20)

	FEMALES	MALES	AGES	
			21-30	31-40
Frequency	10	10	13	7
Percentage	50	50	65	35

As indicated in Table 2 seventy five percent (75%) of the participants were single, fifteen percent (15%) were married, five percent (5%) were living with a partner and five percent (5%) were widowed.

Table 2: Distribution of participants by marital status and occupation (N = 20)

	SINGLE	MARRIED	LIVING WITH PARTNER	WIDOWED	UNIVERSITY STUDENT
Frequency	15	3	1	1	20
Percentage	75	15	5	5	100

Data in Table 2 further indicate that all the participants in the control group were university students.

4.3. Pre – test results of control group

Responses to questions on knowledge about HIV/AIDS that were found in the control group participants protocols are given in Table 3.

Table 3: Respondents knowledge about HIV/AIDS (N = 20)

FREQUENCY OF RESPONSES										
QUESTIONS	MALES				FEMALES				BOTH GENDER GROUPS IN %	
	YES		NO		YES		NO		YES	NO
	Responses and %		Responses and %		Responses and %		Responses and %			
	N	%	N	%	N	%	N	%	%	%
2.1 Is AIDS a curable disease?	2	20	8	80	3	30	7	70	25	75
2.2 People with multiple sexual partners are at great risk of getting infected with HIV.	8	80	2	20	9	90	1	10	85	15

FREQUENCY OF RESPONSES										
QUESTIONS	MALES				FEMALES				BOTH GENDER GROUPS IN %	
	YES		NO		YES		NO		YES	NO
	Responses and %		Responses and %		Reponses and %		Responses and %			
N	%	N	%	N	%	N	%	%	%	
2.3 Does HIV cause AIDS?	10	100	0	0	10	100	0	0	100	0
2.4 Everybody is at risk of contracting HIV.	6	60	4	40	9	90	1	10	75	25
2.5 Women are at greater risk of contracting HIV.	6	60	4	40	6	60	4	40	60	40
2.6 Unprotected sex with anybody place men at risk of becoming infected with HIV.	9	90	1	10	9	90	1	10	90	10
2.7 HIV is the disease that mainly affects gay people.	3	30	7	70	9	90	1	10	20	80
2.8 Prompt treatment of STI's is one sure way of reducing HIV.	4	40	6	60	5	50	5	50	45	55
2.9 You can get infected with HIV through kissing.	0	0	10	100	0	0	10	100	0	100

FREQUENCY OF RESPONSES										
QUESTIONS	MALES				FEMALES				BOTH GENDER GROUPS IN %	
	YES		NO		YES		NO		YES	NO
	Responses and %		Responses and %		Responses and %		Responses and %			
	N	%	N	%	N	%	N	%	%	%
2.10 It is safe to share the same cups, plates and utensils with HIV positive people.	7	70	3	30	9	90	1	10	80	20
2.11 Have you ever been exposed to condom use?	8	80	2	20	6	60	4	40	60	40
2.12 Have you ever been exposed to condom use demonstration?	6	60	4	40	8	80	2	20	70	30
2.13 Do you know about retroviral treatment?	6	60	4	40	8	80	2	20	90	10
2.14 Is it important to know your HIV/AIDS status?	9	90	1	10	9	90	1	10	90	10

Table 3 shows that of the ten (10) male participants in the control group, eighty percent (80%) and of the ten (10) female participants, seventy percent (70%) knew that AIDS is not a curable disease. Twenty percent (20%) of male participants and thirty percent (30%) of female participants did not know that AIDS is not a curable disease. Looking at all

control group participants, it is evident that seventy five percent (75%) knew that AIDS is not a curable disease and twenty five percent (25%) did not know. Eighty percent (80%) of male participants and ninety percent (90%) of female participants agreed with the statement that people with multiple sexual partners are at great risk of being infected with HIV/AIDS. Of all the control group participants eighty five percent (85%) knew that having multiple partners places individuals at great risk of becoming infected with HIV/AIDS. Sixty percent (60%) of male participants and ninety percent (90%) of female participants knew that everybody is at risk of contracting HIV. Of all control group participants seventy five percent (75%) knew that everyone is at risk of being infected with HIV/AIDS and twenty five percent of them did not know.

Sixty percent (60%) of male participants and 60% of female participants were aware that women are at greater risk of contracting HIV. Of all participants of the control group (male and females) sixty percent (60%) indicated knowledge on women being at greater risk of contracting HIV and forty percent (40%) did not know. Ninety percent (90%) of female participants and 90% of male participants knew that unprotected sex with anybody places men at risk of becoming infected with the virus. It is shown that ninety percent (90%) of all the participants supported the idea that unprotected sex with anybody places individuals at risk of being infected with HIV/AIDS.

It is clear from Table 3 that seventy percent (70%) of male participants and 90% of female participants knew that HIV does affect a particular group of individuals. Of all the participant in the control group, it is shown that eighty percent (80%) knew that HIV does not only affect guy people and twenty percent did not. It is depicted that forty percent (40%) of male participants and fifty percent (50%) of female participants were aware that prompt treatment of sexually transmitted infections is one sure way of reducing HIV. Looking at both gender groups (males and females), it is shown that less than half of control group participants, that is, forty five percent (45%) knew that prompt treatment of sexually transmitted infections is one sure way of reducing HIV infections.

Table 3 further shows that all participants, that is, 100% did not know that one can be infected through kissing. Seventy percent (70%) of male participants and ninety percent

(90%) of female participants knew that it is safe to share dishes with the person who is infected with HIV. Considering all gender groups, it is indicated that eighty percent (80%) knew that sharing cups plates and utensils with people who are infected with HIV is not harmful. Eighty percent (80%) of male participants and sixty percent (60%) of female participants were once exposed to condom use. Sixty percent (60%) of all participants were once exposed to condom use. It is indicated in Table 3 that sixty percent (60%) of male participants and 80% of female participants were once exposed to condom demonstration. Of all the participants in the control group, Table 3 shows that seventy percent (70%) were once exposed to condom use demonstration.

It is indicated on Table 3 that sixty percent (60%) of male participants and eighty percent (80%) of female participants knew about retroviral treatment. Looking at both gender groups (males and females), it is indicated that ninety percent (90%) knew about retroviral treatment. Ninety percent (90%) of male participants and 90% of female participants were knowledgeable about the importance of knowing one's HIV/AIDS status. Of all the control group participants (males and females) ninety percent (90%) considered it essential to know one's HIV/AIDS status.

Responses to questions on attitudes towards HIV/AIDS and people infected with HIV/AIDS that were found in the control group participants protocols are given in Table 4.

Table 4: Respondents attitudes towards people infected with HIV/AIDS (N = 20)

FREQUENCY OF RESPONSES										
QUESTIONS	MALES				FEMALES				BOTH GENDER GROUPS IN %	
	YES		NO		YES		NO		YES	NO
	Responses and %		Responses and %		Responses and %		Responses and %			
	N	%	N	%	N	%	N	%	%	%
3.1 If you were to have a roommate/classmate who is living with HIV, would you accept him/her?	10	100	0	0	10	100	0		100	0
3.2 If you were to have a roommate/classmate who is fully blown to AIDS, would you accept him/her?	8	80	2	20	9	90	1	10	85	15
3.3 Do you think people who are infected need sympathy?	9	90	1	0	8	80	2	20	85	15
3.4 Do you think people who are infected need your support?	10	100	0	0	10	100	0	0	100	0
3.5 Do you think people who are infected are entitled to treatment?	9	90	1	10	10	100	0	0	95	5
3.6 Do you think it is important for infected people to tell their sexual partners about their status?	10	100	0	0	9	90	1	10	95	5
3.7 Do you think it is important for infected people to tell their families about their status?	9	90	1	10	9	90	1	10	90	10

Table 4 depicts that all (100%) participants in the control group indicated a positive attitude towards accepting a person who is living with HIV. Further more eighty percent (80%) of male participants indicated a positive attitude towards a person who is fully blown to AIDS. Looking at both gender groups (males and females), it is reflected that 80% of participants could accept a person who is fully blown to AIDS and 20% could not. Ninety percent (90%) of male participants and eighty percent (80%) of female participants indicated a positive attitude towards giving sympathy to people who are infected with HIV/AIDS. Eighty five percent (85%) of all participants were shown to have a positive attitude towards sympathizing with people who are infected with HIV.

Table 4 further shows that all participants in the control group reflected a positive attitude towards supporting people who are infected with HIV/AIDS. All female participants, that is, 100% and ninety percent (90%) of male participants indicated a positive attitude towards giving treatment to people who are infected with HIV. Only five percent (5%) of all participants indicated a negative attitude towards giving treatment to people who are infected with HIV/AIDS.

Responses of participants to questions on perceptions and behavioural practices are displayed in Table 5.

Table 5: Participants perceptions and behavioural practices (N = 20)

FREQUENCY OF RESPONSES										
QUESTIONS	MALES				FEMALES				BOTH GENDER GROUPS IN %	
	YES		NO		YES		NO		YES	NO
	Responses and %		Responses and %		Responses and %		Responses and %			
	N	%	N	%	N	%	N	%	%	%
4.1 Are you sexually active?	7	70	3	30	4	40	6	60	55	45
4.2 Do you have penetrative sex with your partner?	6	60	4	40	5	50	5	50	55	45
4.3 Do you condomise?	5	50	5	50	5	50	5	50	50	50
4.4 Do you carry your own supply of condoms?	5	50	5	50	5	50	5	50	50	50
4.5 Do you decide on condom use?	5	50	5	50	5	50	5	50	50	50
4.6 Can you say no to sex?	3	30	7	70	7	70	3	30	50	50

Table 5 shows that seventy percent (70%) of male participants and forty percent (40%) of female participant were sexually active. Looking at both gender groups (males and females) it is clear that more than half of the participants, that is, fifty five percent (55%) were sexually active and forty five percent (45%) of them were not. Fifty percent (50%) of male respondents and 50 % of female respondents were practicing penetrative sex with their partners. It is indicated in Table 5 that half the of participants, that is, fifty percent

(50%) were having penetrative sex with their partners and fifty percent (40%) of them were not.

Table 5 shows that sixty percent (60%) male participants and fifty percent (50%) female participants were using condoms. Of all the control group participants, it is displayed that half of them, that is, fifty percent (50%) were using condoms and 50% of them were not. Fifty percent (50%) of male participants and 50% of female participants indicated that were carrying their own supply of condoms. It is displayed that fifty percent (50%) of female and 50% percent of male participants were involved in decision making about condom use in their relationships. Looking at both gender groups (males and females) Table 5 shows that half of them, that is, fifty percent (50%) were involved decision making on condom use in their relationships and 50% were not. Seventy percent (70%) of male participants and 70% of female participants indicated that they could say no to sex. of all the participants in the control group Table 5 displays that half of them, that is, fifty percent (50%) could say no to sex and 50% of them could not.

4.4 Control group post test results

The pre –test and post – test responses of the control group were compared. Results indicated no significant change in knowledge, attitudes and behavioral practices of the control group. For this reason it was considered not essential to display them in a tabular form here.

4.5. Experimental group demographics

As shown in Table 6 of the twenty (20) participants in the experimental group ten (10) were males and ten (10) were females with ages between twenty one (21) and forty (40) years. Ninety percent (90%) of participants were aged between twenty one (21) and thirty (30) and ten percent (10%) were between ages thirty one (31) to forty (40).

Table 6: Distribution of experimental group participants by gender and age (N = 20)

	FEMALES	MALES	AGES	
			21-30	31-40
Frequency	10	10	18	2
Percentage	50	50	90	10

The distribution of participants by marital status is given in Table 7.

Table 7: Distribution of participants by marital status and occupation (N = 20)

	SINGLE	MARRIED	LIVING WITH PARTNER	WIDOWED	UNIVERSITY STUDENTS
Frequency	19	0	1	0	20
Percentage	95	0	5	0	100

According to Table 7, ninety five percent (95%) of the participants were single and 5% were living with partners. None of the participants in the experimental group were married or widowed. Data in Table 7 further indicate that all the participants in the experimental group were university students.

4.6. Experimental group pre test – result presentation

Responses to questions on knowledge about HIV/AIDS that were found in the experimental group participants protocols prior to exposure to the HIV/AIDS peer education program are given in Table 8.

Table 8: Respondents knowledge about HIV/AIDS (N = 20)

FREQUENCY OF RESPONSES										
QUESTIONS	MALES				FEMALES				BOTH GENDER GROUPS IN %	
	YES		NO		YES		NO		YES	NO
	Responses and %		Responses and %		Reponses and %		Responses and %			
	N	%	N	%	N	%	N	%	%	%
2.1 Is AIDS a curable disease?	2	20	8	80	1	10	9	90	15	85
2.2 People with multiple sexual partners are at great risk of getting infected with HIV.	10	100	0	0	8	80	2	20	90	10
2.3 Does HIV cause AIDS?	9	90	1	10	10	100	0	0	95	5
2.4 Everybody is at risk of contracting HIV.	7	70	3	30	6	60	4	40	65	35
2.5 Women are at greater risk of contracting HIV.	5	50	5	50	6	60	4	40	55	45
2.6 Unprotected sex with anybody places men at risk of becoming infected with HIV.	10	100	0	0	9	90	1	10	95	5
2.7 HIV is the disease that mainly affects gay	1	10	9	90	2	20	8	80	15	85

FREQUENCY OF RESPONSES										
QUESTIONS	MALES				FEMALES				BOTH GENDER GROUPS IN %	
	YES		NO		YES		NO		YES	NO
	Responses and %		Responses and %		Responses and %		Responses and %			
	N	%	N	%	N	%	N	%	%	%
2.8 Prompt treatment of STI's is one sure way of reducing HIV.	5	50	5	50	5	50	5	50	50	50
2.9 You can get infected with HIV through kissing.	1	10	9	90	0	0	10	100	5	95
2.10 It is safe to share the same cups, plates and utensils with HIV positive people.	8	80	2	20	10	100	0	0	90	10
2.11 Have you ever been exposed to condom use?	7	70	3	30	8	80	2	20	75	25
2.12 Have you ever been exposed to condom use demonstration?	6	60	4	40	9	90	1	10	75	25
2.13 Do you know about retroviral treatment?	9	90	1	10	10	100	0	0	95	5
2.14 Is it important to know your HIV/AIDS status?	10	100	0	0	10	100	0	0	100	0

Eighty percent (80%) of male participants and ninety percent (90%) of female participants knew that AIDS is not a curable disease. Only twenty percent 20% of male participants and ten percent 10% of female participants were not aware that AIDS is not a curable disease. Of all participants more than half of participants, that is, eighty percent (80%) knew that AIDS is not a curable disease. All male participants that is, 100% and ninety percent (90%) of female participants knew that having multiple sexual partners places individuals at great risk of getting infected with HIV. It is indicated that of all participants in the experimental group more than half, that is, 90% were aware that having multiple sexual partners pre - exposes individuals to the risk of getting infected with HIV. All female participants, that is, 100% and ninety percent (90%) of male participants knew that HIV causes AIDS. Of all participants, when looking at both gender groups, it is indicated that ninety five percent (95%) knew that HIV causes AIDS.

In the statement that women are at great risk at contracting HIV only half, that is, fifty percent (50%) of male participants and more than half, that is, sixty percent (60%) of female participants knew that women are at great risk of contracting HIV. Looking at both gender groups (males and females) it is shown that more than half of participants, that is, fifty five percent (55%) knew that women are at great risk of contracting HIV. All male participants, that is, 100% and ninety percent (90%) of female participants knew that unprotected sex with anybody places men at risk of becoming infected with HIV. Looking at both gender groups (males and females) it is displayed in Table 8 that ninety five percent (95%) knew that having unprotected sex with anybody places individuals at risk of becoming infected with HIV/ AIDS.

It is shown in Table 8 that ninety percent (90%) of male participants and eighty percent (80%) of female participants knew that HIV does not only affect guy people. Looking at both gender groups (male and females) it is shown that eighty five percent (85%) knew that HIV/AIDS does not only affect guy people. In the statement that prompt treatment of sexually transmitted infections is one sure way of reducing HIV, sixty percent (50%) of male participants and fifty percent (50%) of female participants agreed. In both gender groups (males and females) only half of the participants, that is, fifty percent (50%) were aware that prompt treatment of sexually transmitted infections is one sure way of

reducing HIV and fifty percent (50%) of them were not. All female participants, that is, 100% and ninety percent (90%) of male participants agreed with the statement that one can not get infected with HIV through kissing. Of both gender groups, it is shown that ninety five percent (95%) of participants were of an opinion that one can not get infected with HIV through kissing and five percent (5%) knew that one can be infected with HIV through kissing. Half of male participants (50%) and all female participants (100%) agreed with the statement that it is not harmful to share dishes (plates, utensils, and glasses) with people who are infected with HIV. Looking at both gender groups (males and females), it is shown that ninety percent (90%) of participants knew that it is not harmful to share dishes with people who are infected with HIV/AIDS and only ten percent (10%) did not know.

Table 8 shows that seventy percent (70%) of male participants and eighty (80%) percent of female participants were once exposed to condom use. Looking at both gender groups (males and females) it is shown that eighty five percent (85%) of participants were once exposed to condom use. Sixty percent (60%) of male participants and ninety percent (90%) of female participants had been exposed to condom demonstration. It is indicated that seventy five percent (75%) of all participants of the experimental group were once exposed to condom demonstration and twenty five (25%) were never. Ninety percent (90%) of male participants and all female participants, that is, 100% knew about retroviral treatment. Looking at both gender groups (male and females), it is shown that ninety five percent (90%) knew about retroviral treatment and five percent (5%) did not know. All male and female participants acknowledged the importance of knowing one's HIV/AIDS status.

Responses to questions on attitudes towards HIV/AIDS and people infected with HIV/AIDS that were found in the experimental group participants protocols prior to exposure to the HIV/AIDS peer education training are given in Table 9.

Table 9: Respondents attitudes towards people infected with HIV/AIDS (N = 20)

FREQUENCY RESPOSES										
QUESTIONS	MALES				FEMALES				BOTH GENDER GROUPS IN %	
	YES		NO		YES		NO		YES	NO
	Responses and %		Responses and %		Responses and %		Responses and %			
	N	%	N	%	N	%	N	%	%	%
3.1 If you were to have a roommate/classmate who is living with HIV, would you accept him/her?	9	90	1	10	10	100	0	0	95	5
3.2 If you were to have a roommate/classmate who is fully blown to AIDS, would you accept him/her?	7	70	3	30	9	90	1	10	80	20
3.3 Do you think people who are infected need sympathy?	8	80	2	20	5	50	5	50	65	35
3.4 Do you think people who are infected need your support?	10	100	0	0	10	100	0	0	100	0
3.5 Do you think people who are infected are entitled to treatment?	8	80	2	20	5	50	5	50	65	35
3.6 Do you think it is important for infected people to tell their sexual partners about their status?	9	90	1	10	10	100	0	0	95	5
3.7 Do you think it is important for infected people to disclose?	9	90	1	10	10	100	0	0	95	5

Table 9 indicates that ninety percent (90%) of male participants and all female participants, that is, 100% displayed a positive attitude towards accepting a mate who is living with HIV. Of all the experimental group participants, ninety five percent (95%) indicated a positive attitude towards accepting a mate who is infected with HIV/AIDS. Seventy percent (70%) of male participants and ninety percent (90%) of female participants indicated that they could accept a mate who is fully blown to AIDS. Considering both gender groups (males and females) it is shown that eighty percent (80%) of participants could accept a person who is fully blown to AIDS and twenty percent could not.

More than half of male participants, that is, eighty percent (80%) and half of female participants, that is, fifty percent (50%) indicated a positive attitude towards sympathizing with people who are infected with HIV/AIDS. Looking at all the participants of the experimental group, it is shown that sixty five percent (65%) could sympathize with a person who is living with HIV. In the statement on the importance of disclosing one's HIV/AIDS status to sexual partners, ninety percent (90%) of the male participants and all female participants, that is, 100% considered it important to disclose one's HIV status to his or her sexual partner. When looking at both gender groups, Table 9 shows that ninety five percent (95%) deemed it important to disclose one's HIV/AIDS to their sexual partners and their families and five percent (5%) did not.

Responses to questions on perceptions and behavioural practices that were found in the experimental group participants protocols before exposure to the HIV/AIDS peer education training are given in the Table 10.

Table 10: Participants perceptions and behavioural practices (N = 20)

FREQUENCY OF RESPONSES										
QUESTIONS	MALES				FEMALES				BOTH GENDER GROUPS IN %	
	YES		NO		YES		NO		YES	NO
	Responses and %		Responses and %		Responses and %		Responses and %			
	N	%	N	%	N	%	N	%	%	%
4.1 Are you sexually active?	6	60	4	40	3	30	7	70	55	45
4.2 Do you have penetrative sex with your partner?	5	50	5	50	6	60	4	40	55	45
4.3 Do you condomise?	5	50	5	50	4	40	6	60	45	55
4.4 Do you carry your own supply of condoms?	8	80	2	20	7	70	3	30	75	25
4.5 Do you decide on condom use?	9	90	1	10	9	90	1	10	90	10
4.6 Can you say no to sex?	7	70	3	30	8	80	2	20	75	25

Table 10 shows that sixty percent (60%) of male participants and seventy percent (70%) of female participants were sexually active. Looking at both sexes (males and females) it is clear that more than half of participants, that is, fifty five percent (55%) were sexually active and forty five percent (45%) of them were not. Fifty percent (50%) of male participants and sixty percent (60%) of female participants had penetrative sex with their partners. Of all participants of the experimental group (males and females) fifty five

percent (55%) indicated that they had penetrative sex with their partners and forty five percent (45%) of them were not. It is indicated that Fifty percent (50%) of male participants and forty percent (40%) of female participants were using condoms. It is shown that of all participants of the experimental group less than half of participants, that is, forty five percent were using condoms and fifty five percent more than half, that is, fifty five percent (55%) of them were not. Eighty five percent (85%) of male participants and seventy percent (70%) of female participants indicated that they were carrying their own supply of condoms. Seventy five (75%) of all participants reported to carry their own supply of condoms and twenty five percent were not. Table 10 further shows that ninety percent (90%) of male participants and ninety percent of female participants were involved in decision making about the use of condoms in their relationships. Of all participants of the experimental group, it is indicated that ninety percent (90%) were participating in decision making about condom use in their relationships.

Seventy percent (70%) of male participants and eighty percent of (80%) of female participants indicates that they can say no to sex. Table 10 shows that of all participants seventy five percent (75%) could say no to sex and twenty five percent (25%) could not.

4.7 Experimental group post test results

Responses to questions on knowledge about HIV/AIDS that were found in the experimental group participants protocols, post an exposure to the HIV/AIDS peer education program are given in Table 11.

Table 11: Respondents knowledge about HIV/AIDS (N = 20)

FREQUENCY OF RESPONSES										
QUESTIONS	MALES				FEMALES				BOTH GENDER GROUPS IN %	
	YES		NO		YES		NO		YES	NO
	Responses and %		Responses and %		Responses and %		Responses and %			
	N	%	N	%	N	%	N	%	%	%
2.1 Is AIDS a curable disease?	1	10	9	90	0	0	1	100	5	95
2.2 People with multiple sexual partners are at great risk of getting infected with HIV.	10	100	0	0	10	100	0	0	100	0
2.3 Does HIV cause AIDS?	10	100	0	0	9	90	1	10	95	5
2.4 Everybody is at risk of contracting HIV.	9	90	1	10	9	90	1	10	90	10
2.5 Women are at greater risk of contracting HIV.	8	80	2	20	9	90	1	10	85	15
2.6 Unprotected sex with anybody place men at risk of becoming infected with HIV.	10	100	0	0	10	100	0	0	100	0

FREQUENCY OF RESPONSES										
QUESTIONS	MALES				FEMALES				BOTH GENDER GROUPS IN %	
	YES		NO		YES		NO		YES	NO
	Responses and %		Responses and %		Responses and %		Responses and %			
	N	%	N	%	N	%	N	%	%	%
2.7 HIV is the disease that mainly affects gay people.	1	10	9	90	1	10	9	90	10	90
2.8 Prompt treatment of STI's is one sure way of reducing HIV.	8	80	2	20	6	60	4	40	70	30
2.9 You can get infected with HIV through kissing.	2	20	8	80	2	20	8	80	20	80
2.10 It is safe to share the same cups, plates and utensils with HIV positive people.	10	100	0	0	9	90	1	10	90	10
2.11 Have you ever been exposed to condom use?	8	80	2	20	6	60	4	40	70	30
2.12 Have you ever been exposed to condom use demonstration?	10	100	0	0	8	80	2	20	90	10
2.13 Do you know about retroviral treatment?	8	80	2	20	9	90	1	10	85	15
2.14 Is it important to know your HIV/AIDS status?	10	100	0	0	10	100	0	0	100	0

Table 11 indicates that of the ten (10) male participants ninety percent (90%) and of the ten (10) female participants 100% knew that AIDS is not curable. Of the all participants of the experimental group (males and females) ninety five percent (95%) were aware that AIDS is not curable. 100% of male participants and ninety percent (90%) of female participants knew that HIV causes AIDS post an exposure to the HIV/AIDS peer education program. Ninety percent (90%) of female participants and ninety percent of male participants knew that everybody is at risk of contracting HIV/AIDS. Looking at all participants, that is, males and females it is indicated that ninety percent (90%) knew that everybody is at risk of contracting HIV/AIDS. Eighty percent (80%) of male participants and ninety percent of female participants knew that women are at great risk of contracting HIV. Eighty five percent of all participants of the experimental group knew that women are at great risk of contracting HIV/AIDS and fifteen percent did not know.

It is shown that all participants, that is, 100% knew that unprotected sex with anybody places men at risk of becoming infected with HIV/AIDS. It is indicated in Table 11 that ninety percent (90%) of male participants and ninety percent (90%) of female participants were aware that HIV/AIDS does not only affect guy people. Of all the experimental group participants ninety percent (90%) were aware that HIV/AIDS does not belong to a certain group of people and ten percent (10%) were not. In the statement that prompt treatment of sexually transmitted infections is one sure way of reducing HIV, eighty percent (80%) of male participants and sixty percent (60%) of female participants agreed. It is displayed in Table 11 that of all experimental group participants seventy percent (70%) were knowledgeable about the fact that prompt treatment of sexually transmitted infection is one sure way of reducing HIV/AIDS and thirty percent (30%) were not.

Table 11 further shows that twenty percent (20%) of male participants and 20% of female participants knew that one can be infected with HIV/AIDS through kissing. Looking at both gender groups (males and females) it is reflected in Table 11 that twenty percent (20%) were aware that one can be infected with HIV/AIDS through kissing and eighty percent (80%) of them were not. Eighty percent (80%) of male participants and sixty percent (60%) of female participants indicated that they had been exposed to condom use. Of all participants in the control group seventy percent (70%) indicated to have been

exposed to condom use and thirty percent (30%) were never. All male participants, that is, 100% and eighty percent (80%) of female participants had been exposed to condom demonstration and ten percent (10%) of them were never. Looking at both males and females participants it is shown that ninety percent (90%) were once exposed to condom demonstration and ten percent (10%) of them were never. It is reflected in Table 11 that eighty percent (80%) of male participants and ninety percent (90%) of female participants knew about retroviral treatment. Out of all participants, that is, males and females eighty five percent (85%) knew about retroviral treatment and fifteen percent (15%) did not. Table 11 further shows that all participants of the experimental group, that is, 100% realized the importance of knowing one's HIV/AIDS status.

Responses to questions on attitudes towards HIV/AIDS and people infected with HIV/AIDS that were found in the experimental group participants protocols, post the HIV/AIDS peer education program are given in the Table 12.

Table 12: Respondents attitudes towards people infected with HIV/AIDS (N = 20)

FREQUENCY OF RESPONSES										
QUESTIONS	MALES				FEMALES				BOTH GENDER GROUPS IN %	
	YES		NO		YES		NO		YES	NO
	Responses and %		Responses and %		Responses and %		Responses and %			
	N	%	N	%	%	N	%	N	%	%
3.1 If you were to have a roommate/classmate who is living with HIV, would you accept him/her?	10	100	0	0	9	90	1	10	95	5
3.2 If you were to have a roommate/classmate who is fully blown to AIDS, would you accept him/her?	8	80	2	20	7	70	3	30	75	25
3.3 Do you think people who are infected need sympathy?	7	70	3	30	7	70	3	30	70	30
3.4 Do you think people who are infected need your support?	10	100	0	0	10	100	0	0	100	0
3.5 Do you think people who are infected are entitled to treatment?	10	100	0	0	10	100	0	0	100	0
3.6 Do you think it is important for infected people to tell their sexual partners about their status?	10	100	0	0	10	100	0	0	100	0
3.7 Do you think it is important for infected people to tell their families about their status?	10	100	0	0	10	100	0	0	100	0

Table 12 depicts that all male participants and ninety percent of female participants indicated a positive attitude towards accepting a mate who is living with HIV. Of all participants of the experimental group ninety five percent (95%) indicated a positive attitude towards a mate who is living with HIV/AIDS and five percent (5%) of them displayed a negative attitude. Of the male participants, eighty percent (80%) and of the female participants seventy percent (70%) indicated a positive attitude towards accepting an individual who is fully blown to AIDS. Looking at both gender groups (males and females) it is shown that seventy five percent (75%) of the participants indicated a positive attitude towards accepting a person who is fully blow to AIDS and twenty five percent (25%) of them displayed a negative attitude.

Table 12 further shows that seventy percent (70%) of male participants and 70% of female participants indicated a positive attitude towards sympathizing with people who are infected with HIV. Of all gender groups (males and females) seventy percent (70%) indicated a positive attitude and thirty percent (30%) of them displayed a negative attitude towards sympathizing with people who are infected with HIV/AIDS. It is further shown that all participants indicated a positive attitude towards supporting individual who are infected with HIV/AIDS and they all realized that people who are infected with HIV are entitled to treatment. All gender groups (males and females) indicated a positive attitude towards disclosing their HIV/AIDS status to their partners and families.

Responses to questions on perceptions regarding HIV/AIDS and sexual behavioural patterns that were observed in the experimental group participants protocols, post the HIV/AIDS peer education program training are given in the Table 13.

Table 13: Participants perceptions and behavioural practices (N = 20)

FREQUENCY OF RESPONSES										
QUESTIONS	MALES				FEMALES				BOTH GENDER GROUPS IN %	
	YES		NO		YES		NO		YES	NO
	Responses and %		Responses and %		Responses and %		Responses and %			
	N	%	N	%	N	%	N	%	%	%
4.1 Are you sexually active?	5	50	5	50	5	50	5	50	50	50
4.2 Do you have penetrative sex with your partner?	4	40	6	60	5	50	5	50	45	55
4.3 Do you condomise?	7	70	3	30	6	60	4	40	65	35
4.4 Do you carry your own supply of condoms?	4	40	6	60	3	30	7	70	35	65
4.5 Do you decide on condom use?	9	90	1	10	9	90	1	10	90	10
4.6 Can you say no to sex?	7	70	3	30	9	90	1	10	80	20

Table 13 shows that of the ten (10) male participants and of the ten (10) female participants fifty percent (50%) of male participants and fifty percent (50%) of female participants were sexually active. Looking at both gender groups (males and females) it is clear that fifty percent (50%) of participants were sexually active and fifty percent were not. Forty percent (40%) of Male participants and fifty percent (50%) of female participants indicated that they had penetrative sex with their partners. Looking sat all participants of the experimental group it is shown in Table 13 that forty five percent

(45%) had penetrative sex with their partners and fifty five percent (55%) of the did not. In the statement about the use of condoms, seventy percent (70%) of male participants and sixty percent (60%) of female participants were using condoms. Looking at both gender groups (males and females) it is clear that more than half, that is, sixty five percent (65%) were using condoms and thirty five percent (35%) were not. It is further indicated that 40% of male participants and 30% of female participants were carrying their supply of condoms. Looking at Table 13 it is clear that more than half of participants, that is, sixty five percent (65%) did not carry their own supply of condoms.

Table 13 further reflects that ninety percent (90%) of male participants and 90% of female participants were involved in decision making about condom use in their relationships. It displayed that of all the experimental group participants, ninety percent (90%) were involved in decision making about the use of condoms in their relationships. Seventy percent (70%) of male participants and ninety percent (90%) of female participants could say no to sex. Of the twenty (20) participants of the experimental group, it is shown that eighty percent (80%) could say no to sex and twenty percent of them could not.

CHAPTER 5

DISCUSSION AND CONCLUSION

5.1. Introduction

This chapter presents *discussion of results and conclusion based on the study as a whole.*

5.2. Discussion of results

Findings obtained from data analysis for experimental and control groups were compared. According to Nachmias and Nachmias (1996), to assess the effect of the independent variable, researchers take measurements on the dependent variable, designated as scores, twice from each group. One measurement, the pre – test, is taken prior to the introduction of the independent variable in the experimental group. A second, the post- test, is taken after the experimental group has been exposed to the treatment. The difference in measurement between post – test and pre – test is compared between two groups.

The pre – test findings of this study indicated no significant differences between both control and experimental groups. It is indicated that the experimental group was more knowledgeable about HIV/AIDS after having been exposed to the peer education training program when compared to the control group, which was not exposed to the peer education program. As Clarke (1999) states, the extent of the effectiveness of a program is indicated by the size of difference in the outcome measures of the two groups (control and experimental groups). According to Nachmias and Nachmias (1996), if the difference in experimental group is significantly larger than in the control group, it is inferred that the independent variable (treatment) is causally related to the dependent variable (scores).

Looking at the pre and post – test responses to questions on knowledge about HIV/AIDS of the experimental group in this study, it is clearly indicated that participants had some knowledge about HIV/AIDS even prior exposure to the HIV/AIDS peer education

program. Both gender groups in the experimental group indicated some knowledge about HIV/AIDS; however, it is shown that female participants were more acquainted with HIV/AIDS information. It is further indicated that knowledge about HIV/AIDS of both gender groups improved post the peer education training program. Based on these findings it is clearly indicated that the HIV/AIDS peer education program was effective in providing participants with knowledge about HIV/AIDS. According to Ostrow (1990), Knowledge of what constitutes risk is an essential prerequisite for promoting healthy behaviour change, particularly in persons who see themselves as being at risk and are initially less informed about the disease and the routes of HIV transmission.

Findings further suggest that the majority of participants in both groups (experimental and control groups) held a positive attitude towards HIV/AIDS and people who are infected with HIV/AIDS even before the training. These attitudes were maintained by both experimental and control groups even after the training. There were no significant differences between the control and experimental groups with regard to attitudes towards HIV/AIDS victims. Based on these findings it is not clearly indicated whether or not HIV/AIDS peer education had any impact on participants attitudes.

Looking at the pre and post – test results of the experimental group from responses to questions on perceptions regarding HIV/AIDS and sexual behavioural patterns, it is indicated that there was a significant improvements in perceptions regarding HIV/AIDS and behavioural patterns of participants post the HIV/AIDS peer education training. As health belief model indicates, perception of personal risk appears to be more important in motivating behavioural change.

5.3. Conclusion

The aim of this study was to determine whether HIV/AIDS peer education is effective in changing students behavioral practices towards condom use. The hypothesis was that there is a significant difference in behavioural patterns of the students at the University of Zululand main campus before and after exposure to the HIV/AIDS peer education program. Based on the findings of this study and evidence from literature HIV/AIDS peer

education program was found to be effective in changing participants behavioural patterns towards safer sexual practices. In this study it has been acknowledged that sexual behaviour is influenced by the interplay of many factors, such as socioeconomic and sociocultural factors in sexual decision making. This decision making process often has little to do with maintaining good health and more to do with satisfying motivational needs that have a psychological basis or with options that are socially or economically or emotionally determined. Therefore, an effective HIV/AIDS prevention strategy must also consider these specific factors that also contribute in perpetuating the transmission of HIV rather than focusing only on the use of condoms.

5.4. Limitations for the study

The limitation of this study is that it was based only on fulltime students of the University of Zululand main campus. Findings can not be generalized to all students at tertiary institutions. A larger sample would have been better in terms of validity and reliability, and a correlational study across different tertiary institutions would indicate differences in terms of cultures pertaining knowledge, attitudes and behavioral practices regarding HIV/AIDS. It is hoped that in future, research projects of this nature will consist of samples that will be at best representative of all students at tertiary level.

5.5. Recommendations for future research

HIV/AIDS spreads like wildfire in the country today. Since the progression of HIV/AIDS is rooted in the life style of individuals, studies that evaluate the effectiveness of programs that can assist in changing the behaviour of students towards safer sexual practices are necessary to undertake. It is hoped that this study will help in planning and improving policies for addressing issues related to HIV/AIDS at the University of Zululand main campus. The fact that HIV/AIDS is mainly sexually transmitted will not stop people from having sexual contacts. Therefore there is a need for future research studies to investigate how often or consistent people are with the use of condoms. A broader study across several tertiary institutions is also recommended so as to get a sample that will be the best representative of all students at tertiary level.

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<http://www.hst.org.za/sahr/2000/chapter16.htm>

APPENDIX A

The impact of HIV/AIDS peer education program on condom use of the fulltime students at the University of Zululand main campus

This study is undertaken as part of masters in Clinical Psychology in the department of psychology at the University of Zululand.

Information provided will be utilized to complete the dissertation. To ensure anonymity you do not have to write down your name.

Please read and complete all questions carefully.

Thanks for your co-operation.

UNIVERSITY OF ZULULAND
Baseline data on HIV/AIDS

The objective of this survey is to obtain information about knowledge, attitudes and behaviour on HIV/AIDS pandemic. The information supplied will be strictly confidential. There are no wrong or write answers

Please answer all questions by placing a cross (X) in the appropriate box.

SECTION 1

1.1 Gender

Female	<input type="checkbox"/>	Male	<input type="checkbox"/>
--------	--------------------------	------	--------------------------

1.2 Age in years

21 – 30	<input type="checkbox"/>	31 – 40	<input type="checkbox"/>	41 – 50	<input type="checkbox"/>	50 and above	<input type="checkbox"/>
---------	--------------------------	---------	--------------------------	---------	--------------------------	--------------	--------------------------

1.3 Marital status

Single	<input type="checkbox"/>	married	<input type="checkbox"/>	Living with partner	<input type="checkbox"/>	Widow	<input type="checkbox"/>	divorce	<input type="checkbox"/>
--------	--------------------------	---------	--------------------------	---------------------	--------------------------	-------	--------------------------	---------	--------------------------

1.4 Race

African	<input type="checkbox"/>	Colored	<input type="checkbox"/>	Indian	<input type="checkbox"/>	White	<input type="checkbox"/>
---------	--------------------------	---------	--------------------------	--------	--------------------------	-------	--------------------------

1.5 Work section

Academic	<input type="checkbox"/>	Administration	<input type="checkbox"/>	Support	<input type="checkbox"/>
----------	--------------------------	----------------	--------------------------	---------	--------------------------

SECTION 2

2.1 Is AIDS a curable disease?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2.2 people with multiple partners are at greater risk of getting infected with HIV.

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2.3 Does HIV cause AIDS?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2.4 Everybody is at risk of contacting HIV.

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2.5 Women are at greater risk of contacting HIV.

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2.6 Unprotected sex with anybody place man at risk of becoming infected with HIV.

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2.7 HIV is the disease that affects mainly the gay people

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2.8 prompt treatment of STIs is one sure way of reducing HIV transmission.

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2.9 you can get HIV infection through kissing.

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2.10 It is safe to share the same cups, plates and utensils with HIV positive people.

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2.11 have you ever been exposed to condom use?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2.12 have you ever been exposed to condom use demonstration?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2.13 do you know about retroviral treatment?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

2.14 It is important to know your HIV status

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

SECTION 3

3.1 If you were to have a room- mate/class- mate who is living with HIV, would you accept him or her?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

3.2 If you were to classmate/ roommate who has fully blown AIDS, would you accept him/her?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

3.3 do you thing people who are infected need sympathy?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

3.4 do you thing people who are infected need your support?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

3.5 do you think people who are infected are entitled to treatment?

Yes		No	
-----	--	----	--

3.6 do you think it is important for infected people to tell their sexual partners about their HIV status?

Yes		No	
-----	--	----	--

3.7 do you think it is important for HIV infected people to tell their families about their HIV status?

Yes		No	
-----	--	----	--

SECTION 4

4.1 Are you sexually active?

Yes		No	
-----	--	----	--

4.2 Do you have penetrative sex (penis to vagina) with your partner?

Yes		No	
-----	--	----	--

4.3 Do you condomise?

Yes		No	
-----	--	----	--

4.4 Do you carry your own supply of condoms?

Yes		No	
-----	--	----	--

4.5 Does your partner decide about condom use in your relationship?

Yes		No	
-----	--	----	--

4.6 Can you say no to sex without a condom?

Yes		No	
-----	--	----	--

THANK YOU FOR YOUR CO-OPERATION IN THIS SURVEY.

UNIVERSITY OF ZULULAND
Baseline data on HIV/AIDS

The objective of this survey is to obtain information about knowledge, attitudes and behaviour on HIV/AIDS pandemic. The information supplied will be strictly confidential. There are no wrong or write answers

Please answer all questions by placing a cross (X) in the appropriate box.

SECTION 1

1.3 Gender

Female	1	Male	2
--------	---	------	---

1.4 Age in years

21 – 30	1	31 – 40	1	41 – 50	3	50 and above	4
---------	---	---------	---	---------	---	--------------	---

1.3 Marital status

single	1	married	2	Living with partner	3	Widow	4	divorce	5
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1.5 Race

African	1	Colored	2	Indian	3	White	4
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1.5 Work section

Academic	1	Administration	2	Support	3
----------	---	----------------	---	---------	---

SECTION 2

2.1 Is AIDS a curable disease?

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

2.2 people with multiple partners are at greater risk of getting infected with HIV.

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

2.3 Does HIV cause AIDS?

Yes	1	No	1
-----	---	----	---

2.4 Everybody is at risk of contacting HIV.

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

2.5 Women are at greater risk of contacting HIV.

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

2.6 Unprotected sex with anybody place man at risk of becoming infected with HIV.

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

2.7 HIV is the disease that affects mainly the gay people

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

2.8 prompt treatment of STIs is one sure way of reducing HIV transmission.

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

2.9 you can get HIV infection through kissing.

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

2.10 It is safe to share the same cups, plates and utensils with HIV positive people.

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

2.11 have you ever been exposed to condom use?

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

2.12 have you ever been exposed to condom use demonstration?

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

2.13 do you know about retroviral treatment?

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

2.14 It is important to know your HIV status

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

SECTION 3

3.1 If you were to have a room- mate/class- mate who is living with HIV, would you accept him or her?

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

3.2 If you were to classmate/ roommate who is fully blown AIDS, would you accept him/her?

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

3.3 do you thing people who are infected need sympathy?

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

3.4 do you thing people who are infected need your support?

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

3.5 do you think people who are infected are entitled to treatment?

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

3.6 do you think it is important for infected people to tell their sexual partners about their HIV status?

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

3.7 do you think it is important for HIV infected people to tell their families about their HIV status?

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

SECTION 4

4.1 Are you sexually active?

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

4.2 Do you have penetrative sex (penis to vagina) with your partner?

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

4.3 Do you condomise?

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

4.4 Do you carry your own supply of condoms?

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

4.5 Who decides about condom use in the relationship?

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

4.6 can you say no to sex without a condom?

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

THANK YOU FOR YOUR CO-OPERATION IN THIS SURVEY.

APPENDIX B

P.O BOX 1254
PONGOLA
3170

23 April 2005

The Research Committee
University of Zululand
Private Bag X 1001
KWA-DLANGEZWA
3886

Dear Sir or Madam

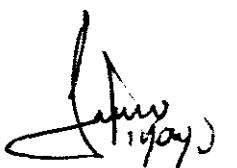
REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I write to request for the permission to conduct research within the University of Zululand main campus. My research study is entitled *The impact of HIV/AIDS peer education program on condom use of fulltime students at the university of Zululand main campus.*

I am currently enrolled with the University of Zululand doing Masters Degree in Clinical Psychology in the department of psychology. This study will benefit HIV/AIDS peer education program facilitator and students to stop the spread of HIV/AIDS at the University of Zululand.

Looking forward to hearing from you.

Yours Faithfully



VUSI SIYAYA

P.O Box 1254
PONGOŁA
3170

20 October 2006

HIV/AIDS Committee
University of Zululand
Private Bag X 1001
KWA- DLANGEZWA
3886

**REQUEST FOR INFORMATION ON HIV/AIDS PEER EDUCATION
PROGRAM AT THE UNIVERSITY OF ZULULAND**

I write to request for information on the HIV/AIDS peer education program at the University of Zululand.

I am currently registered with the University of Zululand in the Department of Psychology doing Masters degree in Clinical Psychology. I am conducting a research study within the University of Zululand entitled *The impact of HIV/AIDS peer education program on condom use of fulltime students at the University of Zululand main campus.*

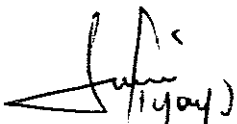
The information requested includes:

- the implementation of the HIV/AIDS peer education program at the University of Zululand and
- the objectives of the program.

The information provided will be used to complete the Masters dissertation.

Thank you.

Yours Faithfully


VUSI SIYAYA