

SUBMITTED IN PARTIAL FULFILMENT OF:
MASTERS DEGREE (EDUCATIONAL PSYCHOLOGY)

DEPARTMENT OF EDUCATIONAL
PSYCHOLOGY AND SPECIAL
EDUCATION

UNIVERSITY OF ZULULAND

NAME: Julie Lenore Cromhout

STUDENT NUMBER: 021486

QUALIFICATIONS: B.A. (Hons) Psychology (Rhodes University, East London)
H.D.E. (Rhodes University, Grahamstown)

POSTAL ADDRESS: P.O. Box 19070
Tecoma, 5214
East London

TELEPHONE NUMBER: (043) 737-4843

THESIS TOPIC: **“WILDFIRE” AS AN EFFECTIVE PREVENTATIVE
INTERVENTION FOR HIV/AIDS AMONG SECONDARY
SCHOOL LEARNERS.**

FACULTY: Education

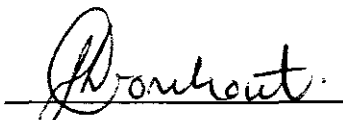
DEPARTMENT: Educational Psychology and Special Education

SUPERVISOR: Professor D.R. Nzima

DECEMBER 2005

DECLARATIONS

Unless specifically stated to the contrary in the text, this thesis is the original work of the undersigned.

A handwritten signature in cursive script, appearing to read "J. Cromhout", is written over a horizontal line.

JULIE CROMHOUT

I hereby declare that this thesis/dissertation has been submitted for examination with/without my approval.

PROFESSOR D.R. NZIMA

(Supervisor)

DATE

ACKNOWLEDGEMENTS

I wish to thank the following people for their assistance:

From the Department of Education in the Eastern Cape: Dr. Greef, Mrs Broberg, Johann Rich, and Ms Moniwa. The Principals and Life Orientation educators of the participating schools who I cannot name for confidentiality purposes, all of whom went out of their way to support the research process in spite of busy schedules.

From the Small Projects Foundation (SPF): Paul Cromhout for guidance and fulfilling the role of research assistant in administering “Wildfire”. Visa Magadla for translations of letters to parents into Xhosa. Vuyelwa Ngcaba and Liziwe Tiya, for their roles as research assistants and data capture. Ruth Backhouse for her help with data capture, typing and helping with the final document.

I wish to acknowledge that Professor Nzima was in charge of supervising this project.

Don Junor for ongoing encouragement. Heidi Smulders, Jane Ingham and Barbara Gerber for contributing to the proof reading. Lorraine Holmberg for assisting with data. Lauren and Allison Kidson and Gabriela Cromhout for pre-testing and helping with the preparation of the questionnaire.

Margaret Irvine and Xoliswa Mtose from the University of Fort Hare’s Department of Education for helping with orientation that prepared me for the project.

My husband Paul and children Gabriela, Luke and Sarah for their love, patience and support, including help with cross-checking contents.

Most of all I wish to thank the young people all one hundred and four, who volunteered to participate in this joint venture in the fight against HIV/AIDS.

NOTE: It is acknowledged that this investigation is larger than is necessary for academic purposes but the reasons for this in terms of relevance, will become evident to the reader.

ABSTRACT

The aim of the study was to conduct a formative investigation into the effectiveness of “Wildfire” as a preventative intervention for HIV/AIDS. “Wildfire” is an experiential activity-based psycho-educational workshop/game that guides participants through the process of ‘exposure’ to HIV/AIDS, voluntary counseling and testing (VCT). It stimulates discussions and active reflections while imparting knowledge and information that goes beyond preventative awareness campaigns. The target population was Grade 9 learners. A representative sample of rural and township school contexts in the East London area of the Eastern Cape constituted the sites for intervention. The schools selected constituted a convenience sample and learner participation was voluntary, depending on parental permission. A total of 104 learners participated, 95 in the “Wildfire” intervention and 9 in the control group.

The methodology applied included a pre- and post-test questionnaire, behavioural observations and verbal responses during the intervention, as well as focus-group notes arising from the debriefing after “Wildfire”.

The findings indicated that “Wildfire” was an effective and powerful psycho-educational tool for mediating an in-depth understanding of issues around HIV/AIDS and personal vulnerability for adolescents. The triangulation of methods provided evidence that the intended learnings of “Wildfire” were internalized to both group and individual levels. Furthermore, these points of planned learning were sustained over time. “Wildfire” provided psycho-social, emotional and cognitive ‘maps’ for individuals about how quickly HIV/AIDS can be spread, how to manage ‘exposure’ and how to treat those infected with the virus.

The study was situated within practices of primary health care and prevention of HIV/AIDS. Its relevance to answering research needs and corroborating current research findings has been discussed. The utility of the study for practical purposes, was that it informed the current and future practices of an NGO and provided information for the Education Department which could enrich the effectiveness of its current HIV/AIDS education in a cost-effective way.

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION

| | | |
|-------|---------------------------------------|----|
| 1.1 | Introduction | 1 |
| 1.2 | Wildfire: The Intervention | 3 |
| 1.3 | Motivation | 4 |
| 1.3.1 | Value of the Study | 5 |
| 1.4 | Statement of the Problem..... | 5 |
| 1.5 | Aims of the Study | 6 |
| 1.6 | Objectives of the Study..... | 6 |
| 1.7 | Research Design/Methodology..... | 7 |
| 1.7.1 | Research Participants / Sampling..... | 7 |
| 1.7.2 | Data Collection / Instruments | 8 |
| 1.7.3 | Data Analysis | 9 |
| 1.8 | Operational Definitions..... | 10 |
| 1.9 | Ethical Considerations | 10 |
| 1.10 | Summary | 11 |

CHAPTER 2

LITERATURE REVIEW

| | | |
|-------|--|----|
| 2.1 | Introduction | 12 |
| 2.2 | HIV/AIDS: A Situational Analysis..... | 13 |
| 2.3 | Preventative Health Care in the South African Context | 16 |
| 2.4 | Preventative Programmes | 19 |
| 2.5 | Issues of Mental Health | 19 |
| 2.6 | Risk Factors | 21 |
| 2.7 | Behaviour Change..... | 23 |
| 2.8 | Wildfire: The Psycho-Educational Intervention | 24 |
| 2.9 | Theoretical Assumptions Underlying the Implementation of “Wildfire”..... | 28 |
| 2.9.1 | Cognitive Theory | 29 |
| 2.9.2 | Educational Theory..... | 32 |
| 2.9.3 | Activity Theory..... | 34 |

| | | |
|-------|-----------------------|----|
| 2.9.4 | Psychoeducation | 35 |
| 2.10 | Summary | 35 |

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

| | | |
|-------|--|----|
| 3.1 | Introduction to the Decision Making Process | 37 |
| 3.2 | Conceptual Framework | 37 |
| 3.3 | Research Question | 38 |
| 3.4 | Research Design / Methodology | 38 |
| 3.4.1 | Ethics/ Permission to Undertake Research In the School Context..... | 38 |
| 3.4.2 | Sampling | 40 |
| 3.4.3 | Participants..... | 41 |
| 3.5 | Data Collection | 42 |
| 3.5.1 | Questionnaire | 42 |
| 3.5.2 | “Wildfire” Intervention..... | 45 |
| 3.5.3 | Research Assistants..... | 46 |
| 3.5.4 | Data Analysis..... | 47 |
| 3.6 | The Role of the Researcher..... | 48 |
| 3.7 | Summary | 49 |

CHAPTER 4

RESULTS AND DISCUSSION

| | | |
|---------|---|----|
| 4.1 | Pre-Test and Post-Test Comparisons | 50 |
| 4.1.1 | Section 1: Demographic Information..... | 50 |
| 4.1.2 | Section 2: HIV/AIDS Exposure to Knowledge And Information | 52 |
| 4.1.3 | Section 3: Knowledge about HIV/AIDS as a Disease | 55 |
| 4.1.4 | Section 4: Psycho-Social Aspects of Aids | 63 |
| 4.1.5 | Section 5: Sexual Contact | 68 |
| 4.1.5.1 | Discussion of Sexual Contact: Section 5 | 70 |
| 4.2 | Phase 2: “Wildfire” | 71 |
| 4.2.1 | “Wildfire” Observation Notes..... | 72 |
| 4.2.2 | Discussion of “Wildfire” Observation Notes..... | 77 |
| 4.2.3 | “Wildfire” Focus-Group Notes..... | 81 |

| | | |
|-------|---|-----|
| 4.2.4 | Discussion of Table 2: Notes from Focus-Group Discussions | 86 |
| 4.2.5 | Summary of Focus Group Results and Discussion..... | 93 |
| 4.3 | Post-Test Results on “Wildfire: Questionnaire: Section 6..... | 95 |
| 4.4 | Summary and Discussion on Post-Test Responses to “Wildfire” | 110 |

CHAPTER 5

| | | |
|-------------------------|---|-----|
| CONCLUSION | 112 | |
| 5.1 | Limitations of Research | 119 |
| 5.2 | Recommendations for Further Research..... | 120 |
| REFERENCES | 122 | |

LIST OF TABLES

| | | |
|-----------|--|-----|
| TABLE 1: | Numbers Participating | 42 |
| TABLE 2: | Responses to Question 4..... | 52 |
| TABLE 3: | Responses to Question 8a) “Do You Know Anyone Who Is Living With HIV/AIDS?” | 55 |
| TABLE 4: | Responses to Question 8b) “Do You Know Anyone Who Has Died From HIV/AIDS?” | 56 |
| TABLE 5: | Responses To Question 11: “If You Were Worried About Having HIV/AIDS Would You Want To Know Your Status?” | 58 |
| TABLE 6: | Responses to Question 19: “Do You Plan to Do Anything To Protect Yourself from HIV/AIDS?” | 64 |
| TABLE 7: | Responses To Question 23: “How Old Were You When You First Had Sexual Intercourse?”..... | 68 |
| TABLE 8: | Points of Planned Learning From “Wildfire” Using Focus-Group Notes | 82 |
| TABLE 9: | Response To Question 28: “Has Wildfire Changed The Way You Think About HIV/AIDS?” | 96 |
| TABLE 10: | Response-Frequency to Sections Of Question 29..... | 97 |
| TABLE 11: | Table: Cognitive – Emotional – Intention Sequence | 98 |
| TABLE 12: | Responses to Question 30: “Do You Think “Wildfire” Should Be Used In Schools to Help Young People Inform Themselves About HIV/AIDS?” | 100 |

| | |
|--|-----|
| TABLE 13: Responses To Question 31: “How Do You Rate “Wildfire” as a Way Of Informing Young People About HIV/AIDS?” | 100 |
| TABLE 14: Personal Responsibilities (Question 32) | 101 |
| TABLE 15: Social Responsibilities (Question 32)..... | 101 |
| TABLE 16: Responses To Question 33: “Has “Wildfire” Had Any Effect On The Way You Would Feel About/ Behave Towards People Living With HIV/AIDS?” | 101 |
| TABLE 17: Points of Planned Learning From “Wildfire” Using Individual Responses in The Post-Test Questionnaire..... | 104 |

LIST OF FIGURES

| | |
|---|-----|
| FIGURE 1: Participants’ Age Range in Grade 9..... | 51 |
| FIGURE 2: Participation of Volunteers across School Contexts, Including Gender..... | 51 |
| FIGURE 3: Behavioural Intentions around Issues of HIV/AIDS | 109 |

LIST OF APPENDICES

| | |
|---|-----|
| APPENDIX 1: “Wildfire”: Process Notes/ Preparation | 129 |
| APPENDIX 2: Full Questionnaire – Including Pre- and Post-Tests | 132 |
| APPENDIX 3: Application for Permission to Conduct Research..... | 144 |
| APPENDIX 4: Permission from East Cape Education Department..... | 150 |
| APPENDIX 5: Letter to Principals and Permission From School Management..... | 151 |
| APPENDIX 6: Letter to Parents and Permission Slip | 153 |
| APPENDIX 7a: Question 1 | 154 |
| APPENDIX 7b: Question 5 | 155 |
| APPENDIX 8: Question 6.1 | 157 |
| APPENDIX 9: Question 7 | 159 |
| APPENDIX 10: Question 10 | 160 |
| APPENDIX 11: Question 12 | 161 |
| APPENDIX 12: Question 13 | 162 |
| APPENDIX 13: Question 14 | 164 |
| APPENDIX 14: Question 15 | 166 |
| APPENDIX 15: Question 16 | 168 |
| APPENDIX 16: Question 17 | 170 |
| APPENDIX 17: Question 18 | 171 |

| | |
|--|-----|
| APPENDIX 18: Question 21 | 173 |
| APPENDIX 19: Question 22 | 175 |
| APPENDIX 20: Question 24 | 176 |
| APPENDIX 21: Question 25 | 177 |
| APPENDIX 22: Question 26 and Question 27 | 178 |
| APPENDIX 23: Question 35: Rank Ordering of Active Intentions | 179 |

CHAPTER 1

INTRODUCTION

“AIDS is different from any other epidemic disease that has ever plagued the world. It is not only incurable...it challenges our deepest secrets and taboos about sex and death – whether as individuals or as a community” (Van Dyk, 2001: 82).

1.1 Introduction

The practice of psychology in contemporary South Africa is in the process of undergoing a major shift from western, clinical frameworks to community-based preventative health care. Mental health services have been located within the domain of primary health care which focuses on policies that are both promotive of physical and mental well-being as well as preventative of ill-health (ANC, 1994; Averasturi, 1998; Denill, King, Lock & Swanepoel, 1995; Freeman, 2004). The challenge presented by this shift, includes the provision of affordable, accessible and relevant health care to a multi-cultural, multi-lingual society currently undergoing rapid social change.

The diverse nature of the South African context is further complicated by the HIV/AIDS pandemic. HIV/AIDS has had far-reaching implications for the physical and mental well-being of the South African population, with HIV/AIDS accounting for one in every four deaths (Mail & Guardian, Oct. 5-11: 2001). Various authors have identified the mental health consequences both in the wider ecological system as well as on an individual level, of the HIV/AIDS pandemic (Freeman, 2004; van Dyk & van Dyk, 2004; Oppong & Ghosh in Kalipeni, Craddock, Oppong & Ghosh, 2004). It is contended therefore, that the challenge on both an individual level and at community level presented by HIV/AIDS, is a primary health care issue which concerns psychological practice and requires psychological intervention.

Freeman calls for “more research and interventions... in order to obviate a potential mental health and social ‘disaster’” (2004: 139). This view is echoed by Macleod who contends that in order for psychology to become more relevant in South Africa, there is a need for “applied work...to inform practices that dovetail with the central

socio-political issues” (2004: 615). Macleod further states that HIV/AIDS enjoys a “relatively low profile” (2004: 618) as do “studies having children or teenagers as participants” (2004: 622). This suggests a gap in research, which needs attention.

Voluntary Counselling and Testing (VCT) has been considered a tool in the management of HIV/AIDS infections as well as a preventative measure supposedly facilitating behaviour change. van Dyk and van Dyk’s research (2003) used participants between 20 and 40 years of age, leaving a gap in information concerning younger populations. Other research has used participants at tertiary levels of education, Peltzer (2003) and Akande (2001) for example – again leaving a gap in information regarding younger populations. Furthermore, research conducted (Macleod, 2002; Kalipeni et.al., 2004) indicates that by the age of 20, the majority of the population is already sexually active. These findings suggest that preventative interventions may possibly be effective if targeted at adolescents at the stage when they are grappling with issues related to choices and decisions around sexual identity formation.

It is the concern of this study to implement and formulate conclusions about the effectiveness of an intervention directly related to HIV/AIDS, which has potential to have preventative repercussions in the age-group represented by Grade 9 secondary school learners and thereby make an attempt to fill the gap referred to by Macleod (2004), in terms of age and relevance of topic. According to developmental theory, adolescence is characterised by *identity formation, including sexual identity as well as the importance of the group* (Santrock, 2002; Craig 1980). This, coupled with research in Sub-Saharan Africa regarding the age of onset of sexual activity, plus epidemiological data indicating that 2 out of 3 young adult HIV/AIDS infections were contracted during adolescence (Nduati & Kiai, 1997; Cleland & Ferry cited in Cohen & Trussell, 1996) provide additional rationale for focussing preventative approaches to HIV/AIDS on this age group.

1.2 “Wildfire”: the Intervention

“Wildfire” is the name given to the intervention or psycho-educational technique which simulates exposure to HIV/AIDS and VCT and is the subject of enquiry in this investigation. It is assumed that the term “Wildfire” refers to the rapidity with which the epidemic spreads, if available precautions are not adopted. This intervention is experiential in nature and requires the consenting target population to immerse themselves in a role-play exercise that simulates the experience of exposure to HIV/AIDS and VCT. For this reason, “Wildfire”, as simulation of a real life situation becomes the mediator – or agent of socialisation (Vygotsky, 1978: 57), potentially providing the participants with the opportunity to engage their higher mental processes around issues of self and HIV/AIDS. It is the intention of this study to take knowledge and information about HIV/AIDS that is already being implemented in schools through the Life Orientation section of the curriculum a step further, by implementing “Wildfire” as a psycho-educational tool. Hoosen and Collins contend that knowledge and information alone is “not enough to translate into safe sexual practices” (2004: 487) and for this reason, “Wildfire” has potential to take prevention onto an experiential level, and hopefully provide opportunities for learners to consider safer practices. Section 2.7 (below) and Appendix 1 contain further details on “Wildfire”.

The following is a brief overview of how “Wildfire” is conducted as a psycho-educational intervention:

The workshop begins with the participants standing in a circle with their eyes closed. Certain people are ‘identified’ as being HIV positive, by being touched on the shoulder – the ‘news’ is only known to that person. Everyone is then invited to engage in ‘casual sex’ in the form of handshaking. The ‘HIV positive’ participants are instructed that they can scratch the hands of whoever shakes hands with them, and by so doing ‘expose’ the other to HIV. These people have then been ‘exposed’ to HIV and can then ‘expose’ others who shake hands with them. Preventative measures (represented by surgical gloves for the purposes of this study) are available in the room, should the participants choose to use them.

The facilitator then asks the participants who have been 'exposed', to identify themselves. All members of the group then engage in a reflective discussion regarding this simulated exposure to the HIV virus. Those who have been 'exposed', are then asked whether they are willing to be 'tested'. Those who are willing to be tested are then handed their 'results' in an envelope (both 'positive' and 'negative' results are given). They are asked how they feel prior to receiving the results and then are invited to open the envelopes. They are then faced with the choice of declaring their 'status'. Discussions on feelings, reflections of actions and reinforcement of knowledge and information then occurs. A thorough debriefing process then takes place, including discussions on plans, feelings and thoughts regarding the experience of the role-play. It is strongly emphasised that this is only a role-play and is not a real situation.

The theoretical underpinnings of this study are based on preventative mental health, community psychology, social learning theory and experiential learning in association with behaviour change, all of which emphasise the process of change involving the shift from explicit to implicit knowledge, using a concrete experience and transferring this to action (Andreasen, 1995; Kolb, Robin & McIntyre, 1984; Vygotsky, 1978). Developmental theory as well as research regarding the age of onset of sexual activity, provides the rationale for the age group of the participants.

1.3 Motivation

The motivation for this investigation is threefold. Firstly it is based on making a contribution to the apparent dearth in research, knowledge and information concerning HIV/AIDS prevention and younger populations. Secondly, this study is in line with current theoretical shifts concerning the relevance of psychology in contemporary South Africa (Gilbert, 1995; de la Rey & Isper, 2004; Macloed, 2004), in that it is community-based (the school context being the particular community targeted). The intention is for the intervention of the research itself, to be preventative and in so doing, promotive of physical and mental well-being. The third and most compelling reason for the research is practical and action research based, in that the findings will inform the practices of a local NGO, the Small Projects Foundation, with regard to the implementation of "Wildfire" on younger populations. In short, the

research is rooted in research needs, current and relevant theory that informs current practices related to the socio-political topic of HIV/AIDS.

1.3.1 Value of the Study

Anecdotal reports on the efficacy of the “Wildfire” technique on adult participants of HIV/AIDS interventions in communities in the Eastern Cape Province, regarding their personal responses on an emotive and cognitive level, beg for verifiable validation and insight. The Small Projects Foundation, an NGO (non-governmental organisation) approached the researcher with the request to examine the efficacy of “Wildfire” on adolescents to inform their current and possible future practices with regard to HIV/AIDS interventions. Furthermore, it is an intervention that is affordable, accessible and relevant to the current South African situation and in this sense, satisfies the criteria represented by the shift in focus from individualised clinical frameworks of mental health, to the domain of primary health care, in South African psychology.

1.4 Statement of the Problem

The issue of HIV/AIDS is a serious and relevant topic in contemporary South Africa. There is no room for trial and error in human relations in the context of naturalistic social learning regarding HIV/AIDS, as the consequences are potentially life-threatening. This is particularly pertinent to the adolescent population. Therefore natural social learning principles such as learning from mistakes and modelling the behaviour of adults becomes null and void in the face of the rising HIV/AIDS pandemic. Indeed, Whiteside and Sunter (2000) claim that in the face of HIV/AIDS, principles that have been taken for granted norms are overturned. Any interventions, strategies and ‘techniques’ regarding HIV/AIDS prevention require scientific investigation and validation for ethical reasons (Weissberg, Kumpfer & Seligman, 2003) – this is especially the case when the intervention is psychological in nature, and “Wildfire” appears to fulfil such criteria.

The core question of this study therefore, is:

Is “Wildfire” an effective preventative intervention for HIV/AIDS among secondary school learners?

1.5 Aims of the Study

The aim that is central to this inquiry, was to conduct a formative investigation of “Wildfire” as a psycho-educational intervention in the secondary school context. A formative study can be defined as “being developmental in nature” the point of which “is to support the teaching and learning process” (van Rooyen & Prinsloo, 2002: 41). In line with this definition derived from outcomes – based education, in assessing the effectiveness of “Wildfire”, the study’s aim was also to support and add to the ongoing input of HIV/AIDS related learning that is part of the Life Skills/Life Orientation section of the new outcomes-based curriculum in schools. Briefly then, the aim of the research investigation was to extrapolate/formulate/explore conclusions about “Wildfire” as an effective psycho-educational tool for HIV/AIDS prevention in a user-friendly way within the school context (targeting adolescents at Grade 9 level), using rigorous research methods.

1.6 Objectives of the Study

In keeping with current research practices as reflected in the South African Journal of Psychology (SAJP) as well as a baseline survey conducted for the East Cape Education Department (Macleod 2002) all of whom have adopted the questionnaire as their instrument of choice, this research investigation’s objectives in terms of data collection are as follows:

In adopting a pre-test, post-test method of data collection, information comparable to other HIV/AIDS research studies, was collected for the purposes of “time trend monitoring” (Peltzer, 2003: 250). This included monitoring regarding:

- a) demographic information,
- b) knowledge and information about HIV/AIDS and through whom/via which forum this information was gained,
- c) questions regarding attitudes toward people living with HIV/AIDS,
- d) questions that adolescents have about HIV/AIDS,
- e) self-efficacy questions on how the adolescents planned to protect themselves from HIV/AIDS and,
- f) sexual behaviour.

The researcher believes that any and all information gathered through data collection is pertinent to the ongoing search for solutions to the HIV/AIDS pandemic. These objectives were formulated with the intention of adding to the 'pool' of knowledge related to an adolescent population for the following purposes: providing feedback to the Eastern Cape Education Department, for providing feedback to the staff at the participating schools and for providing feedback to the learners themselves. The point of providing feedback is to provide information that can potentially inform future HIV/AIDS input in schools. These objectives supplement the aims of the study – namely to evaluate the effectiveness of “Wildfire” - in that in comparing responses to the pre- and post-test questionnaires, adopting these objectives will provide information that may suggest a shift in the participants' responses and thereby indicate the effectiveness of “Wildfire” as a psycho-educational tool.

1.7 Research Design/Methodology

In terms of design, the investigation constituted a formative/process evaluation of the effectiveness of “Wildfire” as a psycho-educational intervention on an adolescent population, using an experimental design to reflect the process. This was conducted in three phases to provide for methodological rigour.

PHASE 1: pre-test questionnaire, to serve as a base-line for the investigation in terms of knowledge and information and so inform the administration of “Wildfire”

PHASE 2: administering the 'test', namely “Wildfire” with data gathering including observation notes on behaviour and verbal responses from the intervention and learners' notes emerging from a focus group discussion.

PHASE 3: post-test questionnaire which was exactly the same as the pre-test, with questions on “Wildfire” added.

1.7.1 Research Participants/Sampling

There were two levels to co-opting participants in this research endeavour. Firstly, there were the schools and secondly, there were the learners. In terms of the schools, five schools participated – two rural (one of which was a boarding school), two township schools (one of which serves a predominantly informal settlement community) and one control school that was a township school. The schools

constituted a convenience sample and were contacted through a member of the Department of Education. In this investigation, Grade 9 learners at secondary school level were targeted for intervention. According to developmental theorists, adolescent learners are grappling with resolution of identity – which includes sexual identity – as well as being influenced by peers. These theoretical underpinnings firmly place the secondary school learner in a vulnerable situation regarding HIV/AIDS and so justify the age of intervention.

The researcher decided to target Grade 9 learners because this level represents one of the exit points from the education system and therefore provided a potential range of learners, some of whom may leave school at the end of the year and so possibly not have the opportunity to be exposed to HIV/AIDS preventative interventions thereafter. Traditionally Grade 9 learners are in the age group 14, turning 15 which, according to research (Macleod, 2002), place them at that stage of adolescence where some will be grappling with and possibly beginning sexual activity. Furthermore, the Child Care Act 74 of 1983 “provides that people over the age of 14 years are competent to consent to any medical [or psychological] treatment...” (Allan, 2001: 31) This provided a clear legal/ethical guide as to the age for intervention –which was considered especially significant in that the Grade 9 learners were invited to volunteer their participation in the schools targeted. No learner under the age of 14 was allowed to volunteer.

The participants therefore consisted of a sample of five different school contexts, in which Grade 9 learners volunteered their participation. There were ninety five participants in the “Wildfire” schools and nine in the control school ($n=104$).

1.7.2 Data Collection/Instruments

Data was gathered using a pre-test questionnaire and a post-test questionnaire as the principal instruments in fulfilling the aims and objectives of this research investigation. The questionnaires included fixed response as well as open-ended questions and their content was exactly the same, with the post-test having questions related to “Wildfire” added at the end. In order to add rigour to the data gathering, the data collection was triangulated by adopting a qualitative approach. In this section, the

researcher adopted the role of observer during the “Wildfire” intervention – specifically to record emerging verbal and behavioural/emotional reactions to “Wildfire”. Additionally, a debriefing exercise was implemented after “Wildfire” itself, in which focus groups of learners were asked to discuss and briefly list what they had learned from “Wildfire”. The same research facilitator presented “Wildfire” in each of the school contexts, to control for variation in presentation and relationship with the learners.

1.7.3 Data Analysis

In adopting the use of the questionnaire as the instrument of choice, it was possible to compare the learners’ self-reported responses between the pre-test and the post-test and analyse it according to the following criteria:

1. determining whether there was a quantitative or qualitative shift between pre-test and post-test questionnaires on the following bases: general, comparing rural-urban responses, comparing responses across gender. This section of the analysis was undertaken and recorded by referring to the sub-sections of the questionnaire. Comparison with data collected from the control school, was made. Data derived from all five schools ie: schools A, B, C and D, and E was used in the analysis.
2. In adopting the role of observer, the researcher made observation notes during the “Wildfire” intervention itself. These notes took the form of behavioural observations and feedback on verbal and emotional responses as communicated by the research assistant during “Wildfire”. These notes were read and re-read as a form of immersion in the experience, to determine whether there were any emergent themes. Data from schools participating in “Wildfire” – ie: schools A, B, C and D, was used.
3. After “Wildfire” was administered, a de-briefing exercise was conducted, during which small groups of learners discussed and recorded, in point form, what they had learned during “Wildfire”. In order to answer the research question as to the effectiveness of “Wildfire”, these written points were organised according to school and then compared to a basic list of the possible

learnings that could be derived from “Wildfire”. Schools A, B, C and D were used for this phase of data analysis.

1.8 Operational Definitions

Adolescents: This term will be referred to interchangeably with youths, teenagers and young people in this study (Kelly, Parker & Oyosi, 2002: 4). This term is defined by the World Health Organisation (WHO) as occurring between 15 and 24 years of age and by the Centres for Disease Control as between 13 and 19 years. For the purposes of this study, adolescence will refer to learners between the ages of 14 and 19 years of age and specifies that group of people who are no longer children but not yet functioning as adults in the sense of being responsible economically productive members of their communities, because of school attendance. Specifically, adolescents will refer to that group of learners represented in Grade 9 of the participating school sample.

Effective: In answering the research question, the term “effective” will relate to Visser’s recommendations for AIDS prevention programmes (1995: 136) and van Dyk’s factors that contribute to behaviour change (2001: 84). Section 2.4 (below) provides details.

1.9 Ethical Considerations

Allan (2001) states that the “Child Care Act 74 of 1983 provides the people over the age of 14 years are competent to consent to any medical [or psychological] treatment...” (Allan, 2001: 31) which provides a clear legal guide for this research i.e. that no learner below the age of fourteen was invited to participate. The provisos for conducting research in school settings, as set out by the Eastern Cape Education Department, were adhered to at all times – including signed permission from the Principal, Head of the Governing Body, parents and the ‘assent’ (Kelly, 2000) of those learners volunteering to participate. In keeping with Kelly’s contention that young people constitute a “special population”, respect for the privacy of these adolescent participants was upheld in the following ways: by using self-report in

answering the questionnaires, by taking general notes and not video-taping the “Wildfire” intervention.

As far as contact with the participants is concerned, full explanations with respect to a basic understanding of research and constitutional rights was provided by the facilitator(s). Confidentiality regarding identity was assured and a simple numbered coding system adopted. The researcher offered counselling services to the school and learners, in case of any need arising from the research intervention.

1.10 Summary

In essence, this research investigation intends to synthesise some contemporary views on the practice of psychology in South Africa in the primary and preventative health care arena (in this case, in the context of schools), with the crisis of the HIV/AIDS pandemic. The theoretical underpinnings of the intervention are grounded in social learning and developmental theory (Chapter 2 below deals with the theory in which this investigation is embedded). Sampling and co-opting of participants occurred at school level (a convenience sample), and through inviting Grade 9 learners to volunteer their participation. After following the requisite ethical and legal guidelines relevant to this population the data gathering was instituted, adopting a pre-test and post-test questionnaire as the instrument of the study. The ‘test’ itself, was the middle phase of data gathering – this was the psycho-educational intervention of “Wildfire” (Chapter 3 below further illuminates the details of the research design).

The data was analysed by comparing rural and urban school contexts, on a gender basis. This was then compared to the control school as well as having observation and feedback notes during “Wildfire”, to provide rigour in the attempt to answer the research question as to whether “Wildfire” is an effective intervention. Chapter 4 will set out the findings of this research investigation, along with a discussion. In Chapter 5, conclusions will be made regarding an answer to the research question and recommendations for further research, made.

CHAPTER 2

LITERATURE REVIEW

“If we say we believe in the future of our country, it also means that we believe in our duty to look after and care for the future of our country, which is our children” (van Jaarsveld: Daily Dispatch 15 November 2001).

2.1 Introduction

This chapter provides the underlying theoretical premises upon which this research investigation is based. There exists an enormous body of research and writing related to HIV/AIDS, which is ongoing and evolving. This ranges over many fields of inquiry from medical monitoring of the disease itself, including symptoms, physical risk factors, progression, treatment and management (Evian, 2000), to an appreciation of the importance of more holistic, ecologically focused societal and community involvement /participation in the maintenance and spread of HIV/AIDS. The potential for adopting multilevel ecological approaches and research studies has also been recognized as well as implemented in prevention programmes, (Shisana & Simbayi, 2002; Macleod, 2002; Akande, 2001; Cohen & Trussell, 1996; Seedat, Duncan & Lazarus, 2001; Bhana, Petersen, Mason, Mahintsho, Bell & McKay, 2004; Rogers, 2000).

The range extends to the recognition that HIV/AIDS can be prevented through the choices and decisions that individuals make. In response to this, theories of individual strengths such as self-efficacy, behaviour change and behavioural intentions (Akande, 2001; Rogers, 2000) have been applied to HIV/AIDS related behaviour. The need for personal empowerment and skills in relationships and the sexual negotiation of, for example the use of condoms has also been highlighted (Akande, 2001)

What is generally agreed upon however, is that awareness is the first step in prevention, but that preventative input needs to extend beyond the notion that awareness is sufficient in the prevention of HIV/AIDS. Indeed, “Promoting sexual health in the age of HIV/AIDS necessitates the acknowledgement of behavioural and social aspects of sexuality, as well as psychosocial approaches and skills that could arm young people with decision-making skills to enable them to make sensible and safe choices out of motives other than fear of disapproval is vitally important”

(Akande, 2001). It is the intention of this study to implement an intervention, “Wildfire”, that will provide opportunities for adolescents to ‘go beyond awareness’.

The body of knowledge related to HIV/AIDS is extensive, much of which is beyond the scope of the present study. Therefore, for the purposes of this inquiry, HIV/AIDS-related theory and research will be focused on issues of youth, community preventative interventions, the educational context and theories of learning underlying the rationale for implementing “Wildfire”.

2.2 HIV/AIDS a Situational Analysis

According to the 2004 Report on the Global AIDS epidemic, released by UNAIDS, South Africa has the largest number of people who are seropositive in any single country in the world (estimates are 5,3 million). The mean prevalence rate for HIV in the age group 15 – 49, is 21.5 %. At the end of 2003, this report gives the mean number of children (0 – 15 years) living with HIV infection, as 230 000 and the estimated number of children (below 17 years) orphaned by the loss of one or more parents to AIDS at the end of 2003, as 1, 100 000. These figures are calculated using published estimates for 1999 and 2001, deaths related to HIV/AIDS and mother-to-child transmission, using a methodology that produces indicators for individual countries. Significant to the present study, East London is indicated on a map showing trends of HIV prevalence in antenatal clinics, as having 20-29 9 % seropositivity in pregnant women, suggesting that it is a nodal risk area that needs attention (UNAIDS, 2004). This report highlights the need for preventative interventions: “Although prevention is the mainstay of the response to AIDS, fewer than one in five people world-wide have access to HIV prevention services. Comprehensive prevention could avert 29 million of the 45 million new infections projected to occur this decade.” (UNAIDS, 2004: 11)

A recent article in the Mail & Guardian (September 2-8, 2005) reports that over 16 % of people under 20 years old are currently infected with HIV/AIDS, a rise of 4 % in just one year. This article in the popular press is reporting information on a study by Rhodes University’s Centre for Aids Development and Research (CADRE), commissioned by the Eastern Cape Government and is controversial in its findings. If

the findings of one in 10 people in the Eastern Cape, being HIV-positive are correct, there is cause for great concern – the projection of these statistics indicate that by 2015, 7 million people will die of Aids. The urgency of finding effective interventions is stressed in this article.

There appears to be a gap in published research in terms of the position of South African youth around issues of HIV/AIDS. MacPhail recommends that “social norms and values affecting adolescents in South Africa require localized research” (1998: 79). This suggests that while research internationally may be relevant and there is a lot of it (Macleod 2004), the situation on the ground in South Africa needs specific investigation. The present study constitutes localized research – specifically in the East London area of the Eastern Cape Province.

The decision to target adolescents as participants in this study, was based on the findings of a Base-Line Survey conducted for the Eastern Cape Department of Education (Macleod, 2002). The findings of this study report that on average, adolescents initiate sexual contact at 14 years, with males beginning earlier at 13,5 years and females at 14,9 years – 28 % of whom report having more than one partner, with more township males reporting this (34,8 %) than urban, rural or female learners. 56,4 % of sexually active learners reported using condoms. Of concern in these findings, was that 23,5 % of learners reported having been coerced into sexual contact and, youngest partners reported to be “4-years –old and the oldest 36-years-old” (Macleod, 2002: ii).

Macleod’s findings, when compared to those reported by Cleland & Ferry (cited in Cohen and Trussell, 1996: 117) show that the age of onset of sexual activity in the Eastern Cape is more or less contiguous with that elsewhere in Africa, with males generally being more active at the age of 15 than females. Various explanations for this are discussed by Cohen & Trussell (1996), including traditional, culturally acceptable ages of marriage/formalisation of partnerships, as well as education being a possible factor in delaying marriage and so increasing the incidence of sexual contact outside marriage. “This young age at sexual debut is important when targeting populations for intervention, particularly in light of the work by Konings et al. showing a correlation between the early onset of sexual activity and large numbers of

partners.” (cited in Cohen & Trussell, 2000) Such findings locally and elsewhere in Africa, provide a clear rationale for targeting interventions in early adolescence in order to control for risk factors.

Other significant findings pertinent to the present study, suggest that learners would prefer to obtain HIV/AIDS information within the school setting and that more information on helping those infected and affected by HIV/AIDS was needed (Macleod, 2002). In being guided by the findings of the Base-Line Survey (some of which have been reported above) this research investigation has adopted the stance that, for preventative purposes, interventions aimed at adolescents need to target the 13 to 15 year age bracket. Grade 9 learners were consequently targeted, working on the assumption that the expected age of entry to Grade 9 is 14 years. Some of Macleod’s (2002) findings will be compared to the data emerging from the present investigation, especially in the ‘sexual contact’ section of the questionnaire.

A survey conducted by Andersson, under the auspices of Community Information, Empowerment and Transparency (CIET) revealed that, of a sample of 27 000 youths participating in the social audit of sexual violence in Southern Johannesburg, “one in 20 school girls aged 15 – 18 had been raped in the year prior to the survey.” (Daily Dispatch, 19 November 2001) This “sexualisation of violence against children and women” (Andersson cited in Daily Dispatch, 2001) which has been widely publicized in the popular press, is a complicating factor in the current state of the HIV/AIDS pandemic in South Africa. This type of information serves to emphasise the urgency of the need for ongoing interventions as well the search for more effective preventative interventions related to HIV/AIDS with the youth in South Africa (Macleod, 2004; Akande 2001; Parker, Dalrymple and Durden, 1998).

While educational interventions cannot, per se, prevent sexual violence being perpetrated against young people, a case can be made for the intervention (“Wildfire” in this case) being useful in terms of rights, choices, and Voluntary Counseling and Testing (VCT), should an adolescent be concerned about his/her status with respect to HIV/AIDS. It is submitted that this investigation on the effectiveness of “Wildfire” in school contexts, is an attempt to fulfill the need for evaluating and searching for interventions that may contribute to the fight against HIV/AIDS, as well as answering

van Jaarsveld's call (see quote at the beginning of the chapter) to take responsibility for our children.

2.3 Preventative Health Care in the South African Context

Authors in the community mental health field are calling for attention to be paid to the mental health needs of children, especially for "disadvantaged children whose parents are not able to afford mental health consultations or even identify problems as being psychological in nature" (Pillay & Lockhat, 2001: 88). The psychological nature of HIV/AIDS in the wider socio-political context has been recognized in studies recently published (van Dyk & van Dyk, 2003; Peltzer, 2003; Freeman, 2004; Macleod, 2004), with references being made to the social barriers regarding the disease itself such as 'stigma' and 'silence' as well as fear and a sense of hopelessness about HIV/AIDS status.

"It is difficult to overemphasise the importance of contextual intervention as a weapon against HIV; policy makers simply must begin to consider reform of laws and policies outside the health sector as legitimate AIDS-reduction strategies." (Cohen & Trussell, 1996: 57). This call to target contexts other than the health sector is currently in process in South Africa and is being recognized by those responsible for education.

It appears that, on a national level, the Education Department and its provincial representatives are embracing the urgent need to focus HIV/AIDS preventative measures on young people through the context of the schools. This is borne out in a recent publication of a draft "Education Sector Policy on HIV and AIDS" (Daily Dispatch, September 2005)

With reference to the draft Education Sector Policy on HIV/AIDS (2005), the points enumerated below are directly relevant to the present study and provide justification for this investigation's relevance in the wider socio-political context:

- a) "Every person has the right to relevant and factual information, knowledge and skills that is appropriate to their age, gender, culture, language and context." The psycho-educational intervention of "Wildfire", includes factual

information, and skills which lead to a more in-depth knowledge of the HIV/AIDS information that learners have been exposed to in the Life Orientation section of the curriculum. See section 2.8 below, for a detailed description of the potential learnings that can be derived from “Wildfire”.

- b) “HIV and AIDS related interventions in the education sector should promote the practice of delayed sexual debut and responsible sexual behaviour.” The intervention in the present study is targeted at Grade 9 learners, who, if at the correct age of entry into Grade 9 may be beginning to grapple with issues of sexual debut; if older, and already sexually active, the intervention has the potential to reinforce safe practices.
- c) Young people’s right to knowledge about condom-use for protection is acknowledged in the draft policy, but promotion of condom-use at primary and secondary levels of the education system is categorically disallowed. The intervention includes discussions on types of preventative practices, most of the information coming from the learners in a question and answer – type situation and does include condom-usage as an option for prevention. In accordance with promotion of condoms not being encouraged, the presentation of the workshop utilizes surgical gloves as symbolic of preventative ‘tools’.
- d) “Voluntary counseling and testing (VCT) shall be promoted by education institutions / organizations as a means of prevention and accessing treatment, care and support.” – both for continuing safe sexual practices as well as management and promotion of productive lifestyles. During the “Wildfire” intervention, VCT is an option with which learners are faced – rights and personal choice are emphasized at this point of the simulated game.
- e) “Recognising that schools are an important part of every community, with the potential to add value to broader HIV and AIDS responses...extend all appropriate parts of its HIV and AIDS programme into communities.” An assumption made by the researcher is that parents are vicariously involved in the intervention in that, by signing/not signing permission for the young

person to participate in the research, they are reminded of their responsibilities around their child's sexual practices in relation to HIV/AIDS.

- f) "Access will be given to research on levels of...access to education...the effectiveness of education programmes...and differential impacts on gender." – amongst others. This inquiry fulfils this section of the draft policy.
- g) "Linkages shall be created with partners to: develop and build on the capacity of learners, employees and employers to utilize, access and/or offer HIV and AIDS preventative services." One of the outcomes of this research investigation, is to inform the Small Projects Foundation on "Wildfire's" effectiveness and so provide possible verification for its future projects which may include extending the implementation of "Wildfire" in schools, in partnership with the Education Department.
- h) "Young people are known to respond better to prevention services which understand and cater for their needs and concerns." The open-ended questions in the questionnaires provide adequate opportunity for learners to express themselves and ask questions around HIV/AIDS in private (self-report), whilst the interaction during "Wildfire" itself provides a social context within which issues around choices and decisions concerning HIV/AIDS can be considered (Daily Dispatch, September 2005).

The policy is sensitive to HIV/AIDS in its ecological context as well as to ethical issues regarding the learners' stage/s of development and recognizes the need for the search for effective, cost-effective interventions and partnerships with other organizations. It is submitted that these broad guidelines are included in this research study which is evaluating the effectiveness of "Wildfire" as an effective HIV/AIDS intervention in secondary schools. Furthermore, this research project is consistent with a checklist compiled regarding research in Africa: "The African Evaluation Guidelines: 2002."

2.4 Preventative Programmes

The African Evaluation Guidelines (2002) consist of 30 recommended points divided into four key areas, drafted with the aim of checking the adequacy of HIV/AIDS intervention programs. The four key areas include utility, feasibility, propriety and accuracy guidelines, all of which provide for valid, pragmatic, cost-effective interventions. These guidelines are consistent with Weissberg et.al.'s recommendations for preventative programs being located within the eco-system of young people and being promotive of well-being (2003). These principles along with Visser's (1995) and van Dyk's (2001) proposals, will form the basis of what "effective" means in the context of this research.

Visser's recommendations as to the content of an AIDS education programme (1995:136), include enabling learners to "evaluate their personal risk" (130) in a realistic way knowledge and information, preventative measures, opportunity to make informed decisions about life-styles. Additionally, that "AIDS education should be part of sex education" (136) and include skills for coping with peer-group pressure, decision-making, assertiveness, amongst others. Most important is the provision of both options "sexual delay or protection against the virus" (Slutkin cited in Visser 1995: 136).

van Dyk's factors which contribute to the realization "that high-risk sexual behaviour should change" (2001: 84), include: individual's self-description of being at risk, perceptions of own vulnerability and serious long term consequences. The belief that certain behaviours reduce risk, good health behaviour, personal contact with someone who is HIV infected, are among other factors named by van Dyk, including HIV positive diagnosis.

2.5 Issues of Mental Health

In a paper discussing contexts of childhood adversity, Dawes and Donald (1994) investigate the concepts of childhood development in terms of existing ontological and epistemological research methods, emphasizing the utility of social construction frameworks which concentrate on process rather than on traditional positivistic

notions of science. They reject universalism in child development but central to their argument, is allowing the child to actively participate in creating their own contexts by providing them with physical and mental tools for choice. These arguments are pertinent to the present study for several reasons. Firstly, the methodology applied in this study is targeted at meeting the learner where he/she is at in terms of HIV/AIDS information and knowledge, by employing open-ended questions in the questionnaires on a self-report basis. Second, the pre-test and post-test questionnaires and “Wildfire” itself, are intended to be mental tools which present choices, options and decisions with which the participants can consider their relationship to HIV/AIDS. Thirdly, the current situation of the HIV/AIDS pandemic, with which these young people are faced can be considered to be a state of adversity. Furthermore, in this state of adversity, traditional models of normative psychology, are turned upside-down (Whiteside & Sunter, 2000).

The number of AIDS orphans, or children who may be faced on a daily basis with the realities of parents living with AIDS-related illnesses as well as the poverty that co-exists with such situations, throws traditional psychology’s assumptions of concerned and able parents and stable family lives, out of the window. In this sense, research as an intervention has potential to mediate social contexts that have changed as a result of HIV/AIDS and can be a process and tool for ameliorating contexts of childhood adversity. The school as a stable institution has the potential to provide input in what may be adverse living circumstances for some young people and so mediate their contexts. Taking the projections of the rise of AIDS related illness and death into account, the school has potential to become the main point of entry for HIV/AIDS prevention initiatives.

Mental health issues in the wider socio-political context provide a compelling case for the urgency of searching for new, effective preventative interventions to help stem the tide of the rising infection rate of HIV/AIDS. Freeman (2004) amongst others concerned about the future in the wake of HIV/AIDS (MacPhail, 1998, for example) has submitted a paper predicting the potential future social ‘disaster’ predicated on the physical, neurological, and emotional effects of HIV/AIDS (2004). For people who are aware of their status and are living with HIV, depression, anxiety, suicide, dementia, delirium, mania and psychosis associated with impending death plus

economic factors such as not being employed and concern, guilt and worry for dependants who will be bereaved, are some of the mental health concerns of those infected by HIV/AIDS (Freeman, 2004). Cournoos and Bakalar maintain that some of the mental health disorders may in themselves result in behaviour that may further contribute to the spread of HIV/AIDS (cited in Freeman, 2004: 149)

Antiretroviral treatment changes the mental health scenario somewhat, but the side-effects of drugs may in themselves cause mental health problems as well as having psycho-social effects such as anxieties around the formation of new relationships, disclosure with its associated stigma and fear, and stress around possibly caring for other family members also infected (AIDS Weekly cited in Freeman, 2004: 144). Research has shown that some individuals would have preferred not to have known their status which mitigates against VCT (van Dyk, 2003) however, stress related to not knowing one's status is also reported to be high (Shisana & Simbayi cited in Freeman, 2004: 146). "Wildfire" deals with VCT in a simulated context and provides participants with information regarding VCT related choices.

The effects that HIV/AIDS has on children, is that very young children may be cast in a care-taker's role. This could result in behavioural disorders, depression and a lack of an organized sense of future for young people who are living with someone infected by HIV/AIDS. Other factors (which can be cumulative), that affect orphans "include economic deprivation and disrupted schooling, multiple losses, the disturbing and uncertain clinical course of the illness, lack of adequate care and control, stigma, secrecy, and social isolation" (Freeman, 2004: 151). These mental health concerns are alarming and call for preventative action to take place, so as to avoid future mental health problems on a wide scale.

2.6 Risk Factors

It appears from a review of literature, that certain groups of people appear to have greater risk-levels when it comes to exposure to HIV/AIDS. Steinberg (1999) has identified groups in the USA that are at risk regarding HIV and these include: inner-city minorities, the homeless, school drop-outs, drug-users, those who have unprotected sex and multiple partners (Cohen & Trussell, 1996: 126) as well as

carriers of sexually transmitted infections (STI). Harrison and Steinberg have named predictors of high-risk sexual behaviours in the South African adolescent age group, including: “coercion, peer pressure, transactional sex and abdication of sexual responsibility by boys” (2002: 1), they go on to say that young teenagers in the 12-14 age group report erratic use of condoms (13) which indicates high risk for contracting HIV/AIDS.

Self-efficacy, according to Bandura (cited in Craig, 1980), or perceived behaviour control (Ajzen cited in van Dyk, 2001) are important determinants of sexual risk behaviour, with low self-efficacy correlating positively with high risk behaviours as well as reticence in changing behaviours. High self-efficacy on the other hand, relates closely to an individual’s motivation to master new situations and work towards specific goals (van Dyk, 2001). Self-efficacy, in adolescents may be significantly influenced by the ‘subjective norms’ of the group ie: the prevailing attitude and belief system of significant others along with the desire to please such “reference groups” (van Dyk, 2001: 86)

Another risk factor with which adolescents are faced, is that of “adolescent egocentrism” (Santrock, 2002: 367) in which the adolescent has heightened self-consciousness and a sense of his/her own uniqueness, or “personal fable” (Elkind cited in Santrock, 2002) where the young person believes in his/her invincibility and possible immunity from the ‘bad’ things that happen to others. Reckless behaviour can result from such beliefs. Therefore, self-efficacy, the influence of the group as well as egocentrism on the part of adolescents may be factors which have lead to “concern about the potential vulnerability of youths to AIDS on the part of helping professionals...has created a climate of concern about AIDS which is not matched among youths” (Akande, 2001: 238). The challenge then, in preventative interventions, is how to close the gap between what professionals perceive as risk factors and adolescents’ perceptions of risk as translated into action ie: behaviour change, or rather, the ability of “individuals to internalize personal risk” (Harrison & Steinberg, 2002).

2.7 Behaviour Change

Behaviour change in relation to HIV/AIDS in general, refers to healthy outcomes of interventions that may either protect the individual from HIV/AIDS or protect others from being infected by the virus. The Fishbein – Ajzen (cited in Armitage, 2001) approach describes behaviour as something that has been influenced by intentions which in turn are influenced by attitudes/subjective norms and perceived control – these attitudes are primarily influenced by behavioural beliefs. Campbell & Williams refer to “sustainable transformation of sexual identities and norms” (1998: 58) in terms of social capital ie: specific processes...that lead to the accomplishment of goals of mutual social benefit” (Kreuter cited in Campbell & Williams, 1998: 59). A review of the literature indicates that behaviour change has developed in its meaning for health behaviour over time – there tends to have been a shift from locating behaviour solely within the individual (as traditional western psychological conceptions tended to do) to situating health within the social system (Macphail, 1998; Seedat, Duncan & Lazarus, 2001; Macleod, 2004).

There appears to be an inconsistency related to the term ‘behaviour change’ when it comes to adolescents and preventative interventions, because the term implies that certain behaviour has already been established and subsequent to its establishment, then requires some sort of re-orientation or re-construction. This may not be the case when it comes to sexual behaviour which, in some cases, has possibly not been established by individuals. However, if one takes ecological frameworks such as that formulated by Bronfenbrenner (cited in Dawes and Donald, 1994) and adapts it to fit South African society (Dawes and Donald, 1994) and situates ‘behaviour change’ within the social context rather than that of the individual, then ‘behaviour change’ takes on different implications. ‘Behaviour change’ then becomes a re-orientation or re-direction of taken for granted beliefs and practices/culturally accepted normative behaviour. This shifts the concept of ‘behaviour change’ from the realm of the individual (micro-system) to that of the meso- system (Donald, Dawes & Louw 2000; MacPhail, 1998) of which that individual is a part. In situating ‘behaviour change’ in the social context then, it becomes a less exact or measurable unit of analysis and becomes a process of social influence/change over time.

Understanding the development of children within an ecological framework, requires acknowledgement of the reciprocal interactions between the person, process, context and time factors that contribute to particular outcomes – Donald and Dawes refer to this as an “ecological-transactional orientation” (2000: 3).

This research investigation is located within such a framework where behaviour change is concerned. It recognizes that context is a “socially constructed system of external influences that is mediated by individuals’ minds...whatever influences local environments have on children must be seen as a product of how these environments are perceived and interpreted by parents and children” (Furstenberg & Hughes, cited in Donald & Dawes, 2000: 3). To be more specific, the behaviour change that is an assumed outcome/product of this investigation is positioned within the context of the participants’ mesosystem (influenced by the macrosystem of policy within education) with the intention of effecting social influence/process over time by mediating the ‘person’ factors through the intervention of “Wildfire”. Thus, in creating a local system in which behaviours that are preventative of the spread of HIV/AIDS are promoted, it becomes easier for the individual to adopt such behaviours or begin to accept them as normative. The reciprocity within this framework in school contexts, assuming that there is ongoing HIV/AIDS education, is iterative.

2.8 Wildfire: the Psycho-Educational Intervention

The Small Projects Foundation (SPF), a Non-Governmental Organisation (N.G.O) based in East London in the Eastern Cape, is currently involved (amongst other projects) in delivering a multi-faceted programme on HIV/AIDS in 26 districts in the Eastern Cape Province. According to the theory on community mental health, NGO’s operate “within a framework of empowerment, seeking to provide skills, training, and networking systems to bring relief and resources to oppressed and disadvantaged communities” (Parekh, McKay, and Petersen cited in Pillay & Lockhat, 2001: 101). The AIDS Action Programme which is being implemented by the SPF, in conjunction with the Phelophepa Mobile Health Care Train fits within this framework and in so doing operates at the primary (prevention) and secondary (home-based care) levels of the health care model described by Pillay and Lockhat (2001), but within a community context rather than within the traditional health care system.

As part of the AIDS Action programme, “Wildfire” is implemented as both a self-awareness tool for community volunteers and as an educational tool that can be used in the communities to create HIV/AIDS awareness within a social context. The original source of “Wildfire” has been traced as far as Dorcas Metsi of United Nations Development Programme (UNDP) in Pretoria, although this has not been officially confirmed. It was encountered by a member of SPF during a provincial workshop on HIV/AIDS conducted by UNAIDS at the Fish River Sun. The powerful impact that “Wildfire” had on the participants, convinced the member of SPF of the potentials of bringing the reality of the epidemic to a personal level-where individuals had a context for thinking about their personal relationship with HIV/AIDS. “Wildfire” was then documented, tested on staff members of the SPF, particular aspects of the wording and ethics were refined, aiming for it to be as culture-neutral as possible and providing for as much input for learning facts as well as factoring in choices and decisions as possible. To date, “Wildfire” has been conducted with adults. One of the implementers of this intervention believes strongly in the potentials of implementing “Wildfire” with young people.

A basic outline of “Wildfire” has been set out in Chapter 1. Appendix 1 sets out the actual facilitator’s process notes for conducting the intervention. Below, the points of planned learning that are built into the psycho-educational intervention, are further illuminated. These will be tabulated from responses of the focus group notes produced by the participants as part of their debriefing after the intervention has been concluded (refer to Chapter 3, Phase 2 of the data analysis). The same table will be used for comparative purposes from responses to Question 34 of the post-test questionnaire. Broadly, the following eight opportunities for learning emerge from the “Wildfire” psycho-educational intervention:

- (i) The speed with which HIV/AIDS spreads is indicated. The name “Wildfire” symbolically suggests the rapacious, uncontrolled way in which the virus spreads under certain conditions. This is actively demonstrated in the workshop through the activity of shaking hands (representing ‘casual, unprotected sex’). As will be reflected in the results, only two members of the group begin the workshop being ‘infected’ (their shoulders are touched) and by the end of this activity all or almost all have been ‘infected’. So the

learning here constitutes reinforcement of the speed with which HIV/AIDS spreads.

- (ii) That HIV/AIDS is spread through sexual contact. Here the relationship aspect of people voluntarily participating in the spread of HIV/AIDS is actively demonstrated through the shaking of hands, representing ‘casual, unprotected sex’.
- (iii) Choices in relationships become an issue and discussion point following on from the hand-shaking exercise. Preventative/protective measures and tools are discussed and the opportunity to reinforce well-known facts that are widely available through media and Life Skills Programs is created. Topics such as not feeling forced to have sex because others are doing it, using a condom, and being faithful to one partner are discussed within the context of the game – for example, the learners could choose only to shake hands with one other person, those “exposed” could choose not to shake hands at all and others could choose to ‘protect’ themselves during the hand-shaking exercise, by putting on the surgical gloves which were placed on a table as ‘available protection’. Again, “Wildfire” provides an opportunity to put knowledge into action – and to create awareness of the need to apply learning/knowledge in social situations.
- (iv) A possible opportunity for learning, is that a person can feel lonely and isolated from the group, if he/she decides not to participate. This makes the consequences of a different type of choice – in this case, about not engaging in ‘casual, unprotected sex’ – explicit. This is a significant learning opportunity for all participants, but as will be demonstrated in the results (Chapter 4), not many participants even consider this option/choice. This is discussed as an option, nevertheless.
- (v) If an individual is concerned about his/her HIV status because of possible ‘exposure’, a decision about whether to go for Voluntary Counselling and Testing (VCT), needs to be made. A discussion on rights ensues at this point in “Wildfire”: the right to choose not to go for VCT; the right to choose to

attend a clinic where such a service is offered as well as what to expect when attending VCT.

Firstly, confidentiality is assured, the process is explained ie; blood is taken and tested; if HIV positive, the tests are over 90 % accurate (rapid) and if positive, the blood will be subjected to the Elisa test which is more accurate and takes longer. If the test registers negative a 3-month window period needs to be given to ensure that exposure close to the date of testing, did not in fact lead to infection – the need to return for re-testing after 3 months is also explained. The person going for VCT is also encouraged to find someone to talk to; as well as being advised to discuss test results with a regular partner and encourage him/her to go for a test. The VCT explains to the counselee that it is safest never to have unprotected sex, and not take on new partners. In the case of women of child-bearing age, mother-to child transmission/breastfeeding needs to be considered; anti-retroviral treatment (CD-count of 200) is an option which is explained. After-counselling takes place, when the results are given, and referrals made to a regular clinic site for maintenance care. As many of these facts, drawn from the protocol on VCT (United Nations) as possible are explained to the participants of the “Wildfire” workshop.

- (vi) Another learning that is reinforced through “Wildfire” is the possibility of testing positive through VCT. The consequence of this is living positively with HIV/AIDS. The meaning of this is discussed with the participants, with regard to nutrition and not to drop the immune status (by drinking too much, for example) and having a social support system. Making a will, having a memory box and preparing the family for loss is an important part of knowledge when testing positive. This latter section is discussed with adult “Wildfire” participants but for the purposes of this study, discussed only if questions emerge spontaneously from the participants themselves.
- (vii) Testing negative also presents the participants with a range of choices/decisions. Firstly, to return for re-testing within three months. Secondly, discussions with a partner are encouraged. Thirdly, decisions

regarding future sexual practices are considered – such as abstinence, being faithful and condomising.

Having outlined the learning which is factored into the psycho-educational intervention “Wildfire”, an interpretation of the utility of such learnings appears to be necessary. “Wildfire” provides the participants with exogenous knowledge and information – both reinforcing what has already been attenuated through Life Skills at school, mass media campaigns or through programmes (Kelly, Parker & Oyosi, 2002), as well as potentially adding to that knowledge.

This transference of knowledge forms what could be termed a socialization process. By socialization process, reference is being made to the need to socialize/conscientise young people to the reality of the social ecology of the epidemic. HIV/AIDS has necessitated a whole shift in society’s treatment of sexuality, culture and adolescence and this has created a gap in the socializing process of young people – the intention of this intervention is to mediate that socialization gap. “Wildfire” also creates a ‘space’ for self-analysis/reflection by the participants in terms of their experiences within the workshop, in which they are presented with choices. Two distinct spaces are created in terms of self-reflection/analysis: firstly, in terms of the self-report questionnaires, a personal space to reflect on self and issues of HIV/AIDS is created and secondly an opportunity for experiencing knowledge about social learning, in a social context (ie: within the group), is created.

2.9 Theoretical Assumptions underlying the Implementation of “Wildfire”

The attenuation of knowledge and information, through teaching input or pedagogic intervention, the reinforcement of that knowledge plus its recall, are traditional approaches to education (Vrey, 1979; Smith, Polloway, Patton & Dowdy, 2001; Engelbrecht & Green, 2001). These are also principles that have been adopted in school input as well as media campaigns regarding knowledge and information about HIV/AIDS (Kelly et.al., 2002). The success of these approaches has been well documented (Cohen & Trussell, 1996) in that people know about HIV and AIDS. However, it has been equally well documented that such information and knowledge has not always been translated into action/behaviour change, thus preventing the

spread of the virus (Hoosen & Collins, 2004; van Dyk, 2001; Whiteside & Sunter, 2000). Thus, in regard to issues of HIV/AIDS, as with other educational approaches, for example those faced by remedial teachers and children with barriers to learning, (Engelbrecht & Green, 2001) there remains the issue of transfer across context or actualization of the content of what has been taught and learned, the process of which remains with the individual, given an enabling social environment.

2.9.1 Cognitive Theory

As a result of this investigation being positioned within the meso-system of the ecosystemic model, with the school being the context for intervention and adolescent learners being the participants, it becomes necessary to review the theoretical underpinnings of how adolescent learning occurs. Firstly however, it is important to locate the adolescent as a developing human being within this theory of learning.

Santrock describes adolescence as “a time of evaluation, of decision making, of commitment, of carving out a place in the world” (2002: 347). Relationships change, with the peer group taking a more influential role than parents had during childhood. Adolescents become capable of more abstract thoughts and idealism and at the same time, they are changing physically with the onset of puberty. Relationships become more intimate and sexual exploration and debut may take place at this time (Santrock, 2002: 348). Some of the most important development tasks with which an adolescent is concerned are: “the acceptance of body changes...integrated gender identity, personal identity...relative independence...exploration and decision-making, regarding a future career...sensitivity to the emotions of others” (Engelbrecht & Green, 2001: 105).

Adolescent cognition is identified in Piaget’s stage theory as being characterized by formal operational thought. The young person moves from concrete thinking to an appreciation of abstract propositions, being able to entertain possibilities and is more able to reason and problem-solve, using verbal logic. However, it is recognized that Piaget’s stage of formal operational thought is not homogenous in that not all adolescents are formal operational thinkers, “only one in three young adolescents is a formal operational thinker” (Santrock, 2002: 366). Other cognitive theorists such as

Donaldson (1988) contest Piaget's claim that deductive reasoning is possible only in adolescence, claiming that young children show themselves capable of such thought in their spontaneous responses to stories (Donaldson, 1988: 195). Piaget's stage theory appears to be limited to cognition and school learning i.e.: subjects such as science and maths would require the thought structures of formal operations and in this sense, does not apply directly to the investigations of this research. However, the potentials of applying verbal problem-solving and abstract reasoning/entertaining possibilities are abilities that can be harnessed or built upon in the context of this study in terms of social learning ie: for preventative purposes around issues of relationship and HIV/AIDS.

Piaget's management of change as informed by his genetic epistemological approach (1970) deals with knowledge. Knowing develops through the interaction between existing knowledge and the object of knowledge, the object of knowledge being an unfamiliar task. Craig (1980) refers to this as a non-balance between what the subject knows and what he/she is required to know ie: when two different paradigms/sets of knowledge meet. This is the situation posed in this research, where a non-balance is set up in the intervention "Wildfire", between what has been learned factually, about HIV/AIDS and applying that knowledge in the game itself. Piaget claims that there are two conditions for cognitive change: one is the presence of a non-balance or conflict and the other is the presence of resources to surmount that conflict. "Wildfire" presents both these conditions with regard to simulated exposure to HIV/AIDS, in which the potentials for cognitive change are present regarding personal cognition through experiential learning.

As Piaget acknowledges the significance of language/speech – which becomes thought - in relation to cognitive development, so the Soviet socio-cultural school of cognitive development, builds on this, taking cognition into society. "Every function in the child's development appears twice: first on the social level, and later, on the individual level; first between people (interpsychological) and then inside the child (intrapsychological)...All the higher functions originate as actual relations between human individuals" (Vygotsky, 1978: 57). Assuming that cognition therefore is primarily an interactive, social function and keeping in mind that adolescents do not necessarily have a culture of safe sexual practices into which to act or to model

(Whiteside & Sunter, 2000) when it comes to HIV/AIDS, it would follow that “Wildfire” as an interactive experience about social things, has the potential to influence the cognitions of adolescents about safe sexual practices. The process of social mediation through collaborative activity is achieved by using “Wildfire” as the mediator.

To further elaborate, taking cognizance of Vygotsky’s theory in which the relationship between the social interactive worlds of individuals and individual cognitive development are inextricably linked, it follows that some sort of input has to be provided in order for this process of internalization to take place. This input would be the tool (Vygotsky, 1981: 73) or social artefact (Terre Blanche & Durrheim, 1999) which mediates the gap in terms of learning. This gap can be described as that space between not knowing (the position of the learner) and knowing (the position of the teacher/facilitator). Carey, in her quest for answers as to whether children are fundamentally different thinkers to adults, characterizes this gap: “the most important source of variance is in domain – specific knowledge. Children know less than adults. Children are novices in almost every domain in which adults are experts” (1985: 135).

Vygotsky has named this gap the “zone of proximal development” (ZDP) and he defines it as the “distance between the actual development level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers” (1978: 86). An analysis of Vygotsky’s theory of how higher mental processes develop, appears to point to the fact that it is higher mental processes that drive behaviour: “the organism that is mastering external influences masters a number of forms of behaviour or assimilates these forms depending on its level of mental development” (in Richardson & Sheldon, 1988: 75). It is in the eventual translation of higher mental functions into behaviour, that Vygotsky’s theory becomes relevant to this study.

In order to situate these theories of learning within the context of this research investigation, it can be postulated that adolescents, having reached that stage of mental maturity where it becomes possible to think and problem-solve abstractly (according to Piaget), can also be considered to be “novices” (Carey, 1985) when it

comes to specific knowledge in the domain of HIV/AIDS. Thus, a gap or ZDP (Vygotsky, 1978) is created in terms of what adolescent learners know and what it is generally agreed that they should know (van Dyk, 2001) in order to protect themselves from the epidemic. In order to close the gap or ZDP, a tool or mediator becomes necessary in order to engage their higher mental processes around issues of self and HIV/AIDS, thereby, influencing behaviour. That tool is the psycho-educational technique, “Wildfire” which explores, in the abstract, the possible choices and decisions that become necessary when exposed to HIV/AIDS. The function served by “Wildfire” is, through collaboration with an experiential hypothetical situation, to mediate or “scaffold” the learner onto a different plane of cognitive functioning (and thus behaviour) regarding HIV/AIDS.

2.9.2 Educational Theory

Political changes in South Africa after 1994, have resulted in changes to the education system. Principles rooted in philosophies promoting the rights, dignity and equity of people as well as respect and non-discrimination in a democratic society are embodied in the new Constitution. The values and principles contained in the Constitution have been embraced in the South African Schools Act (RSA 1996) (Engelbrecht & Green, 2001). In terms of the new curriculum, the learning process is “learner-centred...consistent with Piagetian and Vygotskian notions of the importance of active engagement [and]...is informed by both social constructivism and information processing theories” (Engelbrecht & Green, 2001: 11). Furthermore, the Department of Health has had input into the concept of health-promotion in schools, inclusive of supporting well-being, building capacity in relation to skills acquisition and extending this into the community (Department of Health cited by Engelbrecht & Green, 2001).

Inclusive education has added a whole new dimension to the new education system. What this means in practical classroom situations, is that there may be a wide range of learners with diverse abilities, some of whom will have challenges and barriers to learning. Engelbrecht and Green name some of these barriers as “poverty, violence, crime, substance abuse, the prevalence and spread of HIV/AIDS” (2001: 13) and go further to question the education system’s capacity to deal with such barriers. This in itself, constitutes a barrier for learners – especially in the stated philosophies that

undergird the intended outcomes of education in relation to “building a more just society...extending the responsiveness of mainstream schools to learner diversity” (Engelbrecht & Green, 2001: 4). With specific reference to learners infected or affected by HIV/AIDS, a particular need is created within the education system when it comes to issues of HIV/AIDS. If projections as to the spread of HIV/AIDS (see section 2.2, above) are to be believed, this need will become more explicit with the passage of time. All these points indicate that particular action around issues of HIV/AIDS within the education system, needs to be taken for preventative purposes.

The concept of mediation in education is being embraced within educational approaches particularly relating to learners with special needs. This is a concept developed by Feuerstein and is called mediated learning experience (MLE), in which, in a situation of poorness of fit between the learner and the material to be learned, the educator intervenes. This process is executed by providing the learner with “tools, processes, language labels...so that they can begin to build this area of cognition” (Engelbrecht & Green, 2001: 230). If these principles were to be transferred to the ‘fit’ between the adolescent learner and his/her understanding of HIV/AIDS, which has been found to be a poor ‘fit’ (Akande, 2001), a mediating learning experience (MLE) would then be indicated. “Wildfire” constitutes such a mediated learning experience in that it provides the learners with tools for decision-making within the process of simulated exposure to HIV as well as providing the language and labels related to HIV/AIDS.

An interesting approach to education that relates to the basic principles of the Constitution, as well as being relevant to this investigation, is that of character education. Santrock refers to this as a “direct approach that involves teaching students basic moral literacy to prevent them from...doing harm to themselves or others” (2002: 375). Values clarification is an important sub-section of this approach, in which learners are invited to clarify meaning in their lives and determine “what is worth working for” (Santrock, 2002: 375). Whilst the researcher is not in agreement with the implied power dynamics of this Western approach as it is defined, the relevance of this educational approach in terms of concepts of responsibility, consideration of others and placement of the individual as an interactive and potentially productive member of society, are sound.

These concepts are confluent with some of the premises underlying the prevention of HIV/AIDS as well as the treatment of people infected and affected by HIV/AIDS. Furthermore, in relation to Kohlberg's theory of moral development, adolescents are at the stage of a shift from extrinsically-based moral behaviour to internally-based principles. This is Kohlberg's stage of post-conventional reasoning in which "the individual recognizes alternative moral courses, explores options, and then decides on a personal moral code" (Santrock, 2002: 317). Morality therefore, involves the development of a personal code of the individual in relation to others. It is postulated that the draft policy of the Eastern Cape Education Department regarding HIV/AIDS (refer to section 2.3, above) is adopting a form of moral education in terms of its guidelines of delaying the onset of sexual debut and promoting social responsibility as well as service to the community. Santrock refers to this as the "Hidden Curriculum" (376), or atmosphere promoted by the educational community. It follows then that adolescence is an ideal stage of development at which to adopt such an educational approach in relation to HIV/AIDS prevention.

2.9.3 Activity Theory

It is generally recognised that learning is most effective when the learners are "actively engaged in their learning" (van Dyk, 2001: 104), especially in group situations/activities where peer group learning, discussion and shared experience takes place, such as games. Informed by Vygotskyian principles and the concepts of local and exogenous knowledge, experts and novices, Gilbert proposes a model for "maximizing the emergence of a new community of practice" (1995: 11) i.e.: promoting change with consent. Promoting change in terms of HIV/AIDS has proved to be a challenge and has something of the disagreeable flavour of social engineering. However if one accepts that South Africa is in a process of social transformation and that traditional cultural practices are no longer in use and yet are far-removed from the community of practice adopted by 'change agents' be that teachers, education officials or new government policies, it follows that a gap exists which needs to be mediated. This gap according to Gilbert, exists between the focal community and the change agent's community. In order to mediate this gap, he proposes that a joint activity be engaged in, in which a process of disembedding knowledge occurs. By adopting the following new activities together, a new community of practice emerges:

tasks, goals, actions and tools (Gilbert, 1995: 18). “Wildfire” as a psycho-educational intervention fulfils the requirements of creating a new community of practice in relation to HIV/AIDS by operating as a mediator of knowledge and information through an active, interactive experience, using the participants as the focal community and the facilitator/research process as the activities that the change agent (in this case, the research process) presents to promote safer sexual practices.

2.9.4 Psychoeducation

Psychoeducation is an approach to education that recognizes the importance of the whole child as part of a social environment. Thus, cognitive development on its own in a school, is not enough. In short, psychoeducation broadens the role of the teacher from that of subject specialist to performing mental health functions so as to cater to the whole child. This may involve social skills training, counseling, sibling rivalry issues and health – related issues in the current Life Orientation curriculum. The mental health service in Brisbane claims that “Knowledge of ... illness is crucial for individuals and their support network to be able to design their own... prevention plans and strategies” (<http://www.psychoeducation.com/contact.htm>).

This approach to knowledge about a disease is particularly relevant to the current HIV/AIDS pandemic in South Africa.

2.10 Summary

The theory underlying this research investigation is focused on adolescence, approaches to community interventions in primary health care, preventative health care, the educational context and theories of learning. A situational analysis referring to the UNAIDS Global Report (2004) as well as reports in the press, indicate that East London is a nodal point for HIV/AIDS intervention strategies for youth and that the average age of initiation into sexual activity as being 14 years has been taken into account. The need for preventative interventions in community contexts with the specific mention of targeting schools as sites for intervention as well as the relevance of doing so, has been made.

A discussion of HIV/AIDS being a situation applicable to childhood adversity (Donald, Dawes & Louw, 2000) as well as the mental health consequences of HIV/AIDS (Freeman, 2004), referring to research and literature, has taken place. Risk factors such as self-efficacy and adolescent egocentrism have been discussed in terms of mitigating factors against the success of HIV/AIDS interventions in this age-group. These factors have also been associated with behaviours that may increase vulnerability to HIV/AIDS. The notion of behaviour change applied to the ecological model has been discussed and situated, for the purposes of this research, in the meso-system of the adolescent context.

A background to the development and implementation of “Wildfire” as a psycho-educational intervention, as well as its eight broad areas for reinforcing information, knowledge, social attitudes, future behaviours, choices and decisions has been set out. Cognitive theory relating to adolescents, using Piagetian and Vygotskian principles have been related to contemporary education theories and support the contention that this research investigation is firmly rooted within the social constructionsim paradigm.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction to the Decision Making Process

This research investigation set out to explore how Grade 9 learners in select schools in the East London area, responded to “Wildfire” as a preventative strategy in the fight against HIV/AIDS. There were two levels to the outcomes of this inquiry. Firstly, the voices and reactions of the youth in response to this psycho-educational intervention needed to be heard. Second, in order for the study to be verifiable for practical purposes (such as funding and advocacy) a sample size that could be transferable across contexts (Durrheim, 1999), had to be selected. In this second instance this research is consistent with Durrheim’s definition of applied research which aims to “contribute towards practical issues of problem-solving, decision-making, policy analysis and community development” (1999: 41).

These two levels appeared to lend themselves exclusively to either qualitative approaches, in the case of the voices of the youth or, quantitative methods when considering the verifiability of the data - this created a dynamic tension in relation to the decision making process. This chapter deals with the decisions made in conducting this investigation, keeping in mind the two levels of outcomes guiding the research process.

3.2 Conceptual framework

“Interpretive inquiry begins not from an absolute origin of unquestionable data or totally consistent logic, but at a place delineated by our everyday participatory understanding of people and events (Packer & Addison, 1989: 10). In adopting this stance in approaching the data collected during this investigation and recognising that qualitative research can be a “construction site of knowledge” (Kvale, 1996: 2), this report acknowledges the situatedness of the context of the investigation in time and place. With reference to time, the inference is that it is viewed as a window or photographic image - a view - of a part of the evolving progression of knowledge in the continually developing and escalating face of the HIV/AIDS pandemic. Place,

refers to the practical context in which the research was conducted i.e.: available classrooms in selected schools in the East London area, at a specific time in their approach to the problem of HIV/AIDS, following the injunction of the Minister of Education in the Eastern Cape (see Appendix 4). This is the conceptual base which informed the methodological decisions and process. From a conceptual basis therefore, this investigation is in essence, qualitative.

3.3 Research Question

The question that this investigation seeks to answer is:

Is “Wildfire” an effective preventative intervention for HIV/AIDS among secondary school learners?”

3.4 Research Design and Methodology

Taking the applied nature of the investigation into consideration, the decision was taken to adopt a simple pre-test, post-test experimental design with the ‘test/object/“unit of analysis” (Durrheim, 1999: 37) being “Wildfire”. Babbie (cited in Durrheim, 1999: 37) “distinguishes between four different units of analysis that are common in the social sciences: individuals, groups, organisations and social artifacts” - in terms of this investigation, “Wildfire” as a psycho-educational social interaction technique would qualify, in Babbie’s terms as a social artifact. The data emerging from the responses of the individuals participating is to be analysed in terms of them being members of a group -specifically, a group of grade 9 learners - therefore, in line with Durrheim’s (1999) explanation, the object of the study can be defined as a “group unit of analysis” (1999: 38) of a social artifact.

3.4.1 Ethics / Permission to Undertake Research in the School Context

A decision to target Grade 9 learners was made. The reasons for this, were multifold, including maximising the preventative nature of the intervention from a developmental viewpoint (see chapter 2 above for theoretical justification) as well as the fact that Grade 9 represents an exit point in the education process and so may

provide young people who may exit school at the end of the year, with an opportunity to be exposed to an HIV/AIDS preventative measure.

This research aimed to target a younger population than is reflected in recent published research (Akande, 2001; van Dyk & van Dyk, 2003; Peltzer, 2003). It is generally agreed that children present a 'special population' in relation to research and that legal guidelines, informed consent and 'assent' or volunteering to participate should be stressed throughout the process (Gray, Lyons, & Melton, 1995; Durrheim & Wassenaar, 1999).

Following a rigorous informed consent process, application was made to the Acting District Director of Education in East London, Eastern Cape (see Appendix 3) for permission to co-opt learners to participate. Upon receipt of permission and the freedom to target any grade, an Educational Development Officer (EDO) was contacted with the request to identify secondary schools. The request was for two rural, two urban and one control school. The EDO then contacted a number of schools, explained the research and obtained agreement from principals to participate. Once an appointment was made with the principal, a letter explaining the research was handed over along with a permission form which both the principal and head of the Governing Body had to sign (see Appendix 5). A meeting with all the Grade 9 learners was then organised, at which the researcher explained the research in English, stressing that participation was voluntary. This was then translated into Xhosa by a research assistant. Permission forms for parents (both English and Xhosa translations were available) along with letters were handed out to those wishing to volunteer their participation (refer to Appendix 6).

Following the conditions set out by the Department of Education (Appendix 4), a draft questionnaire was submitted to the Deputy Chief Education Specialist (DCES) for Research for approval and comments. The questionnaire was returned with some advice re: ease of scoring, the recommendation that the questionnaire be translated into Xhosa, to steer away from emotive language and that more specific answer-options be provided especially in relation to school related matters (such as what specific inputs the school could provide, and where/when exactly do sexual encounters take place). This last was particularly interesting in that it added another

dimension to the uses to which the results could be put - namely, that information of specific relevance to schools could potentially be provided as part of the findings of this research.

3.4.2 Sampling

Sampling took place on two levels:

1. Selection of schools. Schools were contacted on the recommendation of the EDO. Four were willing and encouraging. Two urban schools approached independently by the researcher refused on the basis of negative past experiences in relation to researchers disrupting the school routine and it being more work for the teachers. One refused on the basis that the school was already involved in an HIV/AIDS programme involving volunteers - this school's refusal was also based on concern as to the explicit nature of the questionnaire and the possible effects that this could have on vulnerable learners. In terms of sampling at the school level therefore, this investigation constitutes a convenience sample. Two township schools (one serving an urban area and one serving an informal settlement) as well as two rural schools (one with day attendance and one boarding school) formed the basis of the study including the "Wildfire" intervention. In order to protect the school names from being identified, they were coded A, B, C, D and E, with E being the control. The control school, which participated in the pre- and post- test questionnaires was also a township school and took some time for the researcher to locate.

The characteristics of the control school were different to the others in that the principal stated that it was time to "break the silence" around issues of HIV/AIDS, indicating that this school has perhaps not had much input with regard to HIV/AIDS as the other schools appeared to have had. This was further verified when meeting with the Grade 9 learners, who appeared to be reluctant (comparative to responses in schools A, B, C and D) to volunteer their participation. This reluctance reflected the "psycho-social barriers" referred to in the literature around HIV/AIDS (van Dyk & van Dyk, 2003). Some learners asked what to do if they had no parents to sign permission and the teacher explained afterwards that some learners had lost their parents to AIDS. "Many of us take for granted that children will normally be brought up in caring, nurturing

environments. AIDS overturns this principle” (Whiteside & Sunter, 2000: 95) - what is significant about this experience in the research process is that it highlighted the reality of HIV/AIDS with regard to children, underscoring demographic projections (Whiteside & Sunter, 2000) of possible child-headed households as well as projections regarding the mental health consequences of the epidemic (Freeman, 2004). The researcher became poignantly aware of the reality in people’s lives of this epidemic - that this is not simply an academic exercise.

2. Sampling of individual learners to participate. When inviting learners to participate, it was requested that approximately 40 per school would be a useful number. This related to the user-friendly nature of the intervention “Wildfire” ie: it would be commensurate with average numbers in a classroom and so be a useful guide should the findings lead to advocating the introduction of this intervention in the Life Orientation section of the syllabus. Also, allowance had to be made for factors reducing numbers of participants such as: refusal of parental permission, volunteers reserving their right to exit from the research at any time and absenteeism during the process itself. Confidentiality regarding the names of individuals was assured - code numbers were allocated to the volunteers for use on the questionnaire. The researcher allocated numbers and was the only person with access to the names for cross-referencing purposes regarding permission forms and attendance during the three phases of the actual process of the research.

3.4.3 Participants

Table 1 below provides a summary of the numbers of participants, the demographic characteristics of the schools and the simple coding process adopted in this study. It is to be noted that only the results of those participants who were present at all three phases of the process were used in the final results.

TABLE 1: NUMBERS PARTICIPATING ($n=104$)

| SCHOOL CODE | SCHOOL TYPE | FEMALE | MALE | TOTAL |
|---|---------------------------|--------|------|-------|
| A Township (urban) | Urban Residential | 21 | 6 | 27 |
| B Rural | Rural Day attendance | 17 | 5 | 22 |
| C Township (informal settlement) | Urban Informal settlement | 17 | 4 | 21 |
| D Rural (boarding) | Rural boarding | 16 | 9 | 25 |
| E (control) | Urban residential | 4 | 5 | 9 |

As can be seen in Table 1, the participants represented a broad cross section of school contexts and while the results cannot be generalised to the general population, the potential for them to be transferable across contexts (Durrheim, 1999), exists. The research population was homogenous in that all participants were black Xhosa speakers. In planning this investigation, the intention was to target a broad range of schools with learners representative of the diversity of racial and cultural groups in South Africa. However because this was a convenience sample and as a result of refusals by ex model C schools when approached, the schools and learners who were willing to participate, were from demographically traditional black areas.

3.5 Data Collection

3.5.1 Questionnaire

The decision to administer a questionnaire was rooted in following the trends adopted in recent research related to HIV/AIDS. Peltzer (2003), van Dyk & van Dyk (2003), Akande (2001), Macleod (2002) as well as the Nelson Mandela study (Shisana & Simbayi, 2002), to name just a few have used the questionnaire as their instrument of choice in researching facets of the HIV/AIDS pandemic. The practicality of the instrument in terms of gathering data from many participants within the time constrained context of the schools was relevant to this investigation. All questionnaires were self-administered. Another reason for choosing the questionnaire was to gather data for “time-trend monitoring” (Peltzer, 2003: 250) in other words, to provide information similar to that being generated in other studies, for comparative

purposes such as “household composition“ (Cohen & Trussell, 1996). With reference to the two levels of this inquiry referred to in 3.1 (above), the questionnaire potentially provided a way of ‘hearing’ the voices of the youth and fulfilled the objectives of the questionnaire. Internal validity of the data to be gathered was also a consideration - in that the data gathered in the pre-test questionnaire provided a base-line for the study itself and the results could be directly compared to those emerging from the post test.

There were two questionnaires: a pre-test questionnaire and a post-test questionnaire - both of which had identical questions, with the addition of questions relating to “Wildfire” in the post test. The intention was for the pre test to form a base-line for the study itself, ie: to establish the types of knowledge, information, attitudes, sense of self-efficacy and sexual activity of the participants at the start of the investigation and then to compare this baseline with the response to the same questions and after conducting “Wildfire”. The questionnaire was administered in English, a decision based on suggestions by the principals and teachers involved when approached. They contended that translation into Xhosa would be patronising in light of the fact that English is the official language of instruction at Grade 9 level and so competence was expected from the learners with regard to English. Additionally, the cost factor in employing translators to re-transcribe the responses into English for analysis was prohibitive.

It is acknowledged that there are limitations in the use of the questionnaire as a self-report instrument in that objective verification is not possible. Macleod (2002) acknowledges that adolescents are not necessarily reliable self-reporters, a position supported by Akande who states that “information may be subject to socially desirable response problems of honesty of recall, accuracy, willingness to report socially disapproved behaviour, and other sources of bias” (2001: 250). The questionnaire used was constructed by the researcher and therefore is not standardised for judging validity.

In constructing the questionnaire, 5 subsections of information were identified, including: demographic information, HIV/AIDS exposure to knowledge/information, knowledge about HIV/AIDS as a disease, psycho-social aspects of AIDS and sexual contact. A sixth section was added to the post-test, on “Wildfire”. Both closed, fixed

response answers and open-ended questions were adopted as questioning techniques.. The intention of the researcher in designing the questions was not only to gather information but to provide the participants with an opportunity to evaluate their own relationship with HIV/AIDS. In this way, the objectives of the study as well as van Dyk's recommendations regarding effective preventative interventions (2001) were fulfilled. The fixed response questions were designed to vicariously provide them with options when considering, for example, the types of people who can be approached both at school and at home to discuss matters pertaining to HIV/AIDS, where information can be obtained and empowerment opportunities regarding what they themselves can do in the fight against HIV/AIDS. In this sense, the questionnaire was conceived as a reinforcing instrument (reinforcing knowledge already gained from whatever source), a preventative instrument and an instrument of instruction (for those possible participants not yet exposed to HIV/AIDS related matters). This approach to the conception of the questionnaires is consistent with Hoshmand & O'Byrne's contention that " authentic knowledge of the human and social world can only be gained in the process of attempting to change that world, and that authentic change can only happen when it is accompanied by shifts in the knowledge-base of those involved" (cited in Bhana, 1999: 230). The theory underlying this conception is based on cognitive and learning theory (see Chapter 2, above).

Pre-testing the questionnaire was conducted by submitting the draft copy to the research specialist in the Department of Education for comments as to applicability, by inviting comments from a mother of a Grade 9 learner and by seeking commentary from an Educationalist sensitive to psychological issues. Resulting from this, the format of some questions as well as the wording in some questions was altered. It is to be noted that the research specialist did recommend that emotive language may be difficult for Grade 9's. However, based on comments from the educationalist as well as the intention of the researcher to introduce a personal element to the participants' relationship with HIV/AIDS, the decision to retain some emotive language was made. Thereafter, the questionnaire was administered to three Grade 9 learners with the request that they fill in the questionnaire for timing purposes and for comments on the comprehensibility/ accessibility of the questions themselves. The agreement was that the questionnaires would be torn up in front of them afterwards so that their responses would remain confidential. The format of some questions was altered as a result of

this. With regard to timing, completion of the questionnaires ranged from 22 minutes to 28 minutes. It is to be noted that these learners were all first-language English speakers and the researcher took into consideration the extra time that may be factored into responses by second-language English speakers.

It was therefore estimated that a time of 40 minutes would be a reasonable time-period to allow for completion of the questionnaire - making it user-friendly within the school context, where lesson periods are generally 40 or 45 minutes long. For this reason, the schools were requested to make a life-orientation lesson available for the questionnaires to be filled in. This was readily agreed to, because of the relevance of the subject-matter to the life-orientation section of the curriculum. In the process of the research itself, there was a time-completion period ranging from 35 minutes to 90 minutes for participants -there are many possible explanations for this including language factors, the degree of thought invested by participants in answering the questions and barriers to learning - however, such speculations are not the subject of this investigation but may be factors relevant to other research endeavours.

The pre-test questionnaire was administered as soon as permission forms from parents were received. Within one week of the pre-test, the “Wildfire” intervention was conducted. A time period ranging from 3 - 4 weeks lapsed before administering the post-test questionnaire - this was in the case of three of the participating schools. In the context of the school year, the research took place during the second term and prior to mid-year exams which put time-constraints on the availability of participants - this was particularly the case with School C where only five of the volunteers presented themselves for the post-test. The decision was then taken to postpone the post-test until the third term, making the time lapse between pre- and post-test, for School C, approximately 8 weeks.

3.5.2 “Wildfire” Intervention

The need to document/record the learners’ reactions to “Wildfire” was important in terms of researching the intervention in a methodologically rigorous way. Terre Blanche and Kelly define triangulation as “collecting material in as many different ways and from as many diverse sources as possible” (1999: 128). For this reason it

was decided that the researcher would adopt the role of observer during the intervention in order to take observation notes. Observation notes consisted of behavioural reactions and verbal responses during the process. Another way in which data on “Wildfire” itself was collected, was through a focus group de-briefing exercise after the intervention, in which the learners were requested to discuss and document in point form, the learnings derived from “Wildfire”. In adopting these methods of triangulation individual identities were protected and confidentiality maintained.

3.5.3 Research Assistants

Three research assistants participated in the research. They were made available by the Small Projects Foundation. One assisted in the translation on the first contact with the learners, with the aim of making informed consent rigorous. This assistant from the SPF, having extensive experience in administering “Wildfire”, was also available for the “Wildfire” intervention, which was conducted in Xhosa. The others, assisted in the questionnaire section of data collection, in terms of handing out materials and answering questions that arose as the participants progressed through the questionnaires - it is interesting to note that there were more questions asked of these assistants, who were mother-tongue Xhosa speakers, than were asked of the researcher when she administered the questionnaires alone.

In terms of training the research assistants involved in the questionnaire section of this research, the assistants were given the questionnaires to read first. Thereafter, an orientation meeting was held, during which the assistants were informed as to the aims of the research, the content of the questionnaires and aspects of ethics as well as confidentiality. They were then asked if they were willing to comply with the confidentiality component and signed a pro-forma to this end.

The assistant who conducted the “Wildfire” intervention, is experienced with conducting “Wildfire” with adults in both rural and urban communities in the Eastern Cape. He is the managing director of the Small Projects Foundation (SPF). As a result of his experience and the ability to speak Xhosa fluently, was considered by the researcher to be ideally sensitive to the intended research population. An orientation

regarding the research and the type of feedback necessary during the “Wildfire” intervention, was held.

3.5.4 Data Analysis

In order to answer the research question **Is “Wildfire” an effective preventative intervention for HIV/AIDS among secondary school learners?** the data was analysed both quantitatively and qualitatively bearing in mind the aims and objectives of this study as set out in Chapter 1 (above).

The data emerging from the questionnaires - both fixed response and open-ended, was entered per school and in number sequence of the codes allocated to each individual so that all identifiers were removed. The data-base programme Micro-Soft Access was made available by the Small Projects Foundation, for recording. This is the programme used by the Foundation for data-capture in their community-based HIV/AIDS programme evaluation. The data was then analysed in the following ways (where relevant):

- i) according to the sub-sections of the questionnaire, namely: demographic information, HIV/AIDS knowledge/information, knowledge about HIV/AIDS as a disease, psycho-social aspects of AIDS, sexual contact and “Wildfire”. The main question here relates to whether or not the data reflects any shift - either qualitative or quantitative - between the pre and post test questionnaires.
- ii) to determine whether there were any gender differences in responses
- iii) to compare rural and urban responses
- iv) to compare post-test responses of the schools which participated in “Wildfire” with the post-test responses of the control school.
- v) to tabulate responses to learnings from “Wildfire” in Question 34, for cross-referencing with focus group notes.

During the “Wildfire” intervention, notes were taken by the researcher. These notes consisted of behavioural observations as well as relevant feedback comments and translations made by the research assistant in response to the reactions and

interactions of the learners during the intervention itself. Physically, the researcher was outside the circle in which “Wildfire” took place. The “special manner” (Packer & Addison, 1989: 10) by which this section of data analysis was dealt with, included the following: these notes were reflected upon and re-written following the process of “Wildfire”. A reading guide approach as set out by Brown, Tappan, Gilligan, Miller and Argyris (1989) was then applied. In this method of interpreting data, a reading guide asks particular questions of the text which can then be related to the research question. The question asked of the texts of notes from “Wildfire” was:

- a) *‘Are there any themes, statements/reactions which recur across school contexts during the “Wildfire” intervention?’*

The answer to this was analysed on two levels: the behavioural and the verbal levels of learners’ reactions.

The notes generated from the focus-group discussion and debriefing after “Wildfire” were re-written as a form of immersion in the material and then read and re-read following the same method as the researcher’s notes, with the question in this instance being:

- b) *‘Do the learners’ written statements of learning from “Wildfire” reflect the learnings intended by the intervention?’*

These notes were set out in tabular form, comparing the intended potential learnings with the written statements of learnings of the participants. The responses from this section were compared with the same table which answered Question 34 of the questionnaire, in which participants were asked to enumerate the learnings/decisions they were exposed to during “Wildfire”.

3.6 The role of the researcher

“By observing experience we reflexively become a part of that experience.” (Kelly, 1999: 393) Whilst the researcher was involved in every aspect of the research, including administering the questionnaires, perhaps the most active role played, was that of observer during the “Wildfire” intervention. Kelly (1999) cites Adler & Adler

(1994) as identifying the observer as being “non-intrusive” (393) in the research context - in this investigation, this was not possible, although, as observer, the researcher was not a direct participant. Because it was necessary for the research assistant to translate the learners’ reflexive and spontaneous verbal reactions (from Xhosa to English) during “Wildfire”, the presence of the researcher as observer, making and recording observations, was explicit and therefore intrusive in the process. This did not, however, disturb the flow of the psycho-educational technique. In addition to noting significant (according to the assistant) verbal responses during the workshop, the researcher as observer also noted some physical and emotional reactions of the learners. The researcher’s role therefore was to record information emerging spontaneously from the “Wildfire” as part of fulfilling a different form of data collection about “Wildfire” and in so doing performing an essential part of the rigour and triangulation of the methodological process.

3.7 Summary

To answer the question as to whether “Wildfire” is an effective preventative intervention for HIV/AIDS among secondary schools learners, this research investigation targeted Grade 9 learners, following ethical guidelines and stipulations of permission by the East Cape Education Department. A group unit of analysis of the psycho-educational intervention “Wildfire” was the subject of the inquiry. The intended outcome of the research was to gain verifiable data, on administering the intervention with adolescents in school contexts. A convenience sample of schools which represented a demographic cross-section of school contexts participated. After thorough informed consent, Grade 9 learners were invited to participate. A total of 95 Grade 9’s completed the full intervention. The research design was a simple pre-test post-test, adopting the questionnaire as one instrument for data collection. Additionally, qualitative data on behaviour/reactions of the learners as well as their small-group assessment of their learnings derived from “Wildfire” provided information in terms of answering the research question. In essence the methodology was consistent with action research principles, qualitative approaches to research and was a formative study which may be transferable across contexts.

CHAPTER 4

RESULTS AND DISCUSSION

In order to answer the question posed by this research investigation, ie: **“Is “Wildfire” an effective preventative intervention for HIV/AIDS among secondary school learners?”** the data collected has been presented in three phases within this chapter. The sources of the data were individual self-report, observation of emotional reactions, record of spontaneous verbal reactions within the “Wildfire” intervention itself and focus-group notes made by the participants in small groups. The data collected was formative in nature in other words, it reflected the process, rather than the outcome. In terms of the methodological theory the results constituted a group analysis of the social artifact “Wildfire”.

4.1 PRE-TEST AND POST TEST COMPARISONS

In keeping with the fact that this investigation was formative in nature i.e. that it reflected the process rather than the outcome (van Rooyen & Prinsloo, 2002). Responses to the pre- and post-test have been recorded below, according to responses to each question.

4.1.1 Section 1: Demographic Information

This section of the questionnaire was designed to collect general information about the research population for “time-trend monitoring” (Peltzer, 2003: 250) and in so-doing fulfilled one of the objectives of the study.

Note: For space reasons, many records extrapolated from the data, ranked, tabled and listed can be found in Appendix 7, under the relevant question number.

Question 1: “How old are you?”

Note: the control school had three 15 year olds, three 16 year olds, two 17 year olds and one participant of 18 years.

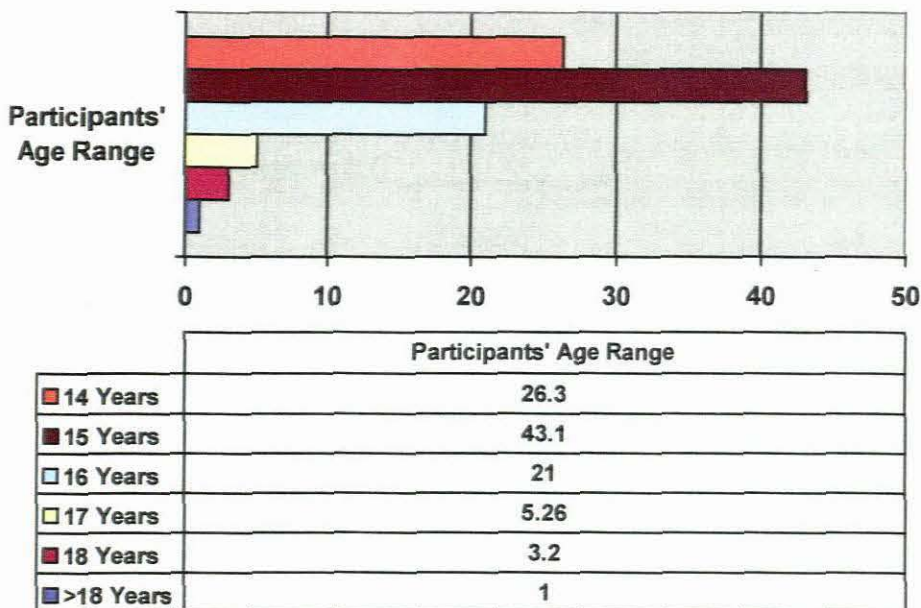


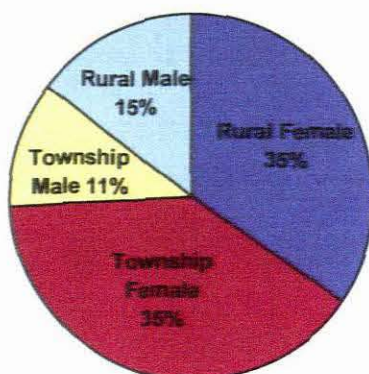
FIGURE 1: Participants' Age Range in Grade 9

APPENDIX 7a) has a detailed table of ages. The majority of participants (69,4%) were in the age range 14-15, with 21% being 16 years of age, confirming the intended age-range of this intervention.

Question 2: “Are you male or female ?”

As can be noted from the figure, more females were willing to volunteer for the research than males. Significantly, more rural males than urban males volunteered. This was possibly because one of the rural schools was a boarding facility.

FIGURE 2: Participation of volunteers across school contexts, including gender.



Note: The Control School was a township school with 4 female and 5 male participants.

Question 3: “Who do you live with?”

The general trend emerging from this question was that more rural and urban participants live with one parent, than both parents. The design of this question was incorrect, making the responses difficult to interpret. One of the intentions was to determine whether, if any, participants live in child-headed households, which did not emerge clearly from the data. This question could be re-designed to extrapolate information about number of people in household, head of household etc., which could lead to determining the current effects of the HIV/AIDS pandemic on households.

4.1.2 Section 2: HIV/AIDS Exposure To Knowledge and Information

This section of the questionnaire fulfilled one of the objectives of the study, which was to determine the level of knowledge and information and the sources of such knowledge and information, as reported by adolescents at this point in the epidemic. Again, such information was for “time-trend monitoring” (Peltzer, 2003: 250) and added to the pool of knowledge about adolescents. This information is potentially useful to the Education Department and to teachers as well as other researchers.

Question 4: Have you ever heard of HIV/AIDS?

TABLE 2: Responses to Question 4

| | YES | | NO | |
|-----------------|----------|-----------|----------|-----------|
| | Pre-Test | Post-Test | Pre-Test | Post-Test |
| Rural Female | 94% | 88% | 6% | 0% |
| Rural Male | 100% | 100% | 0% | 0% |
| Township Female | 84% | 97% | 0% | 0% |
| Township Male | 90% | 90% | 0% | 0% |

The male responses were consistent from pre to post-tests. It appeared that less rural females reported having heard of HIV/AIDS from pre to post-test. This was not possible, given the context of the research, therefore the gaps of no-entries can explain this or possible barriers (Peltzer, 2004) could have emerged as a result of the intervention. The township females reported a 13% increase in terms of having heard of HIV/AIDS.

Question 5: “How did you hear about HIV/AIDS?”

The responses to this question were ranked according to response-frequency across rural/urban, male/female divides and then compared to the control school. Fixed responses within the themes: Community, Church, School and Family were provided. The table in Appendix 7 gives a full ranking of responses. In summary, Life Orientation from the school section rates first, with increases from pre to post test, suggesting that the intervention itself may have stimulated relevant discussions within the school context, regarding HIV/AIDS. It is also possible that the questions, in providing fixed-responses provided information on possible sources and choices of information, which may explain the shift in township male responses from Life Orientation in the pretest (90%) to 60% in the post-test, where Radio and significantly, Clinic (70%) changed in ranking, but not in percentage. This may indicate that Radio is the preferred/primary source of HIV/AIDS information for township males. Friends and youth groups rank in the middle, which was consistent with developmental theory of the importance of peers and the group during adolescence (Santrock, 2002). Pastors, family members such as aunts/cousins as well as guest speakers at school were ranked the lowest. It is possible that if the learners had ranked their responses themselves, the outcome could have been different.

Question 6: What do you know about HIV/AIDS?

In general, the facts emerging from responses here, indicated that the adolescents in the research population were well-informed about HIV/AIDS. This corroborates findings of other authors in the field (Hoosen & Collins, 2004; Cohen & Trussell, 1996; Visser, 1995). The responses to the pre-test in School A, indicated a range of foundational knowledge and information. School C, had more no-entries (8) in the

pre-test and only 3 in the post-test, indicating a shift in either knowledge-acquisition, or preparedness to commit to that knowledge as a result of the research process. School E showed basic knowledge, with more detail in post-test. An interesting shift suggested by “Wildfire” in School D, was where one participant did not respond to this question in the pre-test, but his post-test response was “It is something that a you have by careless mistake but one thing I know most of all bring this to them by themselves”. – this response reflects the choices and decisions with which “Wildfire” deals. Another qualitative shift reflecting Wildfire learning was “...If you have HIV tell you parents and go to clinic for medication”. Many responses dealt with the development of HIV into AIDS, the use of condoms for prevention, discrimination and loneliness of those who test positive, death, mother-to-child transmission, symptoms, living with HIV/AIDS.

Importantly, the participants were aware of how you cannot get HIV/AIDS eg: by sharing dishes, clothing and hugging an infected person. One response was: “I know that you are HIV/AIDS you could dies and you don’t tell someone that you are HIV/AIDS”. – which reflects the culture of stigma and silence issues referred to by van Dyk (2003). Responses in School E pre-test to post-test did not reflect knowledge-acquisition because there was no input but more facts are offered, suggesting that the exercise of completing the questionnaire was positive in terms of expressing knowledge about issues of HIV/AIDS. The Questionnaire therefore could be seen as an intervention on its own.

Question 6.1: “Where did you learn this information?”

Appendix 8 has a table which reflects the responses to sources of information about HIV/AIDS which were ranked by the researcher. According to this, SABC 1, Mothers, Xhosa Radio, Education Radio and during a lesson were ranked highest as sources. Pre to post test, the viewership of SABC 1 was raised with 64% of rural males reporting watching in the pre-test, rising to 71% in the post test, rural females reporting a 14% rise. The township males and females shifted from pre-test (80% of males reported as receiving information during a lesson) to post test, where SABC 1 (70% for males) ranked first. Indications suggest that the fixed-response open ended options were acted upon from pre to post test again suggesting the questionnaire as a

source of information. Mothers were third and fourth, generally higher amongst township females than rural females. Guest Speakers and Assembly as school sources were ranked below 50% and the lowest ranking was attributed to Fathers, Billboards and Pamphlets.

Question 7: “If you want to find out more about HIV/AIDS who would you speak to?”

The trend in ranked responses to this question, showed a general preference for class teachers and mothers as sources of information (with guidance and then standard heads lower on the ranking order). Preferences according to the adolescent respondents showed that personal relationships e.g. class teachers and mother make it possible for adolescents to ask questions. Further, both rural and township participants would prefer to talk with significant others of the same gender – fathers, for example have a below 10% preference to rural females, as a source of information on HIV/AIDS. Full responses are recorded in Appendix 9 under the relevant question.

4.1.3 Section 3: Knowledge About HIV/AIDS as a Disease

This section of the questionnaire fulfilled some of the objectives of this study, in that knowledge and information as applied to questions and attitudes toward people living with HIV/AIDS, are explored and reinforced.

Question 8a) “Do you know anyone who is living with HIV/AIDS?”

TABLE 3: Responses to Question 8a)

| Responses | RURAL | | | | TOWNSHIP | | | | CONTROL | | | |
|-----------|----------|-----|-----------|-----|----------|-----|-----------|-----|----------|------|-----------|------|
| | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | |
| | M | F | M | F | M | F | M | F | M | F | M | F |
| YES | 50% | 52% | 36% | 70% | 40% | 66% | 50% | 89% | 100% | 100% | 100% | 100% |
| NO | 50% | 39% | 29% | 12% | 50% | 11% | 30% | 11% | | 0% | | |
| No Answer | | 9% | 36% | 18% | 10% | 24% | 0% | 0% | | 0% | | |

Responses indicated a positive shift in awareness of PLWA’s from pre-test to post-test for rural males (18% increase) township males (10% increase) and township females (23% increase). It is possible that the intervention increased social awareness for these learners. If this is the case, this question showed the intervention to be effective in terms of van Dyk’s factor contributing to behaviour change – that of personal contact with someone infected with HIV (van Dyk, 2001: 84). Rural males responses decreased by 14% from pre- to post-test, possibly indicating denial and barriers (van Dyk, 2003).

QUESTION 8b) “Do you know of anyone who has died from HIV/AIDS?”

TABLE 4: Responses to Question 8b)

| Responses | RURAL | | | | TOWNSHIP | | | | CONTROL | | | |
|-----------|----------|-----|-----------|-----|----------|-----|-----------|-----|----------|------|-----------|------|
| | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | |
| | M | F | M | F | M | F | M | F | M | F | M | F |
| YES | 36% | 76% | 57% | 79% | 80% | 76% | 70% | 89% | 100% | 100% | 100% | 100% |
| NO | 29% | 18% | 14% | 6% | 10% | 3% | 0% | 5% | 0% | 0% | 0% | 0% |
| No Answer | 35% | 6% | 29% | 15% | 10% | 21% | 30% | 6% | | | | |

There was a general increase from pre to post test, in stated knowledge about individuals known to participants, who either were living with or had died as a result of HIV/AIDS except for township males, whose responses decreased by 10% pre- to post-test. These results indicated that the intervention, including “Wildfire” had increased participants’ awareness of HIV/AIDS sufferers and possibly, that males may be more resistant to awareness of AIDS deaths – however these results may be explained in many different ways.

Question 9: “What do the letters AIDS, stand for?”

The responses to this question varied, with schools C and D having more no-entries and incorrect entries, and schools A, B and E having more correct responses. Many of the responses reflected an understanding. Incorrect spelling where the full 4 word response was entered and could be understood, were counted as correct e.g: “Aquadid Muriom Defisy Syndrome”. In the post test, School C’s no entries diminished to 1, with generally correct, full entries, indicating that the input of the research, increased

knowledge – this was not necessarily directly attributed to “Wildfire” which was a verbal intervention but possibly from input either from the school, or self-study, having not been able to fully answer this question in the pre-test.

Question 10: “How is HIV spread?”

Responses to this question across all school contexts, are summarised in Appendix 10, and include all the facts covered, (not repetitions) plus misconceptions. Schools A, B, D and E reflect solid foundational knowledge through from pre-test to post-test. School C’s response was significant in that there were more no-entries in the pre-test and less no-entries in the post-test. The facts and knowledge communicated in the post-test responses were in line with the facts in the pre-tests of the other schools. There may be many explanations for the lack of entries in the pre-test for School C, including perseverance in the process as many questions (eg: question 6) are similar or lack of knowledge. However, when considering this difference with regard to the research process itself, the contrast in pre- to post-test entries suggested two things with regard to answering the research question:

- 1) “Wildfire” communicated many facts about the transmission of HIV/AIDS.
- 2) The facts communicated by “Wildfire” are comparable to other information / knowledge input received and attenuated by participants in other schools, from other sources.

Another assumption can be drawn from this, in that the intervention of the questionnaires themselves may raise questions from learners which can then be dealt with within the school context (eg: in Life Orientation lessons). Many of the facts duplicate and reinforce preventative knowledge, information and awareness.

There were only 3 misconceptions recorded, which highlighted the risk inherent in any intervention – that not all participants will assimilate the intended learnings in the same way. One presumed misconception recorded in the post-test of School D is “To shoik an hand with other people without clubs”. – this can be directly attributable to “Wildfire”. In interpreting and taking into account that the respondents were second language English users, “clubs” is possibly referring to “gloves”. In “Wildfire” gloves were made available as symbols of all protective articles (eg: condoms) with

respect to the spread of HIV/AIDS, and “shaking hands” was an activity which simulated/symbolized casual, unprotected sex. Therefore, it is assumed that this response was a literal response to the intervention and highlights the importance of checking understandings of any intervention (as in the post-test). The possibility that the cognitive development of individuals varies so that parts of the intervention that are symbolic, could be taken literally, is not to be ruled out and provides useful feedback for future administrations.

Question 11: “If you were worried about having HIV/AIDS, would you want to know your status?”

TABLE 5: Responses to Question 11

| | RURAL | | | | TOWNSHIP | | | | CONROL | | | |
|-----------|----------|-----|-----------|-----|----------|-----|-----------|-----|----------|-----|-----------|------|
| | M | F | M | F | M | F | M | F | M | F | M | F |
| | Pre-test | | Post-test | | Pre-test | | Post-test | | Pre-test | | Post-test | |
| Yes | 79% | 64% | 86% | 94% | 80% | 76% | 80% | 87% | 60% | 75% | 80% | 100% |
| Nos | 7% | 18% | 7% | 3% | 20% | 3% | 20% | 3% | 40% | 25% | 0% | 0% |
| No Answer | 14% | 18% | 7% | 3% | - | 21% | - | 10% | - | - | 20% | - |

The general trend of responses to the question on VCT, showed a rise in stated intention of participants from pre to post test to find out about their sero-status, except for township males, whose intention remained the same (80%). Comparison with the control group showed no significant difference, although this cannot be considered to be reliable, given the fact that the sample size of the control group was so small comparative to the other schools. The whole intervention, including “Wildfire” could be said to have provided opportunities for the participants to consider the possibilities of VCT in a positive light. This data, coupled with the qualitative feedback and responses which reflect that “Wildfire’s” learning regarding a cognitive-mapping of the VCT process, suggested “Wildfire’s” influence in, especially the rural females’ response which rose from 64% in the pre-test to 94% in the post-test. According to this an additional 30% of rural females were more positively disposed to discovering their sero-status, after the “Wildfire” experience. This result strongly favoured “Wildfire” as a mediator to contemplate VCT while providing a preventative experience. Wildfire therefore could potentially be considered to be a pre-cursor and social marketing tool, for the services offered by VCT in the health sector.

Question 11.1: “How can you find out if you have HIV?”

The general trend in answering this question in the pre-test, reflected that the participants had been exposed to knowledge and information regarding blood tests at clinics and hospitals, as well as to guiding health principles, such as prolonged illness being a tell-tale sign of possible infection. In the post-test, responses concentrated more on the fact that clinics and hospitals are where one could seek information. Some responses in the post-test included speaking to parents / friends / teachers. This suggested that the “Wildfire” intervention provided a more specific “how-to” map (to information already gained) on finding out sero-status. Encouraging more openness with and garnering the support of significant others, regarding VCT emerged as a learning.

Question 12: “How can HIV/AIDS be prevented?”

This was similar to Questions 6 and 10, but required the participant to further distil the knowledge/information at his/her disposal. General, as well as direct quotes, can be found in Appendix 11. The majority of responses reflected Aids-jargon and sound knowledge of information and awareness. Some responses, especially in School C, appeared to reflect management of HIV issues (eg: “eat healthy food”, “exercise”), which is not directly answering the question. However, such responses may indicate that these management issues were of direct practical concern to this group of adolescents, and therefore too threatening.

In the post-test responses, the general sense of a shift, possibly as a result of “Wildfire” between the pre- and post- tests was suggested in the detailed application of knowledge of preventative issues, as well as psycho-social issues. Examples include protection from blood in injuries on the netball field, talking, telling parents, sharing knowledge and information. Whilst the data did not point directly to “Wildfire’s” influence in this shift, indications suggest that the whole research intervention had gone some way toward fulfilling what Donald et.al. refer to as the “ecological transactional orientation” (2000: 3) where a “Socially constructed system of external influences that is mediated by individuals’ minds...” was fulfilled by “Wildfire”. Therefore, the assumed outcome/product of this investigation in terms of

shifting and mediating social influence/process over time (refer Chapter 2, Section 2.7 Behaviour Change) could be inferred from the data.

Question 13: “What are other young people saying about HIV/AIDS, and how it is spread?”

The intention with this question, was to gauge the volunteer participants’ views of their peers’ perceptions. In terms of “time-trend-monitoring” (Peltzer, 2003) this may give future researchers a guide as to various current adolescent constructions (and possible misconceptions) of the spread of HIV/AIDS. For the participants themselves, the intention was to acknowledge that many views exist regarding the spread of HIV/AIDS. This question fulfilled one of the objectives of the investigation, regarding attitudes amongst the adolescent population regarding HIV/AIDS.

Most responses were repetitions of responses to question 10 and related to prevention eg: “abstain”, “be faithful” such responses reflect AIDS-jargon and not necessarily application of knowledge. Therefore, only answers that explicitly related to others’ views were considered and then the most powerful from each school and two from School D are recorded in Appendix 12. School E had no responses that were relevant to the question. No particular shifts from pre- to post- test were noted thematically, although there was an increase in entries on this question, from School C.

Question 14: “What questions do you have about the disease HIV/AIDS?”

A summary of participants’ questions around issues of HIV/AIDS was recorded in Appendix 12. No shift in responses from pre-test to post-test were noted, or could be attributed to “Wildfire” as an intervention. These questions reflected the voices of the youth in response to the knowledge and information they had been exposed to. The summary will be useful for Life Orientation educators and provide relevant issues with which guest-speakers can deal in the school context. In this sense, the question served the function of “time-trend monitoring” (Peltzer, 2003).

The questions reflected emotional responses, fear of those living with HIV, misconceptions about the origins of HIV/AIDS, and practical “how-to” or skills based questions e.g.: “how can I talk to my parents about it?” or about family members living with HIV/AIDS. One question, “Do you get it when you’re using contraceptives?” may be an important issue to address in that birth control pills/injections may be considered to be preventative for HIV/AIDS as condoms are also forms of birth control. A distinction between using birth-control and prevention of HIV/AIDS needed to be made – this finding reflects the observations made by Cohen & Trussell (1996) of issues elsewhere in Africa. At times, the cognitive link between sex and HIV/AIDS was not understood e.g.: “Why people get it by having sex?” and “How can we prevent it?” reflect concerns such as Akande’s (2001) about the transfer of knowledge and information into practice in adolescent populations.

The responses raised questions as to how much knowledge and information can be empowering enough for personal preventative action to take place, when a sense of powerlessness sets in and when saturation of knowledge and information occurs around issues of HIV/AIDS. This was reflected by: “is it truly possible that you musn’t have a boyfriend without reaching 21 years?” Again, a distinction needs to be made for adolescents – that a relationship does not have to be sexual.

Question 14: “What questions do you have about the disease HIV/AIDS?”

This fulfilled one of the objectives of this investigation, in that it dealt with the questions adolescents currently have about HIV/AIDS, for “time-trend monitoring” (Peltzer, 2003: 250) purposes. This had a direct practical bearing in terms of providing relevant information and feedback for the Department of Education and for the staff dealing with HIV/AIDS in Life Orientation lessons. This information coupled with participants’ responses to question, 20 (school support) has potential to be supportive of and supplement current HIV/AIDS education programmes. Selected responses were recorded in Appendix 13.

Question 15: “Is there anything that you know/or have heard about HIV/AIDS, that
a) You do not understand b) You do not believe?”

A summary in tabular form, of some of the responses to this question, are in Appendix 14. As in question 14 the participants' responses provided direct information of the types of questions and misconceptions that can result from preventative, as well as knowledge and information input, around HIV/AIDS. These questions and statements are potentially useful to Life Orientation educators/and provide possible explanations for adolescents' difficulty in transferring their knowledge of prevention, into behaviour (Akande, 2001). In providing opportunities for participants to 'voice' their questions, some themes emerged:

- Relationships with the opposite sex. In stressing that sex is the prime cause of HIV transference, a distinction needs to be made between a sexual relationship and a non-sexual relationship in gender relations which give rise to such questions as: "By sleep nex to him/doing nothing." This question of WHEN sexual debut is acceptable, also arises, and needs to be answered for these adolescents.
- Metaphysical explanations such as "is a punishment from God" should be debunked as not being useful.
- More specific information on AIDS grants needs to be given, as money could become an incentive for poverty stricken people to become infected.
- The de-humanising effect of AIDS in terms of perceptions is noted in references to animals.
- "Why don't you see AIDS for the 1st time?" and "How do the doctors know that they disease destroy you immune system?" reflect rationalisations in the denial of the existence of HIV/AIDS. This echoes verbal responses in the "Wildfire" intervention, where participants stated that they could not see HIV/AIDS on others' faces. Elsewhere in Africa, "investigators report that local concepts of disease may not encompass the idea of a healthy carrier" or Asymptomatic Transmission (Cohen & Trussell, 1996:138) which again may explain barriers to behaviour change mentioned by Van Dyk (2003). This may provide the subject matter for further research.

4.1.4 Section 4: Psycho-Social Aspects of Aids

This section of the questionnaire fulfilled two of the objectives set out for this study – attitudes toward people living with AIDS and self-efficacy.

In Questions 16 and 17, the participants are encouraged to think carefully around specific issues of self in relation to a possible HIV positive fellow learner (Question 16) and exploring the same issues from the point of view of a possible HIV positive person (Question 17). Both questions followed the sequence of: thinking, feelings, what is said, and how to act/interact socially in the event of an affected person joining their class.

A selection of responses from each school were recorded in Appendices 15 and 16. These reflected the individuals' responses with no particular difference between pre-test and post-test in the "Wildfire" schools (A, B, C and D) or those responses in the control group.

As can be seen by the responses, the individuals showed sensitivity and general acceptance, which suggested that the questionnaires provided an opportunity for learners to think through such issues that may transfer-to action. The sensitivity with which participants responded, is in keeping with the developmental phase of adolescents, during which the importance of the group and fairness are paramount. This suggested that psycho-social issues around HIV/AIDS may be responded to positively at this stage of development. In this sense, this part of the questionnaire was valuable in terms of prevention of such psycho-social barriers as stigma, silence and non-acceptance at an adolescent level. From a psycho-social viewpoint, responses to this question provided a rationale for the age/stage of development of participants in terms of prevention of psycho-social barriers regarding HIV/AIDS. The reinforcement of these questions pre to post test as well as the responses in the "Wildfire" tables of points of planned learning for the intervention itself (Tables 8 and 17) and for Question 34 reflected positive and accepting psycho-social views throughout the phases of this research intervention.

Question 18a): :What personal strengths do you have, that can help you to protect yourself from HIV/AIDS?”

Appendix 17 provides a brief summary of responses that appeared to answer the question, and not reflect a repeat of AIDS related jargon, such as ‘A, B, C’. What was of concern across school contexts, was the general paucity of understanding concerning personal strengths/self-efficacy. The question was possibly inappropriate in its wording, and should perhaps be re-constructed in the event of a repeat of this research. In light of the responses however, a gap in the Life Orientation section of the curriculum emerged in terms of individual learners being conscientised toward their personal strengths and characteristics – some of which may be useful and empowering in terms of skills / negotiations regarding HIV/AIDS related issues. The relevant schools and Education Department will be informed of this finding.

Question 18b): “What practical things can you do to protect yourself from HIV/AIDS?”

Along with responses to 18a), Appendix 17 has responses to this question which reflect avoidance of risky situations such as bars, preventative measures, skills such as covering open wounds and checking needles at the clinic. Again, the responses were not all as positive in terms of reflecting participants’ personal relationships with HIV/AIDS as had been hoped for. No shift was noted from pre to post test.

Question, 19: “Do you plan to do anything to protect yourself from HIV/AIDS?”

TABLE 6: Response to Question, 19

| | RURAL | | | | TOWNSHIP | | | | CONTROL | | | |
|-----|------------|-----|-----------|-----|----------|-----|-----------|-----|----------|------|-----------|------|
| | M | F | M | F | M | F | M | F | M | F | M | F |
| | Pre-test | | Post-test | | Pre-test | | Post-test | | Pre-test | | Post-test | |
| Yes | 71% | 94% | 79% | 82% | 100% | 82% | 90% | 87% | 60% | 100% | 80% | 100% |
| No | No Entries | | | | | | | | | | | |

No explanation can be found in the pre to post test decrease in responses to this question for rural females, or township males (12% and 10% respectively). The responses of intentions however, are high.

“If, yes – what do you plan to do?”

The responses to this part of the question reflected a range of actions, mostly relating to preventative measures and in-put from various sources. They included – the age factor, waiting until marriage, condomising” “Always carrying a werpon wich is a condom” (15 year old male from School C, pre-test), being careful of strangers, self-respect, maintaining a healthy life-style, having one partner, not touching blood, avoidance of sex: “Abstaining from HIV/AIDS and having no girl lover but having friends which are girls only” (16 year old male, School D, pre-test). One response, concerned the participant’s future: “I want to have long life and I want to be a social worker” (14 year old female from School B, pre-test). Commitment on paper within the context of this research had been made regarding personal intentions to protect from HIV/AIDS, in terms of understanding the consequences of not doing so. According to the Fishbein–Ajzen model (cited in Armitage, 2001), intentions to change behaviour precede the behaviour itself. In this sense, question, 19 leads the participants to thinking about and committing to protective behaviour. This reinforced the fact that the intervention was didactic / psycho-educational beyond simply answering the research question.

No significant difference between the pre and post-test was found, except that there were a few references to attending a clinic in the post-test – this is likely to be a result of the “Wildfire” intervention, which mapped the VCT process. This confirmed the potential for “Wildfire” to be supportive of VCT attendance in the health sector.

Question, 20: “What support do you think the school could provide, to help young people in the face of HIV/AIDS?”

The following points constitute a summary of the types of responses made by the participants sub-divided into themes applicable in the school context. Some were mentioned often and others less frequently. In order to provide as full a report on the “voices” of the youth regarding the types of institutional support they regard as possible in the schools, the following points have been thematised, without school identification:

OUTSIDER INPUT:

“Having an HIV/AIDS awareness campaign, giving out condoms to everyone for them to protect themselves if they do have sexual intercourse”.

People that came to our school to tell us more.

Guest speakers e.g. a member of a clinic.

Mobile clinics with free condoms.

“Member of Wildfire”.

“Let visitors like Mrs Cromhout teach so we can have more know and teach youngster about it”.

FORMATION OF GROUPS:

Youth groups.

HIV/AIDS groups in school.

Make an AIDS formulated association.

Wednesdays as AIDS days.

“They need to have debates about AIDS in the school ...”

Use the youth to teach the youth.

COMMUNITY AWARENESS:

“To give one day the school out somewhere and tell people to protect themselves from it”.

“Opening debates in the community”.

TEACHERS' ROLES/ATTITUDES:

Understanding.

Counselling.

“Teachers must be honest”.

“Teachers must not hide anything because there is nothing we don't know”.

“Be open with HIV/AIDS”.

“Not always shouting them or embarrass them”

Advice, love, care, encouragement, praying, motivating.

“By having one spirit at school”.

“They should tell us to stop having sex”.

“To go to the teacher for information”.

“By giving them good respect”.

GENERAL SCHOOL-RELATED ISSUES:

“The school will give them strength”

Message: “Don’t be afraid of saying you are not ready for sex”.

By providing “magazines like Soul City”.

By allowing opportunities “to hear the radio”.

“To invite clinic member”.

“Take them to the clinic”

Catering for needs e.g.: fruit, money, clothes, medicine, having a garden of vegetables.

Providing things for people in need.

“Our school drama speaks a lot about AIDS”.

“they must put a box of condom in the school yard because young people want to have sex before getting married”.

Responses to this question were consistent with the Draft “Education Sector Policy on HIV and AIDS” (Daily Dispatch, September, 2005) referred to in Chapter 2. Here, “prevention services which understand and cater for their young people’s needs and concerns”, as well as ‘recognising that schools are an important part of every community” are met, in terms of giving the learners a ‘voice’ and involving members of the broader community in their education. Direct and practical outcomes leading from this question, coupled with responses to Question 14, and 18a emerged for the use by the Education Department and Life Orientation teachers in the school context.

Question 21: “What can you and your friends do to combat/fight HIV/AIDS? (including prevention, care and support)?”

Appendix 18 contains responses to this question in summary form. They reflected psycho-social issues of sensitivity to issues around HIV/AIDS – including caring for children, involvement in community outreach and learning from People Living with HIV/AIDS. A lack of faith in adults as role-models provides a significant “voice” for adolescents – it also confirmed Whiteside & Sunter’s claim that norms are overturned in the face of HIV/AIDS (2002).

4.1.5 Section 5: Sexual Contact

This section fulfilled one of the objectives of the research in that it dealt with the sexual behaviour of the participants.

Question 22: “Have you ever had full penetrative sexual intercourse?”

In response to this question 30% of rural females answered “Yes”, 30% answered “No” and the rest were no-entries. Township females however responded as follows:, 20% said “Yes”, 40% said “No” and the rest were no-entries. Rural males’ responses were: 57% as “Yes”, and 21% as “No”. Township males followed the same pattern of responding as the females, in that, 20% answered “Yes”, 40% answered “No” with the rest not responding at all. 80% of the control school males answered “Yes”. All of these responses, were in the post test.

The second part of this question was: “If you answered Yes, please answer the following question: “Were you willing/did you consent to this intercourse?” Of those who responded to this question, 50% of rural males, 21% of rural females, 10% of township males and 18,4% of township females answered “Yes”. Significantly in the “No” response, only the township females responded, with 29% saying “No”, suggesting that township females are more at risk of coercive sexual relations. Appendix, 19 contains tables of responses to this question.

Question 23: “How old were you when you first had sexual intercourse?”

TABLE 7: Question 23: “How old were you when you first had sexual intercourse?”

| Reported ages of first sexual contact | RURAL | | TOWNSHIP | | | |
|---------------------------------------|-----------|-----|----------|-----|-----------|-----|
| | POST-TEST | | PRE-TEST | | POST-TEST | |
| | M | F | M | F | M | F |
| Before 10 Years | 7% | 3% | 60% | | 0% | 5% |
| 10 Years | 43% | 0% | | | 0% | |
| 11 Years | 0% | 0% | | | 0% | |
| 12 Years | 0% | 6% | 20% | | 10% | 3% |
| 13 Years | 0% | 6% | | | 10% | 11% |
| 14 Years | 0% | 6% | | | 0% | 3% |
| 15 Years | 14% | 9% | 20% | | 0% | 11% |
| 16 Years | 14% | 12% | | 25% | 0% | 18% |

As can be interpreted from the table above, 50% of rural males experienced sexual debut at 10 years or under. Rural females reported at 3% at this age. The reasons for this are not explicable without in-depth investigation. Rural females generally reported at 6% for debut at ages 12, 13 and 14 with an increase to 9% at 15 years and 12% at 16 years. This concurred with MacLeod's baseline survey of the Eastern Cape (2002), in which males debut earlier than females. The township self-reports showed discrepancies between pre and post test reporting which places the reliability of this data in question. For example 60% of males reported debut at under 10 years in the pre-test and 0% in the post-test and 25% of females reported debut at 16 years, but in the post-test only 18% report this. Possible explanations for this data could be the intrusive/personal nature of the questions, emerging barriers or the fact that the questions were misunderstood. Statistical correlations may explain such discrepancies, but this is not the intention of this investigation.

Whilst the data needs to be interpreted with great caution, there remained the concern relating to early sexual debut (5% of township females).

MacLeod (2002) refers to concern for early debut and also places general debut at around 12-14 years, which appears to be consistent with the reports from participants who did respond. One of the rationales for targeting participants at this age, was that of sexual debut and the data can tentatively be presumed to confirm this.

Question 24: "How many partners have you had?"

The majority of participants who responded reported having had one partner. Of concern, was the data indicating more than one partner in all ages ranges, the most notable being that a minority of rural males and females reported having more than 5 partners and, 20% of males in the control school also report this. However, the control school's percentage was neither valid or reliable because of the small sample size. What the table in Appendix, 20 indicates therefore, is that risky sexual behaviour (Cohen & Trussell, 1996) was taking place amongst learners at this level of the education system.

Question 25: “What age is or was your latest sexual partner?”

Generally both township and rural males reported having more partners in the 10-13 year age range, whilst the data from the rural and township females indicated partners between 14 and 18 years. This data confirmed the rationale for the age of intervention chosen in this research investigation, suggesting that it is relevant. Appendix 21 contains a table of the responses.

Question 26: “Where do these sexual activities take place?”

Data on sites of sexual practise showed that most females (rural and township) engaged in sexual activities in their partners’ houses, which was confirmed in that both rural and township males reported these activities as taking place in their own houses. Township females (a minority) report other sites. 3% of rural females and 10% of township males reported sexual practise at school. Appendix 22 gives a full breakdown.

Question 27: “At what time of day do sexual activities take place?”

The majority of respondents reported night time as the time of day. Appendix 22 has a full table on the data.

4.1.5.1 Discussion of Sexual Contact: Section 5

Adolescent self-reporters are well known to be unreliable (MacLeod, 2002; Akande, 2001). For this reason and given the small sample, the actual data reported upon in this section should be interpreted with great caution. Factors such as the assumption in the questionnaire design, that all responses in this section are from those who are engaging in sexual contact, plus confidentiality issues and language issues need to be taken into account as possibly confounding the data. However, what this data does, is confirm the rationale for this research in terms of age of intervention. It also pointed to concern about sexual debut at 10 years and under and the risk of multiple partners as being factors increasing vulnerability to HIV/AIDS at this age. The sites of sexual

practise are reported to be mostly in the male's home and at night which is a possible consideration in taking preventative action.

The reliability of the responses in this section of the questionnaire were not validated pre to post test given the intrusive/personal nature of the questions – leading to almost no responses to the pre-test. Trust issues are possible explanations, given that the pre-test was only the second face-to-face contact between participants and the researcher. Another explanation, which ties up with theory of behaviour change, was that participants were still in a phase of pre contemplation (Di Clemente cited in Andreasen, 1995) in the pre-test phase of the investigation, but had, through the research process, shifted to a further phase possibly that of contemplation. The results emerging from the “Wildfire” intervention strongly suggest that “Wildfire” provided a cognitive and emotional ‘mapping’ of these VCT process, as well as supporting the concept of the social advantages of disclosing status in the event of testing positive. This suggested that “Wildfire” gave permission to participants to be more open about issues around sexual contact. If this was the case, as the data suggests, the “Wildfire” experience was key to the significant shift from pre to post test, in this section, and confirms the effectiveness of the intervention with regard to a degree of disclosure.

4.2 Phase 2: “Wildfire”

Phase 2 of the data analysis was qualitative in nature. The intention of the methods utilized was to provide different sources of information/data in order to triangulate the results of the pre-and post-test questionnaires. According to Terre Blanche and Kelly, “collecting material in as many different ways and from as many diverse sources as possible” (1999: 128) provides methodological rigour to the results generated. Therefore, in addition to the self-report of the questionnaires in Phase 1 and 3, this phase provided a record of behavioural and verbal reactions to “Wildfire” employing the observation method, as well as focus group analysis by the participants after consensually reconstructing and co-constructing their learnings and reactions to the intervention.

This section of the results dealt directly with the “Wildfire” psycho-educational intervention itself. It consisted, firstly, of observation notes made by the researcher

whilst observing the process of the “Wildfire” intervention. These notes were intended to capture, as richly as possible, the learners’ reactions to the experience, by recording behavioural reactions as well as the (translated) verbal reactions of the participants. These notes reflect the process of “Wildfire” during the activity. Secondly, the notes generated by the participants from focus group discussions as part of the debriefing at the end of the four “Wildfire” interventions across the different contexts of the schools, was recorded and discussed.

“Wildfire” is an activity and reflection-based psycho-educational tool which simulates, to a group in role-play/as a game, ‘exposure’ to HIV/AIDS and what to do about it. The series of choices that need to be made in consequence of ‘exposure’ (such as VCT, who to tell and how to protect oneself and others) as well as the reinforcement of knowledge, information and feelings pertinent to such a situation, are discussed and reflected upon within the group. “Wildfire” ends with a debriefing in which the learners reflect on and reconstruct their learnings in focus groups. “Wildfire” is referred to in Chapter 1 (section 1.2), Chapter 2 (section 2.6) and in Appendix 1).

4.2.1 “Wildfire” Observation Notes: the Process of the Intervention

Activity 1: ‘Exposure to HIV/AIDS

In this activity, shaking hands represents ‘exposure’ to HIV/AIDS, through ‘casual, unprotected sex’.

NOTE: The facilitator’s actual words will be recorded in italics and the participants’ responses, in normal script.

Behaviours Observed in Reaction to Handshaking:

Learners physically jumped back from handshake. Whole group ‘infected’.

Insecure after explanation of game – two girls holding hands

Boys initiated handshaking, girls stood still. Whole group ‘infected’.

Learners physically jump back; appear to go out of their way to shake hands more; many giggling and holding hands. Most ‘infected’, 4 boys not ‘infected’.

Reflection: Self-Awareness in Relation to Activity 1:

Discussion and verbal analysis of Activity 1 was led by the research assistant, along the lines of “How did you feel, when your hand was shaken?”

“It made me laugh”; “not a nice feeling”; “nervous”; “others were scratching a bit hard” – “*Did this make you sore?*” – “yes”; “*Did anyone feel cross or angry?*”

“No”. “It made me itchy and irritated”; “felt bad”; “shocked at being exposed”; “I got a fright when exposed, I did not think they had it, but if a person has really got it, I would be really angry.”; “Yes, I admit, I scratched others and spread”. “*Why did you engage in casual unprotected sex?*” – “I didn’t know there would be someone or who it was”; “I was only thinking about what was happening”.

This section of the workshop in one of the schools was dominated more by the fact that 4 male learners were not exposed and comments on the fact that the females were all exposed.

Analytical Reflection: Preventative Measures Available in Activity 1:

This stage of “Wildfire” required reflective distancing from the activity in which the learners are asked why they did not use the ‘protective’ measures – represented by gloves – in order to prevent possible ‘exposure’ to HIV/AIDS.

All learners exhibited an emotional response –when they realized that they could have used the gloves to protect themselves from exposure. “I did think of it, but there was no chance to use the gloves.” Laughter at revelation at themselves, for not having used the gloves. Their response was “I was only thinking about what was happening – the action.” “*Did you abstain?*” “NO!” an emotional response to realizing that they neither chose to abstain nor use the glove. Laughter was the behavioural response.

Activity 2: Choosing to Test and Analysis of that Choice:

In this activity, the learners, having been ‘exposed’ to HIV/AIDS, were presented with the choice of VCT, in order to learn their HIV status.

3 males chose not to be 'tested'. Their responses were" "I don't want to know"; "I am scared to know" and "I am scared to tell my parents."

Those who chose to be tested gave the following reasons:

"I want to know my status"; "I want to protect myself and others"; "I want to get help and support" and "I want to eat right and keep my nutritional status."

At the suggestion of VCT, learners physically stepped back from their positions in the circle. Stepping forward, one participant said: ""I want to know my status"; "I want to know my status – positive or negative"; "I don't want to spread to others – keep others safe." "I want to know my status and live a healthy life"; "I want to deal with it, treat it"; "I want to protect other children"

Reasons given by the group for not testing:

"Others will say bad things about me."; "I will not concentrate properly" "I will be criticized", "Can I be fired – yes!" 6 participants chose not to 'test', with the following reasons: "I'm scared I might have HIV"; "Scared of knowing I have HIV"; "I am very frightened – it will make me live badly and worry a lot."; "I could not go to the nurse, all the others will know in the surrounding areas." "Others will see me as being HIV"; "It will be a worry that it will kill me"; "I won't have any rest – like a death sentence, it will make me worry"; "I will never go and test, I can bear the pain of not knowing, rather than knowing I have it." 3 males in one school chose not to be 'tested'. Their reasons were: "I don't want to know"; "I am scared to know" and "I am scared to tell my parents."

Future Anticipation: Position of not Knowing Status:

At this stage of "Wildfire", the participants were invited to explore their feelings, after having chosen to go for 'VCT'.

"I think we will all be positive"; "If I am positive, I am worried, I must tell"; "I will ask for counseling and join a support group, if I am positive" "Thinking I am positive because of unsafe sex"; "Scared of telling others if I am positive"; "I think I am negative because I always use a condom" – "*Did you use one this time?*" – "No!"

shocked realization that she did not this time. “She had sex with people she trusts, not thinking about the consequences.”

“Maybe I’ve got it”; “Maybe I don’t, I’m hoping”; “If I’ve got it I will die”; “How are my parents going to bury me – where will they get the money?”; “If I haven’t got it, I can be happy, healthy and have peace.”; “I want to know so that I can accept it or deal with it”; “I want to know if I have not, so that I can have a girlfriend.”

“I’m feeling frightened, I have got stress”; “What are you going to do if you are positive”; “I am not worried, I know my status”; “Hoping I am negative”; “Afraid”; “I am worried, I tasted nectar on many flower, I may be positive.”

Activity 3 - Receiving Results After VCT:

‘Results’ for the ‘VCT’, were handed out in white envelopes. There were an equal number of positives and negatives – these were randomly distributed to the participants.

As the results were handed out, the behaviours exhibited were: giggling, nervous movements, covering of faces.

Giggles and covering of mouths were the main reactions when receiving the envelopes. Upon opening, the behaviours were to laugh and to jump back.

On receiving their ‘results’ the learners turned around and away, eyes wide, hands over mouths, giggling. They all turned their backs and opened the envelopes quickly. Upon reading the ‘results’ they: laughed, buried heads in hands, one covered her face with an envelope, one physically held the envelope close, keeping the results to herself, and one said “I am killed!”

Verbal-Emotive Reactions After Having Received Results:

Having received their results, the participants were asked to reflect on their reactions to those results by answering the question “*How do you feel?*”

Reactions of ‘negatives’: “Happy, very happy”; “Excited! Excited”; “Happy, but now I need to protect myself”; “overjoyed”. A male and a female both commented “I feel disappointed because I had unprotected sex.”

Reaction of ‘positives’: “Unhappy – I could go away and kill myself”; “A little bit nervous”; “What am I going to say to my parents?”; “What will my parents feel?”

Reactions of ‘negatives’: “I am very joyful that I don’t have HIV/AIDS”; “So, excited, now I’m going to look after myself and make sure I don’t have HIV/AIDS”; “Relieved, but I know I must test after 3 months”; “Relieved, happy but worry because I have to go back after 3 months”; “Worried about my parents and they might have to pay for funeral”; “Now I must keep myself safe”; “I wish I was just finished with the programme”; “I think the positives are brave to know their status – they may need a grant or ARV”; “I want to protect my children.”

Reactions of ‘positives’: “I feel sorry for myself, because at the end I am going to die”; “I was not expecting it at all, I am upset, it is putting me through pain”; “I am worried, I don’t know what to say to my parents”; “I feel bad, I did not expect it, but now I must accept it.”

Reactions of ‘negatives’: “I feel relieved, very”; “Happy, so happy”; “Proud of myself”; “Glad”; “Worried for the positives, sorry about them”: “Glad for myself”; Significantly, one learner was still in such shock from ‘testing’, that the result of negative was not comprehended.

Reactions of positives: “I feel like killing myself”; “Angry – I am angry with myself and angry for testing”; “I feel like committing suicide”; “Scared and lonely”; “Unhappy, I am not proud of myself, I feel shame “ (this was a male); “I have shattered the last, 20 years I planned for my life” (also a male); “I will not tell my friends and family” (male participant); “I feel sorry for myself”; “Unhappy because other people know I am HIV positive.”; “Angry because I was not protected” (male); “Worried that my friends will laugh” (male respondant); “I will be less willing to try my best” (female)

Activity 4: Future Planning/Living with HIV/AIDS

In this final section of “Wildfire”, the participants were invited to put their knowledge about living with HIV into words, being guided by the research assistant/facilitator.

“What are you going to do now that you are HIV ‘ positive?’” “I am going to tell others to abstain”; “Yes, I will tell my friends”; “Exercise/join a support group.” *“Is there a future for you?”* “Yes!”

“What are you going to do now?” “I will go to the doctor to get treatment”; “Eat”; “Go and tell people about HIV – teach them.”; “Join a support group”; “Abstain”. *“Who will you go to for help?”* “The clinic”; “Teacher”; “Best friend”; “A nurse”; “My parents.”

“How will you ‘negatives’ treat the ‘ positives’ now?” “I would like to help them not feel left out”; “Encourage”; “Support”; “Accept what you’ve got”; “Maybe we’ll die early because we don’t know if we’ve got it or not”; “Encourage long life”.

“What will you do now?” “Get more information”; “Continue with life – living properly.” “Go to someone I trust”; “Talk to my family”; “Try to protect my family – so tell them.”

4.2.2 Discussion of “Wildfire” Observation Notes

The observation notes taken during the “Wildfire” intervention, have been arranged above in terms of each stage in the process of “Wildfire”. The process of the intervention had been divided into eight stages, including the four Activities which constituted the simulation of the process of being ‘exposed’ to HIV/AIDS, choosing to go for VCT, receiving the results of VCT and planning a future with those results in mind. Between each activity, the active engagement of the group in discussion and reflection on actions/choices taken during the activities, formed the other four parts of the process of “Wildfire”. This arrangement of the notes is congruent with Kolb’s experiential learning model which integrates cognition with socio-emotional factors within the context of the learning situation (1984). It took a concrete experience in which there is activity, employed reflective tasks (in this case, discussion) in order for abstract conceptualization (an understanding of the role play), followed by decision-making to take place (Kolb, 1984).

Observation notes from Activity 1 indicated the emotional effect of being ‘exposed’ to HIV/AIDS: insecurity, uncertainty and physical avoidance/rejection (in the act of jumping back) were suggested by the behaviours. The verbal reflections which followed the activity were congruent with the interpretation – emotions were named

and the experience reflected upon as a generally negative experience. Comments indicating that the action was what counted most at the time and the lack of awareness that 'infection' could take place, supported comments by other researchers, Akande (2001) for example who claim that knowledge is not sufficient to prevent young people from engaging in 'unprotected sex'. In this sense, within the safety of the intervention, a connection between action and consequences is made. A further connection, namely that action (in the form of using gloves or abstaining) could have been taken in order to 'prevent' 'exposure' and the emotional reactions generally constituted an "AHA" revelation. This was a positive point in favour of "Wildfire", in that the connections between facts were being made at an active-emotive level and then reflected on at a cognitive level without the reality of actual exposure.

In each of the groups in which "Wildfire" was conducted, some participants chose to test and some chose not to test. The reasons given for choosing not to test are congruent with the fears and "social barriers" referred to by van Dyk (2003) in her research on VCT. Choosing to test was an option for some participants with general themes emerging of reasons relating to social conscience/responsibility and healthy lifestyles.

Before 'looking at the results' of the VCT, a discussion of feelings, expectations and thoughts about the 'results' was held. The honesty of the responses as well as their content appeared to cover a range of thoughts that may occur in a naturalistic setting. Such responses are indicative of the following: hope, despondency because of past risk-taking, concern about effects on others, appropriate responses based on knowledge and information gained in the past, plain fear as well as fear of others knowing.

In Activity 3, the participants received their 'results'. Again, behavioural observation indicated that this appeared to simulate real-life contexts – in general it was an emotional and private experience. The verbal reflections of those participants who received 'negative' results ranged from elation to cautious relief, pending a 3-month follow-up to confirm sero-negativity, to sober reflections on past risk-taking behaviour. The verbal reflections of those who 'received positive' results, expressed "feelings of fatalism and mental anguish" (van Dyk, 2003: 119) regarding the future

and suicidal ideation, and “fear of rejection” (van Dyk, 2003: 123) with reference to informing parents and possible social stigma regarding the telling of friends. The expressed reactions in this section of the “Wildfire” intervention were congruent with studies in naturalistic settings in which people attending VCT feared the “psychological turmoil” (van Dyk, 2003: 118) that was part of receiving a ‘positive’ test result.

Significantly, although the intended desire to ‘know’ so that positive living could take place, was expressed by some participants in the previous section of “Wildfire”, not one participant verbalized this, at this point of the intervention – which confirms findings in other studies that intentions are not always matched by behaviour in matters related to HIV/AIDS. Receiving the results can be interpreted, from observation in this study, as an emotional event that had no immediate connection to cognitive links between previous intentions and future plans.

It is assumed that an emotional event such as receiving ‘news’ of being HIV positive which, to interpret the words of some participants, is tantamount to receiving a death sentence, can be mediated by preparation and follow-up care/counseling – this is the intention of VCT, but in simulated form, is also the intention of “Wildfire”. The difference between VCT in naturalistic settings and “Wildfire” is that VCT is essentially a management issue whereas the experience of similar emotions in “Wildfire”, serves to simulate naturalistic experiences, with the intention of it being preventative in nature by providing the participant with real choices in terms of in-depth knowledge about the experience and process of ‘exposure’ to HIV/AIDS.

Activity 4, the final section of the experiential part of “Wildfire” dealt with the cognitive mediation of the emotional event and expression thereof, of Activity 3 in which participants ‘received’ their ‘results’ thus discovering whether their ‘exposure’ to HIV/AIDS led to ‘sero-positivity’ or not. The questions put to the participants were suggestive of choices for action eg: “What are you going to do now?” and so placed the participants in a decision-making position. In answering the question, the participants then committed themselves verbally, to an action. Disclosure to friends and family appears to be a theme of social responsibility, seeking medical intervention is a theme which recognizes professional expertise, garnering social

support and living positively in terms of a healthy lifestyle emerged as a theme of self-care.

It was significant that none of the sense of fatalism and mental anguish of the previous activity permeated the responses at this point of the intervention. A possible influencing factor in these emerging themes, was previous exposure to knowledge and information ie: that the responses were socially acceptable in terms of what had previously been learned either in life-orientation or via media campaigns. A social 'equalising' function of "Wildfire" was indicated by the responses of those who were 'HIV-negative' when asked about their perceptions of "HIV positive' participants eg: "Maybe we'll die early because we don't know if we've got it or not." – this response firmly placed the negatives and positives (in the context of the game) in a similar position.

NOTE: The future-planning section of "Wildfire", while related directly to 'HIV positive results' within the intervention, was reinforced in general, with regard to HIV/AIDS in the post-test questionnaire specifically in Question 33: "Is there anything you have done, or plan to do within the next week about HIV/AIDS?" – this was a fixed-response question with various options for taking action and is suggestive of social responsibility issues.

In terms of answering the research question:" Is "Wildfire" an effective preventative intervention for HIV/AIDS among secondary school learners?" with specific reference to the observation notes and records of verbal responses to "Wildfire", the following is to be noted: the emotional reactions – both physical and verbal reflections, strongly echo those noted in previous research in naturalistic settings with regard to VCT. Therefore, taking into account that the intention of "Wildfire" was to simulate exposure to HIV and the process with which an individual should ideally engage after exposure, the answer emerging from the data of this section is "YES", the intervention was effective in terms of simulation. The assumption that this may serve as preventative was inherent in the process.

4.2.3 “Wildfire” Focus-Group Notes

The final section of “Wildfire” was comprised of a consolidation exercise conducted in focus groups for the purposes of debriefing and for the learners to reflect and co-reconstruct the learnings derived from the intervention. The learners were asked to write, in point form, what they learned from “Wildfire” and what they thought of “Wildfire”. Each school in which the intervention was conducted, had 5 focus groups. Their responses were recorded and compared to a number of points of intended learning in Table 8. It is to be noted that not enough time was spent on this exercise because of the time-constrained nature of the school context.

In placing the responses in particular sections of the table, the researcher adopted a method of identifying key-words associated with the points of planned learning e.g: in the section on ‘Sexual contact’, focus group words such as “sex”, “abstain”, “condomise”, “sleep” were identified as being relevant because they refer-directly or indirectly-to sexual relations. At times, relevant quotes had been recorded in more than one section of the table. There was considerable overlap between knowledge and information, “Wildfire” itself (both of which are relevant in every section) and the more specific learnings derived from “Wildfire”, for example VCT, psycho-social awareness and treating others.

TABLE 8: Points of Planned Learning

| POINTS OF PLANNED LEARNING | SCHOOL A | SCHOOL B | SCHOOL C | SCHOOL D |
|---|---|---|---|---|
| Speed of spread of HIV/AIDS | "how it is spread" | "We now how it spread very quickly and also we don't know this person got it or not." | "We learn how AIDS is spread" | "HIV/AIDS is quick to be spread"; ;It show us how quick HIV/AIDS can be spread within a minute" |
| Sexual contact | "Protected sex every time" "It shows us how to protect ourselves from HIV/AIDS" | "It is good for young people to learn about AIDS because AIDS is dangerous and is deadly diseases, look after yourself or condomise. Thanks." | "don't be a prostitute" "you are not free to have unprotected sex" "You have to abstain from sex or condomise" | "And if you sleep without protecting yourself you can get HIV and it teaches us that we should protect us" "people don't often think about abstaining and using protection" |
| Choices in relationships Prevention and protection | "If you are with your partner you have to be faithful, condomise or rather abstain" | "We hear about how to get HIV/AIDS and you going to prevent yourself with HIV/AIDS" | "have to abstain from sex/condomise" "you are not free to have unprotected sex" | "have help us to know that every second of the game you playing, protection is needed" "To all ladies out there, they must always carry a condom in their pockets" "You should not hold another person without wearing protective gloves when he/she's bleeding blood..." |
| Isolation/loneliness | Not mentioned | Not mentioned | Not mentioned | Not mentioned |
| VCT as an option | "we've learned that testing a HIV is important but its not a force" | "we were not that much of knowing about blood test but this game show us" "we also learned about" | "We learned that you have to do blood test either you are positiv/negative" "Trust yourself when you" | "It has motivated us to go for our HIV/AIDS tests and has shown what is being done when we get" |

| POINTS OF PLANNED LEARNING | SCHOOL A | SCHOOL B | SCHOOL C | SCHOOL D |
|-----------------------------------|---|--|---|--|
| | | that you are not forced to make a blood test” | going to HIV test”; “you got some help to your nurse or doctor” | to the clinics, hospitals etc.”; “when you know your status you can be able to choose/decide to face it with power”; “HIV positive or not we must all know that we are special” “teaches us its right to go check yourself so that you can know if you HIV or not”; “Go forward for your blood test to help those around you” |
| Testing positive and implications | “Showed us how would you feel when you found out that you are HIV positive”; “Makes us not to think its an end of a life if you are positive”; ““We can reveal our status if you are positive”; “Go to the counselors and join support group.” “So I can boost my immune system.” | “If you are HIV positive the only way is to accept HIV/AIDS”; ““and also learned that how do you feel when you found out that you have AIDS.” “That a person living with HIV cannot be seen on his face.” | “You can live longer than you thought”; “Get treatment and healthy food” | “It also teached us to be proud of yourself even if you HIV positive”; “It shows us how many people react when they’ve tested HIV positive and the need to use a condom” |
| Testing negative and implications | “This game make me learn if I am HIV | “We also learned about that if you are negative | “When your results saying you are HIV negative you are | “It teaches us its right to go and check yourself so |

| POINTS OF PLANNED LEARNING | SCHOOL A | SCHOOL B | SCHOOL C | SCHOOL D |
|--|---|--|---|--|
| | negative it doesn't mean that people who are HIV positive I must not love them, I must give them support" | you can still come after 3 months to test your blood" | not free to have unprotected sex or helping someone without gloves" | that you know if you are HIV or not (negative or positive)" |
| Comments specific to "Wildfire" intervention | "It gives us ideas to know HIV"; "it showed us how does HIV/AIDS affect a person"; "It gives us more about HIV/AIDS"; "This game make me how to be aware of HIV virus" | "When we play that game we feel happy and bad because, happily because that game is not a truth, we just play. Bad because we are worried about someone have it because he/she lives a normal life than others"; "it is a good and understandable game" | "Knowledge, skills"; "We learned more about sex and the game was very exciting"; "Young people can learn from what we did"; "More information about HIV and AIDS" | "It made us to be a lot more wiser about HIV/AIDS" "WILDFIRE ROCKS!!!" "Wildfire is a good game to help you to be strong and open about HIV/AIDS." |
| Other comments emerging spontaneously as interpretive of "Wildfire" experience | "It gives us more about HIV/AIDS"; "It shows us that we are all the same whether you are positive or negative"; "We've learned how to prevent our self from HIV. And to make 5 choice." | "We felt scared when we heard the result but we knew that it's a game."; "I think young people, those who don't believe in AIDS were going to believe it."; "We feel excited because is help us to know about HIV/AIDS"; "Wildfire is good for young people because it educate and encourage them, what must you do if you have HIV/AIDS how do you feel when you have | "We are fill bad because you can killing yourself..." "You must be scared about your results"; "You must pay because it was a mistake" | "If we are all the same and gather together we can share to each other when we feel and the ways we can all fight or treat it" "This wildfire called HIV/AIDS is distructive"; "It helps us deal rightly with our status"; "You can be able to face nervous emotions powerful and stronger than ever."; "It is a killer on the loose watch out for |

| POINTS OF PLANNED LEARNING | SCHOOL A | SCHOOL B | SCHOOL C | SCHOOL D |
|----------------------------|--|--|---|--|
| | | HIV/AIDS. Who can help you when you have and who do you tell.” | | it, its dangerous” |
| Treating others | “It showed us how to treat our family and friends when you hear that they are HIV” | “We wish teenager will abstain and look after themselves I’m talking about those were playing this game”; “We will keep playing this game in our community to help young ones or those who know nothing about this dangerous disease” | “you want help at clinic. You want to tell your family” | “Don’t be judgemental towards other people that infected with virus”; “HIV/AIDS is cruel and evil, breaking family and relationships”; “People have different views about HIV/AIDS.” “To help those who were expose to be stronger than ever and to face it with confident”; “To know both people’s feelings” |
| Researcher comments | | | | |

TABLE 8 : Notes made by participants after focus group consolidation and debriefing on “Wildfire”.

4.2.4 Discussion of Table 2: Notes From Focus-Group Discussions

In terms of the first point of planned learning, 'Speed of spread of HIV/AIDS', was mentioned in the debriefing in all the schools, but not by every group. Possibly this was because it was discussed after the hand-shaking exercise and was eclipsed by the realization by participants that they did not use gloves. The point form answers in this section possibly beg for interrogation eg: 'What exactly do you mean by: "how it is spread"?' (School A) in order to derive richer, more explicit answers, although this was not the essential aim of the task. Reference to the spread of HIV/AIDS was mentioned by focus groups in all of the schools.

'Sexual contact' - in this part of the data-gathering the participants associated protection with sex, which suggested that, in this sense, at least some of the groups in all of the schools, were receiving the primary preventative message of "Wildfire". Some of the words used by groups were generalized to the extent that no specifically meaningful feedback about "Wildfire" emerged eg: "It shows us how to protect ourselves from HIV/AIDS" (School A) – this statement was supportive of the intervention and implies its usefulness, without details. Some statements can be interpreted as the participants using 'AIDS-jargon' eg: "You have to abstain from sex or condomise" – such a statement indicates that the message had been transferred and feedback given in appropriate language. However, as many authors (Akande, 2001; Hoosen & Collins, 2004; Freeman, 2004) suggest, this knowledge (or verbalizing such knowledge) is no guarantee of safe sexual behaviour. Some of the statements recorded by participants, appeared to have a fresher, more spontaneous tone and seemed to be directly derived from the "Wildfire" experience, eg: the injunctions applied to real life of "Don't be a prostitute", or "you are not free to have sex" (School C) and the interpretive insight arising from the intervention that "people don't often think about abstaining and using protection" (School D).

'Choices in relationships. Prevention and protection.' Is a section of planned learning that had significant overlaps with the previous point of planned learning. Again, appropriate language was used, suggesting previous exposure to 'AIDS-jargon' (School A, School C and School D) and a suggestion of not internalizing the learnings in School B eg: "We hear...". The words used by participants in one of the responses

from School D were considered to be significant in indicating an in-depth internalization of the “Wildfire” experience: “have help [suggesting that mediation at some level took place] us to know that every second of the game you playing...” indicating an understanding of the full implications of HIV/AIDS in relation to unprotected sex. Another statement used by School D, interpreted the same message ie that there is no room for error in naturalistic settings, but with specific reference to “ladies”.

The point of planned learning in relation to ‘isolation’ did not emerge as a learning derived by the participants in any of the schools as a result of their particular experience of “Wildfire”. Possibly this was due to the fact that almost all the participants were ‘exposed’ in the initial handshaking activity and as a result, the opportunity to create learning from discussion of loneliness in issues of abstaining was not created in these contexts. This provided important feedback for future “Wildfire” interventions with adolescents.

‘VCT as an option’ - is the next step in the process of ‘exposure’ to HIV/AIDS and, according to the participants’ responses, this section of the “Wildfire” intervention constituted new territory in HIV-related knowledge. Statements beginning with “we’ve learned”(School A and C); “we were not that much of knowing...but this game show us” (School B); “it has motivated us”; “teaches us” (School D) suggested a different level of knowledge attenuation. Significant to the theory related to self-efficacy in Chapter 2, were statements that refer to self-empowerment: “trust yourself...” (School C); “...choose/decide to face it with power” (School D); “HIV positive or not we must all know that we are special” (School D).

References to constitutional rights regarding blood tests being voluntary appeared to be a revelation and was referred to by groups in Schools A and B: “its not a force” and “you are not forced to make a blood test”. This aspect of HIV/AIDS education may have caused some misconceptions in young people because the researcher’s experience in recruiting volunteers met with fears of blood tests, which had to be allayed. The fact that medical help and assistance are part of VCT, were mentioned by focus groups in Schools C and D: “you got some help to your nurse or doctor” and “...has shown what is being done when we get to the clinics, hospitals etc.”. Social

responsibility was mentioned in School D, where a moral obligation is suggested by “teaches us its right” in relation to VCT and the rule-forming injunction set out by another focus group, “Go forward for your blood test to help those around you.”

‘Testing positive and implications’, from the point of planned learning emerged statements that are indicative of learning which enables/empowers, some examples of such language usage are: “showed us how...” (School A); “So I can...” (School A); “We can...” (School A) and “You can” (School C) and “to be proud...”, this is reinforced by statements of action/imperatives eg: “Go to the counselors and join a support group” (School A) and “Get treatment and healthy food”. Reflective statements used by the focus groups on the emotional experience of this section of the “Wildfire” intervention indicated new learning eg: “Showed us how would you feel when you found out that you are HIV positive” (School A), “how do you feel...” (School B) and “shows us how many people react...” (School D). The fact that life continues after an HIV-positive test result was noted by Schools A and C, to quote School A, “Makes us not to think its an end to a life...”. Medical matters related to VCT such as boosting the immune system (School A) and social responsibility “We can reveal our status” (School A) were also points of learning from this section of “Wildfire”, each of which was only mentioned once although most awareness and information programs educate along these lines – this suggested that the other statements (above) constituted possible new learnings related to HIV/AIDS. A significant and spontaneous statement emerged from School B: “That a person living with HIV cannot be seen on his face”, implying that, despite awareness of HIV/AIDS, the fact that HIV-positive people are not distinguishable from the rest of the population, constituted a learning derived from “Wildfire” – this further suggested that attention to this fact needs to be emphasized in any AIDS-related intervention with adolescents. It also confirmed Cohen & Trussell’s reference to the importance of the concept of asymptomatic transmission (1996: 138) in understanding personal risk.

‘Testing negative and its implications’ was another point of planned learning into which statements from the focus groups fit. Themes of social responsibility emerged in this section eg: “if I am HIV negative it doesn’t mean that people who are HIV positive I must not love them” (School A) and “It teaches us its right to go and check yourself...” (School D). The fact that an HIV-negative test result needs to be

confirmed within a period of 3 months, emerged as a learning from School B and School C's statement that when "you are HIV negative you are not free to have unprotected sex..." emphasizes the socio-political nature of HIV/AIDS – that it affects everyone in one way or another, "if you are HIV or not" (School D).

'Treating others' was another point of planned learning in the psycho-educational intervention of "Wildfire" and related to themes of HIV/AIDS-related social responsibility/social consciousness in our present socio-political milieu in South Africa. This section constituted the range of psycho-social learnings that can be derived from "Wildfire". Responses of participants reflected a range of statements from "It showed us how to treat family and friends..." (School A) a point further elaborated upon by School D: "To help those who were expose to be stronger than ever and to face it with confident", to a community-action approach, "We will keep playing this game in our community..." (School B) to the personal needs of HIV-positive people, "you want help at clinic...want to tell your family" to attitudes toward HIV-positive people such as "don't be judgemental", understanding "both people's feelings" and recognizing that "People have different views about HIV/AIDS" (School D). A rule-making generalization which is applicable to understanding the psycho-social and mental health ramifications of HIV/AIDS also emerged from the focus group notes: "HIV/AIDS is cruel and evil, breaking family and relationships", a point echoed by various authors in the field (Freeman, 2004; van Dyk, 2001; Whiteside & Sunter, 2000). An interesting point emerging as a generalised 'wish' that "teenager will abstain and look after themselves I'm talking about those were playing this game" (School B) suggested that the participants of this group could possibly be expressing more than just a preventative 'wish' for all participants, but expressing doubts about future behaviours of members of the group who they may consider to be engaging in risk-taking behaviours – however this cannot be a reliable interpretation and was useful only insofar as future research may be concerned ie: that time be made available so that the meanings of certain statements can be checked with participants. What was significant, if the interpretation has some substance, was that it spoke of potential peer-pressure which may be anti risk-taking behaviours – this is positive for HIV/AIDS prevention. However, it also spoke of potential judgementalism which should be avoided by HIV-related education interventions.

The two sections within the points of planned learning table (Table 8) that were specific to “Wildfire” constitute the questions that this section of the research investigation was asking of the focus groups. Essentially then, these points of planned learning were more specifically related to answering the research question, than being ‘points of planned learning’ of “Wildfire” itself. In Table 8, the sections into which focus-group feedback/reflection was divided, are ‘Comments specific to “Wildfire” intervention’ and ‘Other comments emerging spontaneously as interpretive of “Wildfire” experience’ – these will be analysed together here in relation to participants’ views on the effective/preventative nature of “Wildfire”. The themes that emerged from these sections were:

* Wildfire as a game:

“This game make me how to be aware of HIV virus”

“...happily because that game is not a truth, we just play”

“It is a good and understandable game”

“...the game was very exciting”

“Wildfire is a good game to help you to be strong and open about HIV/AIDS”

“We felt scared when we heard the result but we knew that it’s a game”

“Wildfire rocks!!!”

* What “Wildfire” teaches:

“...how does HIV/AIDS affect a person”

“Knowledge, skills”

“...more about sex”

“More information about HIV and AIDS”

“It help us deal rightly with our status”

“...it educate and encourage them, what you must do if you have HIV/AIDS how do you feel when you have HIV/AIDS. Who can help you when you have and who do you tell”

“...we can share to each other when we feel and the ways we can all fight or treat it”

“It shows us that we are all the same whether you are positive or negative”

“More information about HIV and AIDS”

“It made us to be a lot more wiser about HIV/AIDS”

“It gives us more about HIV/AIDS.”

“...make me how to be aware of HIV virus”

“This wildfire called HIV/AIDS is destructive”

“We’ve learned how to prevent our self from HIV. And to make 5 choice”

“It [HIV/AIDS] is a killer on the loose watch out for it, its dangerous”

* Emotional experiences:

“...we feel happy and bad because, happily because that game is not a truth...bad because we are worried about someone have it because he/she lives a normal life than others”

“We felt scared when we heard the result...”

“We feel excited because is help us to know...”

“We are fill bad because you can killing yourself...”

“You must be scared about your results”

“...to help you be strong and open about HIV/AIDS”

“You can be able to face nervous emotions powerful and stronger than ever”

“You must pay because it was a mistake”

* Adolescents and HIV/AIDS:

“I think young people, those who don’t believe in AIDS were going to believe it.”

“Wildfire is good for young people because it educate and encourage them, what you must do if you have HIV/AIDS how do you feel when you have HIV/AIDS.

Who can help you when you have and who do you tell”

“Young people can learn from what we did”

The themes that emerged from the “Wildfire” sections of Table 8, comparing points of planned learning with focus-group notes were: “Wildfire” as a game, what “Wildfire” teaches, emotional experiences, adolescents and HIV/AIDS. These themes constituted feedback relating to the effectiveness of “Wildfire” as an intervention, and were therefore directly related to answering the research question. “Wildfire” is a simulation of the process into which people who have been exposed to HIV/AIDS can ideally engage and the feedback from the learners was positive regarding the fact that the learning was “a game” rather than real-life – direct reference to awareness, VCT

and empowerment were made within this section. The data in this section alone, suggests that “Wildfire” covers more knowledge and information than that to which the participants had previously been exposed.

The data on what “Wildfire” teaches ranges from emotional/affective insight, to an understanding of sex as related to susceptibility to the virus and the choices, including prevention, that are presented. Additionally, specific knowledge about managing status, skills such as knowing who can help and who to “tell” cover the medical and emotional support aspects of HIV exposure. A ‘leveling’ effect in terms of tolerant attitudes to those infected with the virus, was also mentioned by the focus groups. This correlated with findings from the “Wildfire” process itself, where the intervention appeared to serve a ‘social equalising’ function, after the results were handed out.

In being a simulation of events in case of exposure to HIV/AIDS and the fact that “Wildfire” is experiential in nature, made it unique as an intervention in that it provided participants with a ‘pre-view’ of the sequence of events following exposure in natural settings. Emotional understanding appeared to be an area to which the focus groups referred as a learning. Understanding the emotional consequences of exposure was related to fear of receiving results, the consequent suicidal ideation of those receiving positive results was mentioned – these quotes from focus groups are congruent with findings and discussions on the mental health consequences of HIV/AIDS (van Dyk, 2003; Freeman, 2004). Feedback that was particularly hopeful regarding emotions, is that one focus group went beyond the immediate emotional understanding and mentioned empowerment issues relating to status: “You can be able to face nervous emotions powerful and stronger than ever”, suggesting that “Wildfire” had an enabling and empowering influence on overcoming fears related to receiving blood tests in VCT. In being a simulation, “Wildfire” in essence set out an emotional ‘map’ for dealing with the consequences of exposure to HIV/AIDS – potentially breaking down the walls of fear related to VCT and disclosure should the situation arise in naturalistic settings for the participants.

The final theme that emerged from the focus groups’ notes relating specifically to “Wildfire”, was adolescents and HIV/AIDS. The notes strongly indicated that

“Wildfire” could have a conscientising influence on those who refuse to believe in HIV/AIDS or have negative attitudes towards the virus. Also suggested, was the enabling effect of “Wildfire” as a how-to or map of what-to-do when exposed. The fact that other adolescents could benefit from the intervention was clearly stated: “Young people can learn from what we did”.

In analyzing the words used by the focus groups, a factor which recurred in every point of planned learning and in most schools was the use of “we” and “you”. Firstly, because the notes were the result of the co-constructions of particular focus groups, it followed that responses used language referring to the collective and generalizing rule-making injunctions that may employ the term “you”. However when considering that HIV/AIDS prevention programs hope to personalize (Visser, 1995) the message of the threatening nature of the virus, a case could be made in terms of personal pronouns used eg: “people...”, “You...” that full internalization had not yet been made. By far the most common responses consisted of statements including “we” and “us” suggesting partial mediation of the messages to the context of the group. What appeared to be significant, was that the use of pronouns changed within a single statement, moving from the semi-personalised “we” to the less accepting “you” eg: “Showed us how you feel...”. The only times that the pronoun “I” was used was in connection to testing HIV negative and self-care of “boost my immune system” suggesting that self-care and testing negative may be easier for the learners to internalize because they are less threatening. The researcher acknowledges that there were language issues related to second language-usage and that the use of pronouns may be a related issue, however in terms of mediating the personalization of the learnings of “Wildfire”, the language-usage emerging from the focus-groups suggests possible internalization up to peer group level, when difficult issues are considered or reported upon.

4.2.5 Summary of Focus Group Results And Discussion

The intention of this particular section of data analysis was to tabulate the focus group notes and compare the learnings of the participants to the intended learnings of “Wildfire”. As stated in Chapter 3 (section 3.5.4), the question asked of the data was: “Do the learners’ written statements of learning from “Wildfire” reflect the learnings

intended by the intervention?” The answer emerging from the participants’ notes, was ‘yes’. It is to be noted however, that not every focus group wrote down every point of planned learning – but when these points were tabulated for each school, it can be seen that each ‘point of planned learning’ was covered with one exception. The ‘point of planned learning’ that was not mentioned by any of the focus groups was ‘isolation/loneliness’ which confirms the findings in the observation section in which this part of the “Wildfire” intervention was not significant. Possible reasons for this, included the fact that the context of the interventions in each school did not provide opportunities for the facilitator to emphasise this learning. In reflecting on the actual interventions that took place, it could have been possible to have had a discussion around what it must feel like for those not ‘exposed’. The theme of isolation and loneliness is important and this must be kept in mind for future “Wildfire” interventions, as the potential learnings related to aspects of peer pressure are (Visser, 1995) valuable, considering the developmental stage of adolescents.

In terms of the intended levels investigated in this inquiry – this section of the data has dealt with the voices and reactions of the youth, to “Wildfire”. The outcome of hearing these voices, was that “Wildfire” is an effective preventative intervention. While it was obvious from some of the responses, that the participants have already been exposed to a substantial amount of HIV/AIDS information (reflected in the ‘AIDS-jargon’ used in some responses) it appears that new learnings were effected by “Wildfire”. The significant learnings that emerged from this section of the data, appeared to be related to VCT, which provided both an emotional and practical ‘map’ of the process of VCT. Additionally, interpretive insights and possible suggestions of internalization of learnings, at least to the group were positive points emerging about “Wildfire” when considering the theory of learning. A factor that was important was the statement about the fact that HIV-infected people cannot be immediately recognized as being different from anyone else – this should be emphasized in all interventions both from the point of view of assessing personal vulnerability and tolerant attitudes.

The second level of this inquiry dealt with the action/advocacy verification of “Wildfire”. This level of the research was fulfilled in this section of the data collection as being supportive of the effectiveness of “Wildfire”. In terms of the draft

“Education Sector Policy on HIV and AIDS” (Daily Dispatch September, 2005) as enumerated in Chapter 2 section 2.3 above, the data confirmed the usefulness of “Wildfire” as fulfilling the following points relevant to HIV/AIDS: “the right to factual information...”, which was substantiated by responses in the ‘sexual contact’ and ‘choices in relationships’ and VCT sections of Table 8, “the practice of delayed sexual debut and responsible sexual behaviour”, “Voluntary counseling and testing (VCT) shall be promoted”.- this proviso was adequately fulfilled in the data that emerged from the focus groups in the points of planned learning sections ‘VCT as an option’, ‘testing positive and its implications’ and ‘testing negative and its implications’. Therefore, the relevance of “Wildfire” in terms of the kind of input to learners envisaged by the Education Department in HIV/AIDS related matters was confirmed to be effective in the data generated by the focus groups and set out in Table 8.

When considering recommendations concerning the content of an AIDS-related education program (Visser, 1995; van Dyk, 2001) the data in Table 8 reflects attainment of these aims. The following points were covered and can be directly substantiated by the data recorded in the Table 8: “knowledge of transmission” in an understandable way, “preventative measures” including the options of “sexual delay or protection against the virus”, how HIV/AIDS affects health, “a realistic evaluation of each person’s vulnerability to the disease” and “the opportunity to make informed decisions about their lifestyles” (Visser, 1995: 136). In terms of focus-group notes therefore, “Wildfire” had communicated a sense of personal risk and social awareness at least to group level.

4.3 Post Test Results on “Wildfire” Questionnaire, Section 6

The responses to this section are recorded below and cover questions 28 – 35. This section of the data consisted of self-report responses to the post-test questionnaire approximately 3 weeks after the psycho-educational intervention “Wildfire”. It is to be noted, that School C had a break of 2 months between “Wildfire” and the post-test for logistical reasons, including non-arrival, school exams and holidays. In terms of the questionnaires, this section had a direct bearing on answering the research question “Is Wildfire an effective preventative intervention?” It also fulfilled the

primary aim of the research, which is to extrapolate / formulate conclusions about “Wildfire” as an effective psycho-educational tool. This section together with Phase 2 results, serve to fulfil the rigour of the method.

Question 28: “Has Wildfire changed the way you think about HIV/AIDS?”

TABLE 9: Responses to Question 28

| | | FEMALES | | MALES | | NO ANSWERS | | TOTAL |
|---------|-------------------|---------|-----|-------|------|------------|-------|-------|
| | | YES | NO | YES | NO | Females | Males | |
| Urban | A | 15 | 5 | 5 | 0 | 1 | 1 | 27 |
| | C | 11 | 0 | 3 | 0 | 6 | 1 | 21 |
| | Subtotal Township | 26 | 5 | 8 | 0 | 7 | 2 | 48 |
| Rural | B | 7 | 0 | 4 | 0 | 10 | 1 | 22 |
| | D | 12 | 2 | 6 | 1 | 2 | 2 | 25 |
| | Subtotal Rural | 19 | 2 | 10 | 1 | 12 | 3 | 47 |
| TOTAL | | 45 | 7 | 18 | 1 | 19 | 5 | 95 |
| % Rural | | 57.5% | 61% | 71.4% | 7.1% | 36.4% | 9.1% | |
| % Urban | | 68.4% | 13% | 80% | 0% | 18.4% | 5.2% | |

As has been reflected in the table the majority of participants who answered, said “Yes”, with males recording approximately 12% higher than females for both rural and urban responses. Rural females recorded the lowest change and urban males, the highest. The fixed-response nature of the question however, did not serve to communicate the full meaning of “Yes”. Instead, it communicated the influence of “Wildfire”.

Question 29

In response to the question “What specific changes has Wildfire made to the way you.....

- a) Think (about sex and HIV/AIDS)
- b) Feel (about sex and HIV/AIDS)
- c) Do/Act (regarding sex and HIV/AIDS)

- the participants' response-frequency provided an interesting insight into theories of experiential learning, internalisation of knowledge, behaviour-change and self-efficacy.

TABLE 10: Response-Frequency to Sections of Question 29

| | THINK | FEEL | ACT | TOTAL NUMBER |
|----------|--------------|---------------|---------------|--------------|
| School A | 3 no-entries | 5 no-entries | 10 no-entries | 27 |
| School B | 6 no-entries | 9 no-entries | 12 no-entries | 22 |
| School C | 9 no-entries | 11 no-entries | 19 no-entries | 21 |
| School D | 8 no-entries | 13 no-entries | 19 no-entries | 25 |

As can be seen in the table participants in all the schools generally found it more difficult to commit to/externalise their own reflections in relation to the process of thinking, feeling and acting around personal sexuality and issues of HIV/AIDS. The frequency of response to each section suggested that most participants have thought about sex and HIV/AIDS and are grappling with internalising the new knowledge and information to the emotional level (more than half the responses reflect this) and beyond, to conceptualising personal actions. It was therefore concluded that "Wildfire" leads participants into this process mostly to the emotional level and mediated some participants through to committing at least on paper, to some action related to self and HIV/AIDS. In and of itself "Wildfire" was effective in initiating this process. This then needs to be reinforced in the school context.

From a theoretical viewpoint, the intention of this question was to both suggest a sense of power over behaviour and determine "Wildfire's" effect on participants' perceived behaviour control (Ajzen cited in Van Dyk, 2001) as reflected by behavioural intentions (Fishbein & Ajzen 1980 cited in Armitage, 2001) to act, having been provided with a cognitive (thinking) and emotional (feeling) map of the process through which an individual must go, once 'exposed' to HIV/AIDS. The question asked of the data in this section, was therefore: "to what extent has Wildfire mediated on "individuals to internalise personal risk" (Harrison & Steinberg, 2002) and gain a sense of self-efficacy leading to perceived behavioural control with stated intentions to take action.

As reflected in Table 10, the response frequency decreased steadily from thinking through feeling to acting. This reiterated the concern expressed by researchers (Akande, 2001) who note the lack of transference of knowledge to action in adolescent populations. In response to the question posed of this section of the data, two tentative conclusions were drawn. Firstly, “Wildfire” led the majority of participants through the cognitive-mapping and at least half the participants through the emotional mapping sections. According to the Fishbein & Ajzen model (cited in Armitage, 2001), this would cover the behavioural belief-system, affecting attitudes and subjective norms, suggesting “Wildfire’s” efficacy in mediating theoretically informed behaviour-change factors up to a point. Secondly 37% of participants answered the final section, suggesting that “Wildfire” successfully mediated a commitment to intended behaviour as stated on paper for these learners. (Fishbein & Ajzen cited in Armitage, 2001). According to Prochaska and Di Clemente’s model on behaviour change, the data reflected that “Wildfire” stimulated a shift from pre-contemplation to contemplation and for some, to preparation for action (cited in Andreasen, 2001).

Examples of responses to all sections of this question are recorded in the following table:

TABLE 11: Cognitive – Emotional – Intention Sequence

| Participant | THINK | FEEL | ACT |
|-------------------------------------|--|---|---|
| Female School D Aged 15 Years | “I though going for a test was just getting your self stressed out”. | “I though that I had not to love people with AIDS”. | “I thought that I had to joke about their disease”. |
| Female School D Aged 14 Years | “That I should always use a condom when having sexual intercourse, because I might get pregnant and infected”. | “I feel ashamed HIV/AIDS”. | “I’ll protect myself from rape. Won’t force myself to have sex if I don’t want to”. |
| Male School D Aged 15 Years | “That if these someone that is HIV/AIDS must help him”. | “I feel that Wildfire will fight this disease”. | “I will use protection during sex”. |

| Participant | THINK | FEEL | ACT |
|-------------------------------------|---|--|--|
| Male School D Aged 16 Years | "To know my position of life by going to test if I am positive or negative". | "I don't have a feeling about sex and HIV/AIDS". | "Yes I do act". |
| Female School B Aged 16 Years | "I must get out of sex and I am so happy because I broke up everything". | "They make me know that I can fight from AIDS". | "I don't wan any boyfriend now". |
| Male School B Aged 15 Years | "Think about that status". | "Feel sad about AIDS". | "Act right to the people". |
| Female School A Aged 15 Years | "It tells us that AIDS is a very contagious deases and it happen so quickly". | "Sex is just a thing that confuse people". | "Abstain and protect yourself from HIV/AIDS and other deases". |
| Male School B Aged 15 Years | "To know how it spread". | "Tel will feel angry if I have this desase". | "I would act strange". |
| Female School A Aged 15 Years | "I learn how AIDS affects you and how you can get it". | "I feel bad when my boyfriend ask me about sex". | "I say no and go and live him alone". |
| Male School A Aged 16 Years | "The way I think Think careful". | "Bad" | "Angry" |

In terms of analysing the responses in general the following learnings from "Wildfire" have been interpreted: New insights gained, liberation from misconceptions, appreciation of the consequences of 'unprotected sex', self-efficacy and self-worth issues, cognitive-mapping and emotional mapping of the process. Emotional responses included vulnerability, confusion and a sense of being overwhelmed.

Question 30: “Do you think “Wildfire” should be used in schools, to help young people to inform themselves about HIV/AIDS?”

TABLE 12: Responses to Question 30

| | | FEMALES | | MALES | | NO ANSWERS | | TOTAL |
|---------|-------------------|---------|----|-------|----|------------|-------|-------|
| | | YES | NO | YES | NO | Females | Males | |
| Urban | A | 19 | 0 | 6 | 0 | 2 | 0 | 27 |
| | C | 14 | 0 | 2 | 0 | 3 | 2 | 21 |
| | Subtotal Township | 33 | 0 | 8 | 0 | 5 | 2 | 48 |
| Rural | B | 13 | 0 | 5 | 0 | 4 | 0 | 22 |
| | D | 15 | 0 | 8 | 0 | 1 | 1 | 25 |
| | Subtotal Rural | 28 | 0 | 13 | 0 | 5 | 1 | 47 |
| TOTAL | | 61 | 0 | 21 | 0 | 10 | 3 | 95 |
| % Rural | | 84,8% | 0 | 92,9% | 0 | 15,2% | 7,1% | |
| % Urban | | 86,8% | 0 | 80% | 0 | 13,2% | 20% | |

The table’s data is self-explanatory in that of those who recorded answers, over 80% in the rural/urban and male/female divides said that “Wildfire” should be used in schools, with rural males being the most in favour (92,9%).

Question 31: “How do you rate “Wildfire” as a way of informing young people about HIV/AIDS?”

TABLE 13: Response to Question 31

| | | | Excellent | | Good | | Fair | | Poor | | No Entry | |
|------------------|----|---|-----------|------|------|------|------|------|------|---|----------|------|
| | | | No. | % | No. | % | No. | % | No. | % | No. | % |
| Township | 38 | F | 21 | 55,3 | 12 | 31,5 | 2 | 5,3 | 0 | | 3 | 7,9 |
| | 10 | M | 4 | 40,0 | 2 | 20,0 | 2 | 20,0 | 0 | | 2 | 20,0 |
| Rural | 21 | F | 21 | 63,6 | 6 | 18,2 | 1 | 3,0 | 0 | | 5 | 15,2 |
| | 9 | M | 9 | 64,3 | 2 | 14,3 | 1 | 7,1 | 0 | | 2 | 14,3 |
| TOTAL | | | 55 | | 22 | | 6 | | | | | |
| Total Percentage | | | 81,1% | | | | 6,3% | | 0% | | 12,6% | |

In terms of the rating scale, participants were overwhelmingly in favour of using “Wildfire” to inform young people about HIV/AIDS, with 81,1% rating it in the excellent to good scales. Rural participants’ ratings were significantly higher than township, in excellent rating.

Question 32: “Do you believe you could use the experience of “Wildfire” to help fight the spread of HIV/AIDS?”

For yourself: TABLE 14 - Personal Responses to utility of “Wildfire”

| School Type | Gender | YES | NO |
|-------------|---------|-----|----|
| Rural | Females | 85% | 0% |
| | Males | 79% | 7% |
| Township | Females | 37% | 8% |
| | Males | 30% | 0% |

The rural learners responded significantly more positively than the township participants.

In terms of gender comparison, more female participants responded positively than males.

For Others: TABLE 15: Social Responsibilities

| School Type | Gender | YES | NO |
|-------------|---------|-----|-----|
| Rural | Females | 73% | 0% |
| | Males | 50% | 7% |
| Township | Females | 34% | 8% |
| | Males | 10% | 10% |

It was significant that the rural respondents answered positively in terms of using their experience to help fight the spread of HIV/AIDS for others. Again more females responded positively. In terms of the whole question, participants generally appeared to be more empowered by “Wildfire” in terms of using its learnings for themselves than for others – especially rural learners.

Question 33: “Has “Wildfire” had any effect on the way you would feel about/ behave towards people living with HIV/AIDS?”

TABLE 16: Response to Question 33

| School Type | Gender | YES | NO |
|-------------|---------|-----|-----|
| Rural | Females | 42% | 15% |
| | Males | 36% | 29% |
| Township | Females | 37% | 13% |
| | Males | 20% | 0% |

The responses reflected that more rural than urban participants considered themselves to have changed in the way they view people living with AIDS (PLWA). It was difficult to determine what exactly these responses meant in that few participants offered explanations for their answers. For example the 29% of rural males who reported no change in attitudes to PLWA's may be reporting either a positive attitude which remained unchanged or a negative attitude, which remained unchanged. It was concluded that generally more females than males reported a change in attitude towards PLWA's, with township males reporting the lowest change and the highest non-response to questions. This response correlated with responses to question 8a) and 8b) where male participants appeared less responsive to PLWA. This again, was a possible reflection of fears and barriers, especially if the males are more sexually active. It is possible that the wording of this question should be reviewed, in the event of using the questionnaire in other studies.

In terms of the entries made, which offered explanations of the choices made, the following were representative:

Positive attitudes towards people living with HIV/AIDS:

- ↳ "To be not be selfish or scared of them".
- ↳ "Because people living with it are not respected".
- ↳ "Because I know how to take care of someone who leave with".
- ↳ "I were worried about those who live with it".
- ↳ "Because Wildfire have more information".
- ↳ "Because AIDS is a killer" (There was no entry of yes or no in this response).
- ↳ "I was feeling but know I take them as they are".
- ↳ "Because I behave to have respect the people had HIV/AIDS".
- ↳ "Because I helped me to know that we need to love with HIV".
- ↳ "Because I knew how to feel for a person".
- ↳ "It has made have more power than first".
- ↳ "They are one as the same as I am".
- ↳ "There were not aware by the minute they got it".
- ↳ "Some of them did not ask for it".
- ↳ "Because Wildfire give people a fight things to fight the AIDS".
- ↳ "Because we must respect them because they are still humans".

- ↳ “Because before I didn’t even wanna hang around with people living with it”.
- ↳ “It teacher us to lover others”.

Negative attitudes towards people living with HIV/AIDS:

- ↳ “It make me feel like people are not good enough to have this disease because they can not fight it”.

By far the majority of those responses which answered the question, reflected a shift towards a positive view of people living with HIV/AIDS and reiterated the theme occurring in other sections of results – that of the enhancement of social responsibility for adolescents by “Wildfire”. This question fulfilled one of the objectives of the study, in that it dealt with attitudes towards people living with HIV/AIDS.

Question 34: ”What sorts of decisions and information were you exposed to, during the “Wildfire” game?”

This question, although open-ended, gave numbered spaces for 8 possible responses. As a result of this being the last major writing question at the end of a lengthy questionnaire, some participants were requested to return to their seats to give more time to this question. The responses were recorded below in tabular form, and entered according to the “Points of Planned Learning” intended by the “Wildfire” intervention (see Chapter 2 and Chapter 3 on focus group notes). Table 17 below, enumerates the actual responses of learners within the points of planned learning as intended by “Wildfire”. Interestingly, it compared positively with Table 8 emerging from the focus-group notes generated by participants – even to the point of the theme “isolation/loneliness” which did not emerge for the participants as a learning. The responses to this question were therefore significant for the following reasons:

1. They provided evidence that “Wildfire” is an effective intervention, in that it communicated the points of planned learning, that it intended to – except for isolation.
2. They provided evidence that the points of planned learning can be internalised by individuals, and retained, at least in the short term. School C’s responses

were taken approximately 8 weeks after “Wildfire” and the learnings were consistent with responses from other schools.

3. They were consistent with responses from the focus-group notes (see Table 8 above)

Question 34: “What sorts of decisions and information were you exposed to, during the “Wildfire” game?”

TABLE 17: Points of Planned Learning from “Wildfire” using individual responses in the post-test questionnaire.

Note: Entries are direct quotes of participants.

| Points of Planned Learning | SCHOOL A | SCHOOL B |
|--|---|---|
| Speed of spread of HIV/AIDS | Anone can get it | I learned that its easy to get AIDS. AIDS its spread. I know aids spread easy. The Wildfire game it the AIDS to spread it and the it is not true – it is the game. |
| Sexual Contact | Condomise when you are having sex Using condoms To condomise. Ore to have no sex. You must use a condom all the time. Be careful. Be strong. Be faithful. That we must use protection when having To have no sex without a condom | If you have sex protect you self You can get aids by sexual intercourse Stay away from sex. To take a condom on use it Abstain I know u have to condomise when you have If people having sex they must use a condom Use condom. No sex no condom Use condom |
| Choices in Relationships Prevention and Protection | “Look after myself. I decided to look after myself. To be onest to myself. To protect ourselves. That use a condom. To know how to protect people against AIDS. Wearing gloves when going to touch someones blood. To have no boyfriend. I decided to take care of myself. Because the boyfriends now always want sex / to girls so that’s what I don’t like. When touch an effected person that have blood you must use a glove. Be faithful. Condomise. How to protect, yourself against it. Abstain. Prevent it. Do not sharing doctors needles. To protect ourselves. To tell anyone that must abstain. I learned how to prevent HIV/AIDS. I decided to protect myself. To protect ourselves from HIV/AIDS. | Protected sex. To look after myself. I must choose no from sex. I must protect. I must delay. To behave myself. I must reduce I must tell others about it. Don’t toch blod How can you prevent AIDS You must not have it. I’m going to abstain I dicide at have no touching blood any one protects their bodys To be careful. I know when some touch you you protect yourself You protect yourself by a glove Don’t have many boyfriends. Use condom all the time. |

| Points of Planned Learning | SCHOOL A | SCHOOL B |
|--|---|---|
| Isolation / Loneliness | No entries specific to this point. | No entries specific to this point. |
| VCT as an option | <p>Go to the clinic and have a blood test\</p> <p>Going to test your HIV status</p> <p>Wildfire make people to be not afraid if testing. To check your blood everytime</p> <p>To go and have a test. Havind a results of HIV</p> <p>Its good thin to get tested</p> <p>To check your blood every time</p> <p>To give them what they want and what do they want to do. I want to know my status</p> <p>People were so nervous when they find out that they are</p> <p>You must reveal your status</p> <p>You must tell everyone your status</p> <p>I decided to be sure of my status</p> <p>To go to clinics and get testes</p> <p>What acts do you have after you know your results</p> | <p>If you want to know to know your status.</p> <p>You can go to the clinic/hospital.</p> <p>You must not be forced fro blood test</p> <p>Visiting counsellors</p> <p>I must go to test my blood</p> <p>If I have aids I must go to the clinic</p> <p>Do you now your status</p> <p>If I have I know how to help myself.</p> |
| Testing positive and implications | <p>How do you feel when you have HIV</p> <p>I was exposed to be HIV positive</p> <p>People were so necors (nervous) when they find out that they have HIV</p> <p>I learned how HIV/AIDS spreads when you go testing than the results come back said that positive you must know to react to others and tell you family and friends.</p> <p>When I fould out that I'm positive not to hate</p> <p>When I fould out that it's the end of the world</p> <p>Not to feel guilty about yourself because you are not the only one who have die of HIV/AIDS.</p> <p>How shick it is to found that you are HIV positive.</p> | <p>If my results are bad I will warried</p> <p>Feel sorry for myself</p> <p>To accept the disease</p> <p>How to act if you have</p> |
| Testing negative and implications | No entries specifically referencing this aspect | How do not act if you don't. |
| Comments specific to "Wildfire" intervention | <p>What do you do if you are infected</p> <p>Wildfire can change other decision</p> <p>If someone was think of death she/he couldn't because of wildfire</p> <p>Wild have information that tell you to be not afraid to speak about HIV/AIDS. I will be happy if it comes again</p> <p>People were very excited to play the game</p> <p>I learned more about HIV/AIDS</p> <p>How you get HIV/AIDS</p> <p>What we must do is we are HIV/AIDS</p> <p>To accept it where to go. What decision to take ho act or do.</p> | <p>Wildfire game is very good game for me</p> <p>The wildfire is the nice game. I feel so happy after the gom</p> <p>The wildfire game it the AIDS to spred it and the it not true. It is the game. Because it tells to how AIDS spread to another person. I you warried please must not be warried because it is the game.</p> <p>The game is any othe sion of people to HIV/AIDS.</p> <p>The people help use wildfire to use a condom</p> <p>I know a lot about aids thanks wildfire.</p> |
| Other comments emerging spontaneously as interpretive of "Wildfire" | <p>Believe that HIV is real. And it is a killing virus</p> <p>Think careful bout it</p> <p>It can help to think skill of beating HIV/AIDS</p> <p>There are many ways to heal the pain</p> <p>You taught us to fight this disease</p> | <p>Reading books of life or orientation a lot</p> <p>Watching soul city</p> <p>Do you want to have AIDS. If you kiss you are not affected</p> <p>Do you know people have AIDS</p> <p>Do you know people died of AIDS</p> |

| Points of Planned Learning | SCHOOL A | SCHOOL B |
|-----------------------------------|---|--|
| experience | <p>I rearais that you can get AIDS With so many different thing That everyone is afraid of having HIV To no hide when you have these dessese If you have this desease you can have friends To go even to the social workers</p> | <p>Aids the effect aids You can affected by donating blood. You can affected by touch a cuts of other You can affected by sharing needles To know a good thing. What is wrong or right Aids is uncurable disease Don't take toothbrush, don't use same needle</p> |
| Treating others | <p>Ask if I don't understand. Tell others Open about it. They way I feel about people with HIV I should geel strong for him/her. Don't laugh when some one is HIV/AIDS Encourage to those who are HIV positive To talke to my friends. To talk to people To know what I must suppose to do at time to be onest To accept someone who is HIV To tell others which you have HIV Taught us how to treat people To love people who live with it. To care To give them advices. To give them support I learned how to treat an infected person That everyone supports someone who is HIV+ We must take care of them People living with AIDS we must not hate them How we must treat each other.</p> | <p>I must talk to my parents Love's friend's Mother feelings To encourage people living with it</p> |

| Points of Planned Learning | SCHOOL C | SCHOOL D |
|---|--|--|
| Speed of spread of HIV/AIDS | Aids spreading so wildfire | In five days many people are infected with HIV |
| Sexual Contact | <p>Use condom If have sex use condom The game is talk about sex Is to take condom if you make sex</p> | <p>When you have sex you think about it and don't think about being infected When you have sex you say if I get infected I will see it later, I will just go for it Use protection Do not sex at all I've got information you can get AIDS when you have sex without a condom Unprotected sex To use protection when you have sex I learne about having sex wiyh out using condom</p> |
| Choices in Relationships Prevention and Protection | <p>To be faithfull. To think quick To abstain. I learn to protect myself I was tell protect I was tell protect sex. You must know your status and your partner too I was the is important You expect because is your status don't touch a blood with out a glove I learn the take care of myself</p> | <p>To express the way I fell You can abstain. Be faithful. Also you can condomise If you don't want to have sex no one can force you Think twice before taking decision concern intercourse Condoms are there for protection To protect myself in being exposed to sex to</p> |

| Points of Planned Learning | SCHOOL C | SCHOOL D |
|---|--|---|
| | <p>To protected. When you have one partner you must know his status</p> <p>To now</p> <p>To becefell</p> <p>I have learned to protect myself</p> <p>Having one partner</p> <p>Be honest</p> <p>To have one partner not many partners</p> | <p>think before I do.</p> <p>To abstain. Safe sex. Not to sleep around</p> <p>If my boyfriend wants to have sex with me I shouldn't force myself to have sex with him</p> <p>To leave a peson when she say no and still love her</p> <p>To abstain. To protect yourself</p> <p>That people can have HIV/AIDS without knowing to say no to something that don't what to do and something bad.</p> <p>We must not always changing partners because that is wrong.</p> <p>We must be faithful to our partners</p> |
| Isolation / Loneliness | no entries specific to this point | |
| VCT as an option | <p>Is to go to do some blood test</p> <p>This game is teaching me what doing if I me going to the clinic test HIV/AIDS</p> <p>They have test and results come back</p> <p>To know my status. Go for voluntary counselling and testing</p> <p>Now I HIV I must focus and condomise/abstain</p> <p>How could I feel if I have desease</p> <p>I must go and check my status</p> <p>To go to blood test</p> <p>I was decided that I must check myself all time</p> <p>My decisions is to check my status</p> | <p>To go for testing</p> <p>To be go and text</p> <p>Should know my status</p> <p>Have blood test</p> <p>Get information at clinic</p> <p>Always check your status</p> <p>If you want to go for the test after you've been counselled feel free it say no I wont have the test</p> <p>To go and check</p> |
| Testing positive and implications | <p>how you feel when you a HIV and AIDS</p> <p>If I have HIV/AIDS I feel bad</p> <p>We learn status say positive what to do</p> <p>We learn do go with group of AIDS</p> <p>I feel is bad in person get it</p> <p>I feel sorry to person get it</p> <p>If tested positive I will not bear it, I must talk</p> <p>Having HIV is not the end of the world</p> <p>How I feel I have AIDS</p> <p>I learn what to think when I am HIV</p> | <p>Exposed to how HIV/AIDS spread in the game when you have AIDS how do you feel</p> <p>Life does not for you if you are positive</p> <p>Once you get it its yours for life (AIDS)</p> <p>When you get your results you fell like kill yourself if you are positive</p> <p>You don't have to tell anyone you're positive</p> <p>After you've found out that you're positive, you can go for regular counselling to help you feel and be strong</p> <p>HIV is way of life</p> <p>I had to face the challenges. Tell my self that I can fight it.</p> |
| Testing negative and implications | <p>If no HIV feel good</p> <p>We learn status say negative what to do</p> | No specific entries regarding this point |
| Comments specific to "Wildfire" intervention | <p>The game I so good</p> <p>It was so exsiting and wonderful game and I think it is so helpful</p> <p>It was good. It changes the way if feel about HIV/AIDS.</p> <p>I want player the game because teacher me about HIV/AIDS.</p> <p>And the game was nice that day</p> <p>And I renmember about that game and I will never for get. Wildfire teaching your child the game was good.</p> <p>The game was brilliant and nice</p> | <p>That AIDS is really like a veldfire</p> <p>I learnt that you want notice that your're being infected with AIDS.</p> <p>Is to prove that people must prevent it.</p> <p>Games too can somebody a lesson like wildfire game.</p> |

| Points of Planned Learning | SCHOOL C | SCHOOL D |
|---|---|---|
| | <p>And I tell my friends about the game And I wish that we can do it more I love it very much And I learner more things with HIV/AIDS And I love that game very much I this game is important. This game is education me. This game think glove if you have shark hards. I don't think the glove also people don't think gloves I can act a wildfire I had that HIV is a killer disease my decision I want to play the game because teach me everything about HIV/AIDS and teach to use a condom when you have sexual intercourse</p> | |
| Other comments emerging spontaneously as interpretive of "Wildfire" experience | <p>And teacher me. I enjoyed. I tell my friends How this virus gets in to our body I exposed about how HIV get into your body I learner more The game is the tell about AIDS AIDS is dangerous Talk about HIV/AIDS. Is the good game I think about it I can talk about it You can get inform in the clinic, teacher, parents, friend Information is that I must pay HIV</p> | <p>People do not understand the HIV/AIDS but they understand it now some of them AIDS can affect people easily I learned from right and wrong That we could be aware of IADS Is to achieve my goals Is to achieve my dreams of tomorrow Is to know that HIV/AIDS is a killer disease You don't have to tell anyone you're positive To know wants right and want wrong if To understand ourselves Exposed to how HIV/AIDS spread in the game when you have AIDS how do you feel It every bodies business ti fight HIV/AIDS We can fight as the youth</p> |
| Treating others | <p>I learn the way can help people I will tell my parents I've go AIDS</p> | <p>To tell the people about it To love those with HIV To respect them. To not hurt their feelings Talk to friend/friends Talking with our parent about this Is to go and tell the other about this virus Is to talk to my familhy If you have AIDS just talk to the other people If you have a problem to your home about it talk to others Love people live have HIV</p> |

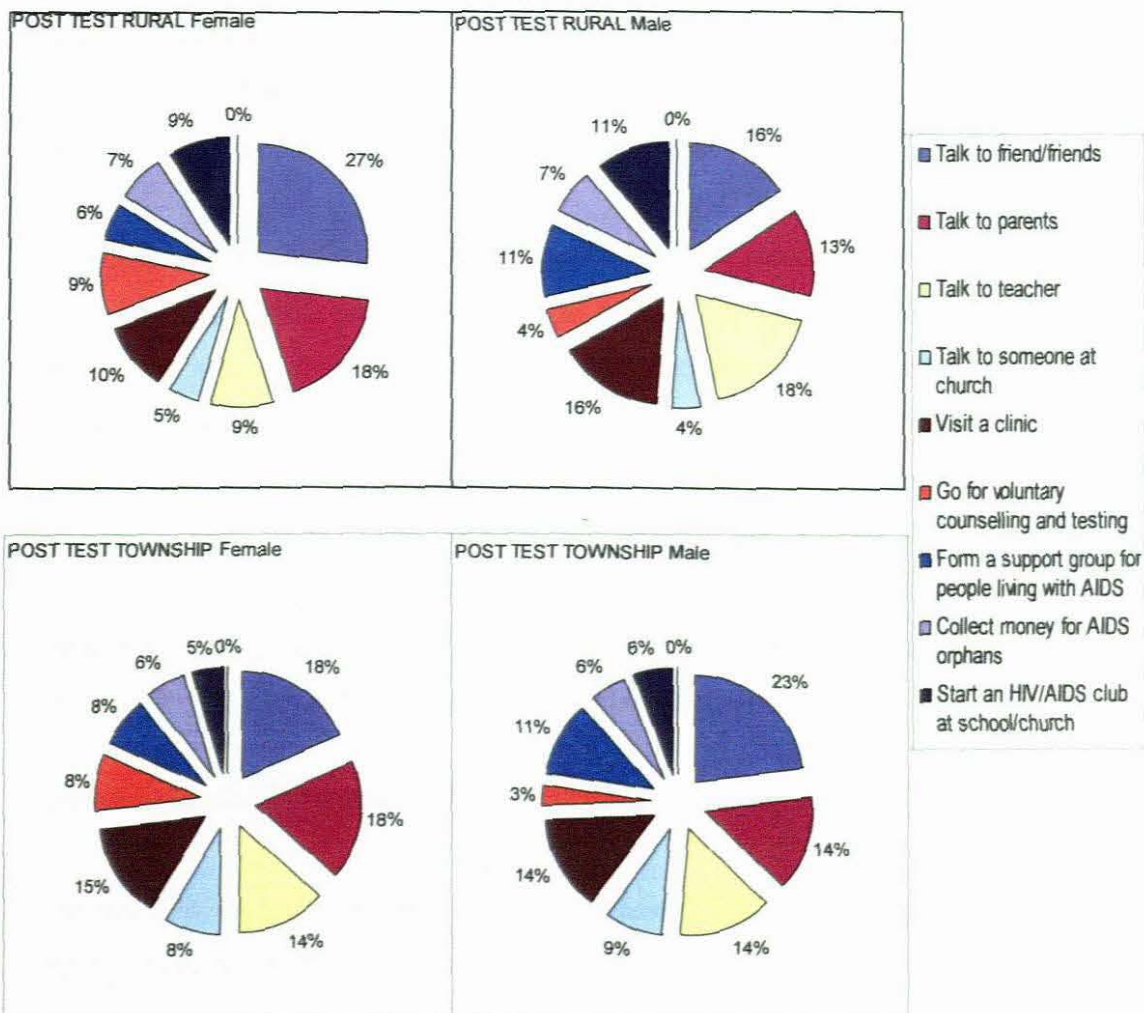
In general, the responses reflected the learnings from "Wildfire" as internalised by the participants. When compared to Table 8 (above) in which the focus-group responses were compared to the Points of Planned Learning of "Wildfire", a positive correlation of the learnings both immediately after the intervention (at group level) and given the time-delay (3 weeks – 2 months) before the post-test questionnaire, (individual level) was found. Further, the responses were individual and indicated a reliable internalisation of the intended learnings of "Wildfire". This question triangulated the

data and answered the research question suggesting that, Yes, “Wildfire” was an effective preventative intervention for secondary school learners.

Question 35: “Is there anything you have done, or plan to do within the next week, about HIV/AIDS?”

The final question in the post-test questionnaire: “Is there anything you have done, or plan to do within the next week about HIV/AIDS?” has been represented below in a pie diagram according to the fixed-response choices provided.

FIGURE 3: Behavioural intentions around issues of HIV/AIDS.



The fixed-response options provided, offered opportunities for the participants to commit to active intentions regarding HIV/AIDS and were divided into two broad categories. Firstly, there were 6 options for personal action ranging from talking to significant others to visiting a health facility and secondly, there were 3 options

suggesting actions relating to social responsibility. With reference to Figure 3, preferred active intentions indicate that personal actions take priority, with talking to peers, being ranked the highest. Males appeared to be more prepared to talk to a teacher about HIV/AIDS and this ranks equal with a visit to a clinic. An interesting discrepancy was evident in male responses, in that while 50% were prepared to visit a clinic, only 10% of township and 14% of rural males were prepared to go for VCT, which also takes place at a clinic. VCT ranked amongst the lowest options for action presented for males, after “Wildfire”, whereas it ranked middle for females, before social responsibility. If the responses to the VCT active behavioural intentions emerging here, are compared with the raise from pre test to post test in question 11 regarding finding out about sero-status, “Wildfire” came out strongly as a mediator towards shifting behavioural intentions towards VCT, for a range of 3% to 9% of the research population. Given the social barriers referred to by van Dyk (2003) around actual VCT in the health sector, this shift was positive.

Avoidance of anticipated VCT was therefore a higher ranked intention for males. The church ranked higher as a social support system, for township adolescents, than for rural, with whom it ranked lowest, possibly because of the isolated nature of rural locations. Rural females ranked speaking to a teacher at 24% (4th) which was significantly lower than other responses. It is possible, that in small rural communities the fear of breach of confidentiality and stigma may be greater and explain such a response – this explanation was congruent with van Dyk’s findings regarding fear of actual VCT and nurse confidentiality as social barriers (2003). Appendix 23 presented these results in tabular form, in rank order.

4.4 Summary and Discussion on Post-Test Responses to “Wildfire”

Briefly, this section of the questionnaire indicated that learners consider “Wildfire” to be an effective intervention, the overwhelming majority of whom say, that “Wildfire” has changed their perceptions, over 80% declaring that it should be adopted in school contexts and rating it as excellent or good on a rating scale.

The data reflected indicators of internalisation of planned learning of the interventions – at least to cognitive and emotional levels of individuals, suggesting “Wildfire” as an

effective mediator for these learners in terms of cognitive and emotional ‘mapping. New insights emerged regarding liberation from misconceptions, and understanding the consequences of unprotected sex. Postive attitudes were indicated to PLWA, except for township males, who appeared more ambivalent.

This section of data-collection was consistent with other sections in terms of “Wildfire” teaching what it intended to (except for the theme of isolation) as well as confirming criteria set out by van Dyk (2001) and Visser (1995) with regard to effective preventative interventions. The behavioural intentions around issues of HIV/AIDS involved themes of social support and seeking support from the health sector – both of which are necessary ingredients in the success of VCT in naturalistic settings.

CHAPTER 5

CONCLUSION

This research investigation set out to explore the effectiveness of the psycho-educational tool of “Wildfire” as a preventative intervention for HIV/AIDS with secondary school learners. The study was located within the broader context of primary mental health in South Africa, situating the intervention outside the health sector and using schools as the site of practice. It intended to fill a gap in research around issues of HIV/AIDS in younger populations and has been theoretically and methodologically informed by previous research on issues of mental health and HIV/AIDS (van Dyk, 2003; Peltzer, 2003; Freeman, 2004; Pillay & Lockhat, 2001; MacLeod, 2002). The theoretical rationales which underlie the investigation include cognitive theory, theories of behaviour change, educational theories including experiential learning and developmental theory. These theories have been discussed in Chapter 2.

The findings of this formative investigation (Chapter 4), were based on the data emerging from the post test questionnaire section dealing with “Wildfire”, the information from the behavioural observation, verbal responses and focus-group notes derived from the intervention itself provide methodological rigour. The findings clearly suggested that “Wildfire” was an effective preventative intervention for HIV/AIDS among secondary school learners within the context of the Life Orientation section of the curriculum. Therefore, in answer to the primary question posed by this study: *“Is “Wildfire” an effective preventative intervention for HIV/AIDS among secondary school learners?”* the answer is YES.

In order to justify the ‘yes’ answer to the research question, the following points constitute a summary of the effectiveness of “Wildfire” as an intervention:

1. The adolescents’ voices in response to “Wildfire” clearly stated its potential for use with other adolescents. The post test response to whether participants recommend the use of “Wildfire” for other learners, met with an 80% and over “Yes” response from all school contexts, with rural males being the most enthusiastic at 92%. Data gathered in the sexual contact section of the questionnaire verified the age and risk-taking behaviour of some adolescents which was congruent both with other research

(MacLeod, 2002; Cohen & Trussell, 1999) and the rationale for the appropriate age of intervention.

2. Themes of social responsibility, social conscientising and the social equalizing function of “Wildfire”, all form preventative functions in relation to social barriers such as stigma and silence. Respondents indicated that they prefer to seek information about HIV/AIDS from people with whom they are in relationship, such as teachers and mothers. The potential for this to contribute to a process of transformation of norms in the social system over time becomes obvious (MacPhail, 1998; Seedat, Duncan & Lazarus, 2001; Whiteside & Sunter, 2000; Macleod, 2004). In fact at one point a participant stated that adult behaviour should not be modeled, suggesting that new norms need to be sought. “Wildfire” therefore did function as an agent of socialization or mediator for participants, within the current situation of the HIV/AIDS pandemic, as was the intention of this study.
3. “Wildfire” provided new learning and insights for adolescents in relation to HIV/AIDS and so added to the knowledge and information garnered from various sources including the school and the media. It reinforced knowledge and information already gained and by the experiential nature of the intervention, exposed learners to in-depth knowledge about the process through which individuals go after ‘exposure’ to HIV/AIDS including VCT. The range of feelings and reactions to the intervention mirrored those of “fatalism and mental anguish” (van Dyk, 2003) recorded from research in naturalistic settings with one important difference. The difference was that, for those not previously exposed, this knowledge provided a map of emotional consequences, making “Wildfire”, as a simulation of real life, preventative in function. Preventative, in that life choices could be made with this new knowledge, prior to actual exposure.
4. “Wildfire’ additionally provided new information to learners that served as a cognitive map in terms of what to do if exposure to HIV/AIDS occurs. Themes emerging from the data suggested that social support, the recognition of professional expertise (clinic visits and services of VCT), disclosure and healthy lifestyles, provided information for those who may have been exposed or for those who may be exposed in the future. With reference to cognitive theory covered in Chapter 2 (above)

the learnings provided the adolescents, who were previously novices (Carey, 1985) in this area with the “tools, language, labels...” (Feuerstein cited in Engelbrecht & Green, 2001: 230) consistent with a mediated learning experience (MLE). This point and point 3 above fulfilled Slutkin’s contention that “the most effective programmes have provided comprehensive education and offered both options: sexual delay and protection against the virus” (cited in Visser, 1995: 138). The tables of points of planned learning clearly indicated that “Wildfire” provided more and new information about HIV/AIDS for the participants. One significant learning was that of asymptomatic/healthy carriers (Cohen & Trussel, 1996: 138) – i.e. it is not possible to recognize by sight, who is HIV positive.

5. Connections between facts and knowledge and consequences were made on an active-emotional level in “Wildfire”. The data suggested that this intervention shifted the learners toward behaviour change in terms of van Dyk’s factors contributing to behaviour change. Van Dyk’s factors include “self-description of being at risk, perception of own susceptibility to infection, perception of consequences of disease” (2001: 84) as well as belief that certain preventative behaviours can be engaged in and a concern for good health. One participant summed up the perception of personal risk as “Believe that HIV is real. And it is a killing virus”. The congruence between the points of planned learning of “Wildfire” and the focus groups’ descriptions of their learning as well as the individual responses to Question 34 (both of which are tabulated against the points of planned learning for “Wildfire”) clearly demonstrated “Wildfire’s” effectiveness in terms of van Dyk’s factors for behaviour change. As one learner put it: “The people help to use wildfire to use a condom”.

What was particularly significant in terms of these tables was that the learnings appeared to have been firmly internalized from group level in the focus groups to the individual level in the post-test questionnaire. Furthermore the data indicated that this internalization of learnings was sustained over time. The accuracy of schools C’s responses to the post-test that occurred more than 8 weeks after “Wildfire” (with a mid-year holiday in-between) , with responses from other schools, focus group notes, as well as the points of planned learning provided clear evidence of this internalization over time. The connections indicated in the data suggest that “Wildfire” may contribute to an answer to concerns expressed by Akande (2001)

about the need to help adolescents understand the consequences of HIV/AIDS and express this in their behaviour. It also suggested that Visser's recommendation (1993) of helping adolescents internalize personal risk, was met in the context of the research.

In relation to the methodology applied in this investigation, the results indicated that the pre-test and post-test questionnaires did not constitute an effective comparative instrument in all the questions, in terms of measuring the effectiveness of "Wildfire" itself. Issues of trust, unfamiliarity with the research process and possible lack of reliability regarding self-report in an adolescent population, as well as the high degree of HIV/AIDS knowledge and information already attenuated by participants, are possible explanations for the lack of success of the questionnaires as research instruments in the traditional scientific sense of experimental design.

The questionnaires rather served to fulfil the objectives of the study, provide rationale for the age of the intervention and provided opportunities for participants to explore their own relationship with HIV/AIDS in relation to protection, risk-taking behaviour and psycho-social issues. Another function served by the questionnaires, was to provide feedback about the process, highlighting, in one instance that the symbolic nature of "Wildfire" could be interpreted literally – useful cautionary information for future use of the intervention.

In the section of sexual contact, where there were virtually no responses in the pre-test making comparison with the post-test impossible as a way of determining whether, if any, personal changes had been made to participants' sexual behaviour. However, what this particular section of the questionnaire (pre to post test) did demonstrate about "Wildfire's" effectiveness was that the intervention fulfilled a different and important objective in terms of preventative interventions- that of 'breaking' the silence around issues of sexuality. The data of this particular section of the questionnaire, clearly suggested that by engaging in the joint activity (Gilbert, 1995) of "Wildfire", participants felt free to disclose aspects of their sexual activity in the post test. "Wildfire" therefore served the purpose of 'giving' permission to participants to disclose, and thereby to own, aspects of personal sexual behaviours and thereby, break the barrier of silence.

Another form of feedback provided by the questionnaire, was to communicate the shift in some participants' views/personal practices as a direct result of "Wildfire" which provided powerful evidence of the intervention's effectiveness. Two examples of such feedback were: *"To leave a person when she say no and still love her"* and *"I must get out of sex and I am so happy because I broke up everything"*. In this sense, the questionnaires served to reinforce and support the preventative nature of the intervention as a whole and could be used as an intervention in itself – as was indicated by the responses from the control school.

The control school had only 9 participants, so the results could not provide reliable comparisons to the quantitative data. It was therefore not necessary or effective in terms of being a control for the intervention. However the participation of the control school does suggest the utility of the questionnaire as an intervention in itself. In light of this outcome of the research process, the researcher concluded that the contents of the questionnaire served a supportive role to "Wildfire" in terms of providing opportunities for learners to investigate their relationship with HIV/AIDS and possibly assist in the internalizations derived from "Wildfire". It is possible that the research design could have demonstrated more of a shift from pre-to post-test (with "Wildfire" as the change factor) in contexts where the levels of knowledge and information about HIV/AIDS were low prior to the intervention. This was not the case in the context of this study. The adoption of the questionnaires in this research, made the scope of the study broader than was necessary to answer the research question and the data analysis bulky and time-consuming – however the utility of the information emerging from the questionnaires as well as the insights provided regarding adolescents and HIV/AIDS, have proved valuable.

With reference to the two levels intended for this enquiry (Chapter 3 above) that of providing a 'voice' for the youth in matters relating to HIV/AIDS and that of providing verifiable data regarding the effectiveness of administering "Wildfire" to an adolescent population (specifically Grade 9 learners), the intentions, motivations, aims and objectives of the study have been fulfilled. The 'voices' of the youth provided useful information that can be used by schools to add to the HIV/AIDS component of the Life Orientation section of the curriculum such as questions arising from their knowledge and suggestions. Additionally this study highlighted the need to focus on self-efficacy and personal empowerment for learners in Life Orientation as these concepts appeared to be little understood by participants. The data pointed strongly in favour of adopting "Wildfire" as an additional component of the

HIV/AIDS intervention programme in schools because it “gives more”. Practically, then, the study provided useful information for the Education Department. In the words of one participant *“Wildfire is good for young people because it educate and encourage them, what you must do if you have HIV/AIDS how do you feel when you have HIV/AIDS. Who can help you when you have and who do you tell.”*

In terms of informing the practices of the SPF, a local NGO, this study provided data which supports the advocacy of using “Wildfire” in school contexts. It also verified through rigorous methodological triangulation, that all “Wildfire’s” intended learnings were attenuated by the participants except for the theme of isolation. Isolation, was an important intended learning in terms of peer pressure and the fact that it can be neglected in the process of the intervention provides important feedback for future practices of the SPF. The SPF can now advocate for the adoption of “Wildfire” in schools and offer to train key personnel from the Education Department in the administration of “Wildfire”. Potentially, “Wildfire” could be offered to educators and staff in order to sensitise teachers and provide preventative or management input for them. Finally and most importantly, the aim of administering an effective preventative intervention around HIV/AIDS has been fulfilled for 95 adolescents (some of whom may be exiting the education process) in the East London area, making the research endeavour a reciprocal process.

The study was therefore consistent with Durrheim’s definition of applied research which aims to “contribute towards practical issues of problem-solving, decision-making, policy analysis and community development” (1999: 41). In terms of problem-solving, the research provided verification of a psycho-educational intervention that mediated, in a non-threatening yet powerful ‘game’, a sense of personal vulnerability to HIV/AIDS for adolescents and so have preventative repercussions. It also highlighted areas that can be built upon in Life-skills programmes. It provided subject matter for further AIDS education in terms of questions that adolescents have, now that they are armed with knowledge and information about HIV/AIDS. Additionally, suggestions about how the school could participate in the fight against HIV/AIDS both internally and within community settings, emerged from the research process.

A cautionary note emerged from the data in that preventative interventions need to deal with realistic issues – such as the fact that having a boyfriend does not have to mean a sexual

relationship and the difference between contraception and protection from HIV/AIDS and how to talk to parents about sex. Preventative interventions need to be sensitive to adolescents' sense of personal power in the face of HIV/AIDS as well as taking the overwhelming nature of knowledge to a level where action becomes more important than barriers. An important learning for participants was that they have the right not to disclose their status or go for VCT. These constitutional rights should be emphasized in all interventions, as they emphasise human dignity and choice in the face of HIV/AIDS.

“Wildfire” was found to be an affordable accessible and relevant psycho-educational tool in terms of preventative health care in the face of the HIV/AIDS pandemic. The administration of “Wildfire” was practical in that it can take place in lesson time, it can form part of – and add to the value of - the ongoing HIV/AIDS interventions already taking place in the schools. The experiential nature of the intervention allowed for learners to internalize the intended learnings through activity rather than being directive, making it a powerful mediator between knowledge and information and decisions regarding personal preventative action on the part of learners. Furthermore, “Wildfire” taught and provided an in-depth understanding and realistic (according to research findings in naturalistic settings) ‘pre-view’ about the process of VCT before it becomes a necessary life choice. It therefore debunks barriers to VCT (more participants were willing to visit clinics, find out their sero-status and go for VCT at the end of the research process than at the beginning). In this sense, “Wildfire” has potential to be a powerful and positive adjunct to the services of VCT that are currently offered (with low uptake, van Dyk, 2003) in the health sector- made it a truly primary mental health intervention. Most importantly, it provided learnings which empowered individuals with choices and decisions. In the words of one participant, “If someone was think of death she/he couldn't because of wildfire.”

The process of this investigation provided evidence that “Wildfire” as a psycho-educational intervention for secondary school learners, was effective. It was effective in that it fulfilled requirements for preventative interventions. It was effective because it taught what it planned to teach. It was effective in that its process reflected recent research findings as well as the theoretical principles underlying its administration. Furthermore within the context of ongoing Life Orientation in schools, it has the potential to contribute to “the dual goals of reducing the incidence of psychological and physical health problems and of enhancing social competence and health” (Cowen, Weissberg & Greenberg, cited in Weissberg et.al. 2003).

5.1 Limitations of the Research

It is acknowledged that the findings of this investigation cannot prove conclusively, that “Wildfire” can in fact prevent HIV/AIDS. Firstly, the period of study is short - a longitudinal study could provide more compelling evidence, on sustained prevention. Secondly, the only incontrovertible evidence of successful prevention in a population over time would be sero-negativity from blood tests - this was outside the legal, ethical and cost scope of this investigation.

The data derived from the questionnaires was based on self-report, which various authors acknowledge, is subject to bias especially in an adolescent population. In terms of using the questionnaires as a measuring instrument on the effectiveness of “Wildfire”, the responses did not provide reliable data pre- to post-test or even within the section dealing with sexual contact, possibly because of the sensitive nature of issues relating to HIV/AIDS.

The section on “Wildfire” was added to the end of the post-test questionnaire which was a possible disadvantage in terms of deriving full and rich information. By the time the participants had reached this section, they were observed to be tired, so it was possible that the effort and thought put into responding to the questions, was not as committed as the researcher had hoped.

With regard to the post-test questionnaire, the questions on “Wildfire” were not pre-tested for appropriate wording with the three adolescents, and many participants asked about how to answer question No.33 and needed clarification on answering question 34.

In targeting Grade 9 learners only, for preventative purposes, this research and its findings were limited to this particular range of participants. An approach in which a range of learners across the spectrum from grades 8 to 12 were targeted, could have provided more convincing evidence for an ideal age/grade for intervention, by making comparative inferences.

Language was a possible limitation of this research investigation. The learners targeted, answered their questionnaires in their second language, which had two setbacks: firstly, completing the questionnaires took longer than planned and secondly, the potential for rich, emotional responses was possibly lost in that process. The inverse was probably true at the point of the researcher's role in observation note-taking during the "Wildfire" intervention - where lack of knowledge of Xhosa meant that the researcher had to rely on the facilitator to translate spontaneous responses from the learners. Again, rich individual responses were possibly lost here. Language issues and translation are realities in the South African context and so observations of behaviour on the part of observer-as-ethnographer, take on significance.

The multiple functions which the questionnaires fulfilled in terms of the objectives of the study, made them a clumsy measuring instrument in terms of answering the research question about the effectiveness of "Wildfire". Data analysis was also bulky as a result. Questions 3 and 28 could be re-phrased should the research be repeated.

Given these limitations, the findings of this research study can, at best, make inferences about the effectiveness of "Wildfire" as a preventative intervention during the time period and within the context of the investigation, given certain current assumptions inherent in preventative approaches to HIV/AIDS: "To make an inference is to draw a conclusion on the basis of evidence, to make a claim that is supported and follows from data or from premises" (Tredoux & Smith, 1999: 331).

5.2. Recommendations for further Research

To conduct a case study in which "Wildfire" is administered in a localized area to both adults in the community and adolescents in schools to determine whether the uptake of VCT services are improved.

To conduct an in-depth analysis of the processes of internalization of "Wildfire's" intended learnings, using video-tape recordings and in-depth interviews.

To institute a study within the school context where educators are firstly exposed to "Wildfire" and self-reflections, then trained in its administration for the learners.

To conduct long-term follow-up on the effects of “Wildfire” in a school context, regarding Life Orientation lessons, school policy and school input on a community level.

An analysis which draws on data and compares shifts in participants’ responses to “Wildfire”, directly to theories of behaviour change, such as Fishbein & Ajzen’s model (cited in Armitage, 2001) and Prochaska & DiClemente’s model (cited in Andreasen, 1995) may provide insight into the process of change in adolescents as well as produce a model that could inform future preventative interventions.

To conduct research on various age-groups to determine “Wildfire’s” effectiveness and the age at which its intended learnings are most effective.

REFERENCES:

- Akande, A. (2001). Risky Business: South African youths and HIV/AIDS prevention, *Educational Studies*. Vol. 27, 3, pp. 237-256.
- Allan, A. (2001). *The Law for Psychotherapists and Counsellors*. South Africa: Inter-Ed Publishers.
- (1994). *ANC: A National Health Plan for South Africa*.
- Andreasen, A.R. (1995). *Marketing Social Change. Changing behaviour to promote health, social development and the environment*. San Francisco: Jossey-Bass.
- Armitage, C. *The theory of planned behaviour*. Presentation at the DFID conference 25 May 2001.
- Averasturi, L.G. (1998). Psychological factors and Health. The Cuban Model. In Dasen, P.R. Berry, J.W. and Sartorius, N. (Eds.). (1998). *Health and Cross-Cultural Psychology. Toward Applications*. London: Sage.
- Bhana, A. (1999). Participatory action research: a practical guide for realistic radicals. In Terreblanche, M. & Durrheim, K. (Eds.). *Research in Practice. Applied Methods for the social sciences*. Cape Town: University of Cape Town Press.
- Bhana, A., Petersen, I., Mason, A., Mahintsho, Z., Bell, C. & McKay, M. (2004). Children and youth at risk: adaptation and pilot study of the CHAMP (Amaqhawe) programme in South Africa. *African Journal of AIDS Research*. 3(1), 33-41.
- Brown, L.M., Tappan, M.B., Gilligan, C., Miller, B.A. & Argyris, D.E. (1989). Reading for self and moral voice: A Method of Interpreting Narratives of Real-Life Moral Conflict and Choice. In Packer, M.J. & Addison, R.B. (Eds.). *Entering the Circle: Hermeneutic investigation in Psychology*. Albany: State University of New York Press.

- Campbell, C. & Williams, B. (1998). Evaluating HIV-Prevention Programs: conceptual challenges. *Psychology in Society (PINS)*. 24, 57-68.
- Carey, S. (1985). Are children fundamentally different thinkers and learners than adults? In Richardson, K. & Sheldon, S. (Eds.) (1988). *Cognitive Development to Adolescence*. Open University Press: U.K.
- Cohen, B. & Trussell, J (Eds.) (1996). *Preventing and Mitigating AIDS in Sub-Saharan Africa. Research and Data Priorities for the Social and Behavioural Sciences*. Washington D.C.: National Academy Press.
- Craig, G.J. (1980). *Human Development*. Englewood Cliffs, New Jersey: Prentice-Hall.
- Daily Dispatch* 15 November 2001. South Africa united against child rape.
- Daily Dispatch*, 19 November 2001. Survey finds rape ingrained in SA society.
- Daily Dispatch*, 2 September 2005. Department of Education (Zwelitsha). Education Sector Policy on HIV and AIDS.
- Dawes, A. & Donald, D. (1994). Understanding the Psychological Consequences of Adversity. In *Childhood Adversity: Psychological Perspectives from South African Research*. Cape Town: David Philip.
- De la Rey, C. & Ispier, J. (2004). The call for relevance: South African Psychology ten years into democracy. *South African Journal of Psychology*. 34(4) pp.544-552.
- Denill, K., King, L., Lock, M & Swanepoel, T (Eds.) (1995). *Aspects of Primary Health Care: Community Health Care in South Africa*. Halfway House: Southern Book Publishers.
- Donald, D., Dawes, A. & Louw, J. (Eds.) (2000). *Addressing Childhood Adversity*. Cape Town: David Philip.

- Donaldson, M. (1983). Children's Reasoning. In Richardson, K. & Sheldon, S. (Eds.) (1988). *Cognitive Development to Adolescence*. Open University Press: U.K.
- Durrheim, K. (1999). Research Design. In Terre Blanche, M. & Durrheim, K. (1999). *Research in Practice. Methods for the social sciences*. Cape Town: University of Cape Town Press.
- Durrheim, K. & Wassenaar, D. (1999). Putting Design into Practice: writing and evaluating your research proposals. In Terre Blanche, M. & Durrheim, K. (1999). *Research in Practice. Methods for the social sciences*. Cape Town: University of Cape Town Press.
- Engelbrecht, P. & Green, L. (Eds.) (2001). *Promoting Learner Development. Preventing and working with barriers to learning*. Pretoria: van Schaik.
- Evian, C. (2000). *Primary AIDS Care*. (3rd Ed.). Durban: Jacana Education.
- Freeman, M. (2004). HIV/AIDS in Developing Countries: Heading Towards a Mental Health Disaster? *South African Journal of Psychology*. 34(1) 139-159.
- Gilbert, A.J. (1995). *Small Voices Against the Wind: Local Knowledge and Social Transformation*. Paper presented at the Rhodes University East London Academic Forum.
- Gray, J.N., Lyons, P.M. & Melton, G.B. (1995). *Ethical and Legal Issues in AIDS Research*. London: The John Hopkins University Press.
- Harrison, D. & Steinberg, M. (2002). *Behaviour Change: The cornerstone of HIV Prevention*. (paper presented on Lovelife).
- Hoosen, S. & Collins, A. (2004). Sex, sexuality and sickness: Discourses of gender and HIV/AIDS among KwaZulu-Natal women. *South African Journal of Psychology*. 34(4) 487-505.

- <http://www.psychoeducation.com> (2003). *Psychoeducation*. Queensland Government, Queensland Health. Inner Worth Brisbane Mental Health Service, Royal Brisbane and Women's Hospital Health Service District.
- Kelly, K. (1999). From encounter to Text: data-gathering in interpretive research. In Terre Blanche, M. & Durrheim, K. (1999). *Research in Practice. Applied methods for the social sciences*. Cape Town: University of Cape Town Press.
- Kelly, K., Parker, W. & Oyosi, S. (2002). *Pathways to Action, HIV/AIDS prevention, Children and young people in South Africa*. Save the Children: CADRE Grahamstown.
- Kolb, D.A., Robin, I.M. & McIntyre, J.M. (1984). *Organisational Psychology: Readings on Human Behaviour in Organisations (4th Ed)* Englewood Cliffs: N.J.: Prentice Hall.
- Kvale, S. (1996). *InterViews: An Introduction to Qualitative Research Interviewing*. California: Sage Publications.
- Macleod, C. (2002). *BASE_LINE SURVEY for the Secondary school HIV/AIDS and Life Skills education programme* The AIDS Directorate: Department of Education Eastern Cape.
- Macleod, C. (2004). South African Psychology and Relevance: Continuing Challenges. *South African Journal of Psychology*. 34(4) 613-629.
- MacPhail, C. (1998). Adolescents and HIV in Developing Countries: New Research Directions. *Psychology in society (PINS)*. 24, 69-87.
- Mail & Guardian*. 5-11 October 2001. Shocking Aids Report leaked.
- Mail & Guardian*, 2-8 September 2005. Why don't we know?

- Nairobi M & E Network, African Evaluation Association Secretariat, Reseau Nigerian de Suivi et Evaluation, Cape Verde Evaluation Network, Reseau Malagache de Suivi et Evaluation, Comores Evaluation Network, Eritrean Evaluation Network, Malawi M & E Network, Reseau National de Chercheurs de Burundi, Rwanda Evaluation Network, UNICEF Eastern and Southern Africa, Region M & E Network (2002). *The African Evaluation Guidelines: 2002. A checklist to assist in planning evaluations, negotiating clear contracts, reviewing progress and ensuring adequate completion of an evaluation. Evaluation and Program Planning.* 25 (4), 481-492.
- Nduati, R. & Kiai, W. (1997). *Communicating with Adolescents about AIDS. Experience from Eastern and Southern Africa.* Ottawa: International Development Research Centre.
- Oppong, J.R. & Ghosh, J. Concluding Remarks: Beyond Epidemiology. In Kalipeni, E., Craddock, S., Oppong, J.R. & Ghosh, J. (Eds.) (2004). *HIV and AIDS in Africa. Beyond epidemiology.* USA: Blackwell Publishing.
- Packer, M.J. & Addison, R.B. (Eds) (1989). *Entering the circle. Hermeneutic Investigation in Psychology.* Albany: New York Press.
- Parker, W., Dalrymple, L. & Durden, E. (1998). *Communicating Beyond Aids Awareness: A Manual for South Africa.* RSA: Beyond Awareness Consortium.
- Peltzer, K. (2003). HIV/AIDS/STD knowledge, attitudes, beliefs and behaviours in a rural South African adult population. *South African Journal of Psychology*, 33(4) 250-260.
- Piaget, J. (1970). Extracts from Piaget's theory. In Richardson, K. & Sheldon, S. (1988). *Cognitive Development to Adolescence.* Sussex: The Open University.
- Pillay, A. & Lockhat, R. (2001). *Models of Community Mental Health Services for Children.* In Seedat, M., Duncan, N. & Lazarus, S. (2001). *Community Psychology. Theory, Method and Practice.* Cape Town: Oxford University Press.
- Rogers, E.M. (2000). Introduction. *Journal of Health Communication.* 5 (Supplement) 1-3.

- Santrock, J.W. (2002). *Life-span Development (8th ed.)* McGraw Hill: Boston.
- Seedat, M., Duncan, N. & Lazarus, S. (2001). *Community Psychology, Theory, Method and Practice. South African and Other Perspectives.* Cape Town: Oxford University Press.
- Shisana, O. & Simbayi, L. (2002). *Nelson Mandela/HSRC Study of HIV/AIDS. South African National HIV Prevalence, Behavioural Risks and Mass Media. Household Survey 2002.*
- Smith, T.E.C., Polloway, E.A., Patton, J.R. & Dowdy, C.A. (2001). *Teaching Students with Special Needs in Inclusive Settings.* (3rd Ed.) London: Allyn and Bacon.
- Steinberg, L. (1999). *Adolescence.* (5th Ed.) USA: McGraw-Hill.
- (2004) Report on the global AIDS epidemic. Switzerland: Joint United Nations Programme on HIV/AIDS (UNAIDS).
- Terre Blanche, M. & Durrheim, K (Eds.) (1999). *Research in Practice. Applied Methods for the Social Sciences.* Cape Town: UCT Press.
- Tredoux, C. & Smith, M. (1999). Jumping to conclusions: an overview of inferential statistical methods. In Terre Blanche, M. & Durrheim, K (Eds.) (1999). *Research in Practice. Applied Methods for the Social Sciences.* Cape Town: UCT Press.
- Van Dyk, A. (2001). *HIVAIDS Care and Counselling: A multidisciplinary approach.* (2nd Ed.) South Africa: Pearson Education.
- Van Dyk, A.C. & van Dyk, P.J. (2003). "What is the point of knowing?": Psychosocial barriers to HIV/AIDS Voluntary Counselling and Testing Programmes in South Africa. *South African Journal of Psychology.* 33 (2) pp.118-125.
- Van Rooyen, M. & Prinsloo, F. (2002). *Outcomes-based assessment: A comprehensive handbook for South Africans.* Cape Town: Cambridge University Press.

- Visser, M.J. (1995). The need for AIDS education in schools: an analysis of knowledge, attitudes and behavioural intentions of students. *Suid Afrikaanse Tydskrif van Opvoedkunde*, 15 (3).
- Vrey, J.D. (1979). *The Self-Actualising Educand*. Pretoria: University of South Africa.
- Vygotsky, L.S. (1978). *Mind in Society: The development of higher psychological processes*. Cambridge (Mass.): Harvard University Press.
- Vygotsky, L.S. (1981). The Genesis of Higher Mental Functions. In Richardson, K. & Sheldon, S. (Eds.) (1988). *Cognitive Development to Adolescence*. Open University Press: U.K.
- Weissberg, R.P., Kumpfer, K.L. & Seligman, M.E.P. (2003). Prevention that works for Children and Youth. In *American Psychologist*. Vol. 58, No. 6/7, 425-432.
- Whiteside, A. & Sunter, C. (2000). *AIDS: The Challenge for South Africa*. Tafelberg: Human & Rousseau.

PROCESS NOTES PREPARATION

Venue : With no disturbance (preferably with curtains).

Equipment: Rubber Gloves
20 envelopes (10 = “HIV Positive”)
(10 = “HIV Negative”)

STEPS:

1st Step: Stand in a circle.

2nd Step: → Think about what you know or have heard about HIV/AIDS.
→ What are the 3 ways HIV is spread – blood, sexual intercourse, mother to child transmission.
→ How do you know you have HIV/AIDS.

3rd Step: Explain the game
This is a pretend game.
→ Remind the person who has been touched to scratch anyone who they shake hands with.
→ Each person scratched must in turn scratch any person they shake hands with.
→ Hand-shaking is “engaging in casual unprotected sex”.
→ Note Well:
○ Does anyone abstain from shaking hands?
○ Does anyone only shake hands with one person (faithful)?
○ Does anyone look for and use rubber gloves (condomise)?

4th Step: Stop

5th Step: Reform circle. Stand in the centre.

6th Step: Ask “Who has been scratched/exposed”? – put up your hands.
→ “Did you expect it to be so quick”?
→ “What was your reaction”?
→ “What did you think of the person who scratched/exposed you”?
→ “How do you feel”? – sad, angry.
→ “Anyone else want to say something”?

7th Step: All exposed – take one step forward.
All not exposed – take one step back

8th Step: Record on Newsprint:
To those **not exposed**.
→ How do you feel now?
→ Did anyone think to use the gloves for protection?
→ Did anyone think to be faithful and only had sex with one person?

- How do you feel that you have not been exposed? – Sit back, but please be quiet.

9th Step:

To those **exposed**

- How did it make you feel? (Claps)
- Is there anything you would like to say?
- I am going to ask you to make a decision – VCT (½ minutes to think)
- VCT – Yes or No (no right or wrong answer)
 - Take a step back = **No**
 - Take a step forward =- **Yes** to VCT.
- Ask **No's** why? (Clap) All to go and sit down.
- To **Yes's**: “I think you are brave”.
 - Why do you want to be tested/affirmed?

10th Step:

Remind the class that this is a game!!

Give make-believe test results in envelope.

11th Step:

Before opening your envelope think:

- How are you feeling?
- What are you planning to do?
- What are you thinking about?

12th Step:

Open envelopes to get results.

Remember, this is your own business:

- You do not have to tell anybody the results of this test.
- Those who do not want to, to sit. For the game, it would be nice if you disclosed.

13th Step:

Ask all participants:

- Those “HIV negative” step back
 - What is your reaction
 - How do you feel
- What does a negative result mean?
 - 3 month window period
 - May need to be re-tested.
- How does the negative result make you feel?
- How does this make you feel about those who are HIV positive>

All negatives to go and sit down.

14th Step:

All to give a clap to recognise all “HIV Positives”.

Ask each person:

- What was your reaction
- What are you going to do?

Remind them this is only a game!!

Remind them this is only a game!!

Remind them this is only a game!!

We have no way of knowing if you have been exposed.

This has been a powerful experience. I am available to counsel.

Thank each one.

Ask observers to join us.

Form a circle.

Game is over – All clap and shake hands.

Repeat

1. This is a powerful game, but it is pretend and not real life.
2. Hand out lists of resources.
3. Remind them again that this was only a game.

Give ourselves a clap.

Are there any questions?

Prayer

QUESTIONNAIRE

Dear Learner,

I am working on a study approved by the Eastern Cape Department of Education. Thank you for volunteering to participate in this research. I am interested in learning more about what adolescents know, think and feel about HIV/AIDS. It is the “voices” and opinions of the youth that we need for this project.

There are no right or wrong answers. This is *not* a test. Nobody will know your name, except me. You will be given numbers by me, so that I can put the information together. Otherwise, your name is not what the study is about.

Some people may feel shy or embarrassed when filling in the questions. Nobody you know will see the answers. The results will be used to add to information about what young people are thinking about HIV/AIDS.

INSTRUCTIONS

1. Please be honest. Accurate information is important if we are to fight HIV/AIDS together.
2. If you do not understand a question, please put up your hand and you will be helped.
3. Please do not talk while you are filling in the Questionnaire.
4. Please tick answer where there are blocks.

SECTION 1: DEMOGRAPHIC INFORMATION

Name of school: _____

Your code number: _____

Grade: _____

1. **How old are you?**
- 14 Years
 - 15 Years
 - 16 Years
 - 17 Years
 - 18 Years
 - Over 18 Years

2. **Are you Male** **or Female**

3. **Who do you live with?**
(Who have you lived with in the past 5 years)
(You may tick more than one block)
- Both parents
 - One parent
 - Brothers/Sisters
 - Grandparents
 - Cousins
 - Aunts / Uncles
- Other : _____

SECTION 2: HIV/AIDS EXPOSURE TO KNOWLEDGE/INFORMATION

4. **Have you ever heard about HIV/AIDS?**

Yes No

5. **How did you hear about HIV/AIDS? (You may tick more than one block)**
- Community:
 - Friends
 - Clinic
 - Radio
 - Church:
 - Youth Group
 - Pastor
 - Visitors

5. *(Continued)*

- School: Guest Speaker
- Life Orientation
- Family: Brother
- Sister
- Uncle
- Aunt
- Cousin

Other (include any other information about how you learned of HIV/AIDS):

6. **What do you know about HIV/AIDS? (give as many facts as possible)**

6.1 **Where did you learn this information? (You may tick more than one block)**

- Parents: Father
- Mother
- Guardian
- Schools: Assembly
- Guest Speaker
- During a Lesson
- Friends: Direct Talking
- Over Hearing

- T.V. – Which Programme SABC 1
- SABC 2
- SABC 3

Radio: Xhosa

Education

Pamphlets:

Billboards:

Clinic:

Magazines - which _____

Other (anything you want to add): _____

7. If you wanted to find out more about HIV/AIDS:

Who would you speak to? Educator: Class Teacher

Guidance Teacher

Std Head

Parents Father

Mother

Friends Male

Female

Clinic: Where _____

When _____

Other : _____

8a Do you know anyone who is living with HIV/AIDS?

Yes No

8b Do you know of anyone who has died from HIV/AIDS?

Yes No

SECTION 3: KNOWLEDGE ABOUT HIV/AIDS AS A DISEASE

9. What do the letters AIDS, stand for?

A _____ I _____ D _____ S _____

10. How is HIV spread? (Give as much information /facts, as possible)

11. If you were worried about having HIV/AIDS, would you want to know your status?

Yes No

11.1 How can you find out if you have HIV?

12. How can HIV/AIDS be prevented? (Write down as many points as possible)

13. What are other young people saying about HIV/AIDS, and how it is spread?
(Write down as many points of view as you can)

- a) _____
- b) _____
- c) _____
- d) _____
- e) _____
- f) _____
- g) _____

| | | |
|------------|---|--|
| 14. | What questions do you have about the disease HIV/AIDS? | |
| | a) | |
| | b) | |
| | c) | |
| | d) | |

| | | |
|------------|--|--|
| 15. | Is there anything that you know/or have heard about HIV/AIDS, that: | |
| | a) You do not understand (Please write down in point form) | |
| | 1. | |
| | 2. | |
| | 3. | |
| | 4. | |
| | b) You do not believe (Please write down in point form) | |
| | 1. | |
| | 2. | |
| | 3. | |

SECTION 4: PSYCHO-SOCIAL ASPECTS OF AIDS

| | | |
|------------|--|--|
| 16. | If a new person came to join your class at school, and said they had HIV/AIDS, what would <u>you</u>: | |
| | a) Think about him/her? (What thoughts?) | |
| | 1. | |
| | 2. | |
| | 3. | |
| | b) Feel about him/her? (What emotions?) | |
| | 1. | |
| | 2. | |
| | 3. | |
| | c) Say about him/her? (What would you tell others?) | |
| | 1. | |
| | 2. | |

| | | <i>For Official Use Only</i> |
|-----|--|----------------------------------|
| | <p>d) How would you act toward him/her?</p> <p>1.</p> <p>2.</p> <p>3.</p> | |
| 17. | <p>If a new person came to join your class and said they have AIDS, what do you think he/she would be:</p> <p>a) Thinking about AIDS?</p> <p>_____</p> <p>b) Feeling about AIDS?</p> <p>_____</p> <p>c) Saying about AIDS?</p> <p>_____</p> <p>d) How would this person expect you to act towards him/her?</p> <p>_____</p> <p>_____</p> <p>_____</p> | |
| 18a | <p>What personal strengths do you have, that can help you to protect yourself from HIV/AIDS?</p> <p>1.</p> <p>2.</p> <p>3.</p> | |
| 18b | <p>What practical things can you do to protect yourself from HIV/AIDS?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | |

19. Do you plan to do anything to protect yourself from HIV/AIDS?
Yes
No

If, YES – what do you plan to do?

20. What support do you think the school could provide, to help young people in the face of HIV/AIDS?

- 1.
- 2.
- 3.
- 4.
- 5.

21. What can you and your friends do to combat /fight HIV/AIDS? (including prevention, care and support)

SECTION 5: SEXUAL CONTACT

22. Have you ever had full penetrative sexual intercourse?
Yes
No

If you answered YES, Please answer the following question:
Were you willing/did you consent to this intercourse?

- Yes
No

| | |
|--|--|
| <p>23. How old were you when you first had sexual intercourse?</p> <p>Before 10 Years <input type="checkbox"/></p> <p>10 Years <input type="checkbox"/></p> <p>11 Years <input type="checkbox"/></p> <p>12 Years <input type="checkbox"/></p> <p>13 Years <input type="checkbox"/></p> <p>14 Years <input type="checkbox"/></p> <p>15 Years <input type="checkbox"/></p> <p>16 Years <input type="checkbox"/></p> | |
| <p>24. How many partners have you had?</p> <p>One (1) <input type="checkbox"/></p> <p>Two (2) <input type="checkbox"/></p> <p>Three (3) <input type="checkbox"/></p> <p>Four (4) <input type="checkbox"/></p> <p>Five (5) <input type="checkbox"/></p> <p>More than Five (5) <input type="checkbox"/></p> <p>24.1 If more than one (1). Do you have a regular partner</p> <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>If YES, how many?</p> <p>Current sexual/lovers _____</p> <p>New partners (1st time sex) _____</p> <p>How many new partners have you had in the last year _____</p> | |
| <p>25. What age is or was your latest sexual partner?</p> <p>10 – 13 <input type="checkbox"/></p> <p>14 – 15 <input type="checkbox"/></p> <p>16 – 17 <input type="checkbox"/></p> <p>18 – 20 <input type="checkbox"/></p> | |

| | | | <i>For Official Use Only</i> |
|------------------------------|---|--------------------------|----------------------------------|
| | 21 – 23 | <input type="checkbox"/> | |
| | 23 – 25 | <input type="checkbox"/> | |
| | 26 – 30 | <input type="checkbox"/> | |
| | Over 30 years | <input type="checkbox"/> | |
| 26. | Where do these sexual activities take place? | | |
| | In your house | <input type="checkbox"/> | |
| | In your partner's house | <input type="checkbox"/> | |
| | In a car | <input type="checkbox"/> | |
| | At a bar/shebeen | <input type="checkbox"/> | |
| | At School | <input type="checkbox"/> | |
| | On the sports field | <input type="checkbox"/> | |
| 27. | At what time of day do sexual activities take place? | | |
| | Day: | <input type="checkbox"/> | |
| | - At School | <input type="checkbox"/> | |
| | - After School | <input type="checkbox"/> | |
| | Night | <input type="checkbox"/> | |
| | Day and Night | <input type="checkbox"/> | |
| SECTION 6: "WILDFIRE" | | | |
| 28. | Has Wildfire changed the way you think about HIV/AIDS? | | |
| | Yes | <input type="checkbox"/> | |
| | No | <input type="checkbox"/> | |
| 29. | What specific changes has Wildfire made to the way you | | |
| | a) Think (about sex and HIV/AIDS) | | |
| | _____ | | |
| | _____ | | |
| | b) Feel (about sex and HIV/AIDS) | | |
| | _____ | | |
| | _____ | | |

| | | |
|--|--|--|
| <p>c) Do/Act (regarding sex and HIV/AIDS)</p> <hr/> <hr/> | | |
| 30. | <p>Do you think “Wildfire” should be used in schools, to help young people to inform themselves about HIV/AIDS?</p> <p style="text-align: right;">Yes <input type="checkbox"/></p> <p style="text-align: right;">No <input type="checkbox"/></p> | |
| 31. | <p>How do you rate “Wildfire” as a way of informing young people about HIV/AIDS?</p> <p style="text-align: right;">Poor <input type="checkbox"/></p> <p style="text-align: right;">Fair <input type="checkbox"/></p> <p style="text-align: right;">Good <input type="checkbox"/></p> <p style="text-align: right;">Excellent <input type="checkbox"/></p> | |
| 32. | <p>Do you believe you could use the experience of Wildfire to help fight the spread of HIV/AIDS?</p> <p>a) For yourself Yes <input type="checkbox"/></p> <p style="text-align: right;">No <input type="checkbox"/></p> <p>If Yes, please explain your answer:</p> <hr/> <hr/> | |
| | <p>b) For others Yes <input type="checkbox"/></p> <p style="text-align: right;">No <input type="checkbox"/></p> <p>If Yes, please explain your answer:</p> <hr/> <hr/> | |
| 33. | <p>Has “Wildfire” had any effect on the way you would feel about/ behave towards people living with HIV/AIDS?</p> <p style="text-align: right;">Yes <input type="checkbox"/></p> <p style="text-align: right;">No <input type="checkbox"/></p> <p>Please explain your answer:</p> <hr/> <hr/> | |

| | | <i>For Official Use Only</i> |
|-----|--|----------------------------------|
| 34. | <p>What sorts of decisions and information were you exposed to, during the “Wildfire” game?</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p> <p>6. _____</p> <p>7. _____</p> <p>8. _____</p> | |
| 35. | <p>Is there anything you have done, or plan to do within the next week, about HIV/AIDS? (You may tick more than one block)</p> <p>Talk to friend/friends <input type="checkbox"/></p> <p>Talk to parents <input type="checkbox"/></p> <p>Talk to teacher <input type="checkbox"/></p> <p>Talk to someone at church <input type="checkbox"/></p> <p>Visit a clinic <input type="checkbox"/></p> <p>Go for voluntary counselling and testing <input type="checkbox"/></p> <p>Form a support group for people living with AIDS <input type="checkbox"/></p> <p>Collect money for AIDS orphans <input type="checkbox"/></p> <p>Start an HIV/AIDS club at school/church <input type="checkbox"/></p> | |

Thank you for being willing to participate in this research with me. I appreciate your time and effort.

Julie Cromhout

APPLICATION FOR PERMISSION
TO CONDUCT RESEARCH IN SECONDARY
SCHOOLS IN THE EAST LONDON AREA.

SUBMITTED TO THE EDUCATION DEPARTMENT OF THE EASTERN CAPE.

DATE SUBMITTED: 15 MARCH 2005

SUBMITTED BY: Julie Cromhout

CONTENTS:

1. Letter of application
2. Brief motivation
3. Letter of support
4. Process notes on "Wildfire"
5. Draft copy of questionnaire
6. Explanations of the research
7. Permission forms.

P.O. BOX 19070
TECOMA
5214
Tel: (043) 7374843
Cell: 073 2203141
e-mail: juliejiraffe@yahoo.co.uk

Dear Mrs Broberg

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH IN SECONDARY SCHOOLS IN THE EAST LONDON AREA.

I am currently registered at the University of Zululand, reading for a Masters Degree in Educational Psychology (M.ED) which will lead to registration with the Health Professions Council of South Africa. Having completed the course work in 2003 and internship in 2004 (which was served at the Education Support Centre in East London), I have to fulfill the final requirement of the degree. This is a mini-dissertation.

In terms of the subject matter of the degree I plan to do an educationally-related study. I am passionate about issues surrounding HIV/AIDS, preventative mental health care and interventions that are promotive of well-being and empowerment. I also believe that adolescents find themselves in a position of vulnerability in their development – which is complicated in the face of the rising tide of the HIV/AIDS pandemic. For these reasons, coupled with evidence from theory and past research, I wish to conduct an investigation on a specific intervention related to HIV/AIDS.

The intervention I wish to investigate is called “Wildfire”. “Wildfire” is a psycho-educational technique which simulates the spread of HIV/AIDS and in the role-play, exposes the participants to decisions and choices regarding Voluntary Counselling and Testing (VCT). Attached is a step-by-step account of what the intervention involves. This intervention is currently being implemented in 23 districts in the Eastern Cape. The Small Projects Foundation, an NGO, in conjunction with the Phelophepa Mobile Health Care Train are using “Wildfire” as a mobilization tool mostly with adults in rural areas where volunteers are operating in communities around issues of HIV/AIDS. The use of “Wildfire” requires scientific investigation in the form of a formative evaluation. My mini-dissertation will be an evaluation of “Wildfire” specifically in schools. The Small Projects Foundation has offered to provide support in terms of personnel for such an enquiry (attached, please find a letter to this end).

The research undertaking is based on experimental design, ie: it will involve a pre-test and post-test questionnaire – with the ‘test’ being “Wildfire” (attached, please find a draft copy of the Questionnaire). The data will be analysed qualitatively with some quantitative input. In my capacity as researcher, I will adopt the role of observer and note-taker as well as the prior training of research assistants.

For ethical reasons, I require permission from the Education Department to go ahead with this investigation. Thereafter I will need the permission of Principals of the

2.

targeted schools and then, because the research population is under 21 years of age, permission from the parents of adolescents voluntarily electing to participate in the enquiry, is needed.

I am planning to target two rural and two urban secondary schools in the East London area. I will also need a school to target as a control in the data gathering. The ideal schools would be ones that have community support systems in place, such as educators involved in guidance or life-orientation, educators who have undergone some sort of HIV/AIDS related training and/or, schools that are close to clinics which provide voluntary counseling and testing and other HIV/AIDS support. I will be available as a support and am prepared to provide counseling should it be necessary. I also believe that community support systems need to be advocated to the learners as resources in case of need.

In terms of the research population, I plan to target learners (plus or minus 100 participants in all) over the age of 14 and preferably not Grade 12's as their academic responsibilities are a priority. This leaves Grade 9, Grade 10 and Grade 11 as potential participants. I would like to seek your advice on which would be your choice of grade for the intervention. The following points of consideration are relevant:

1. Grade 9 represents an exit point in the educational system. In terms of this research's aims to provide a form of preventative education around HIV/AIDS, this would be an ideal age group to target as many may leave the education system and so will not have the opportunity of exposure to preventative interventions thereafter. There is the added consideration of such learners being at developmental phases where sexuality /sexual identity is relevant, coupled with the fact that on a baseline survey of schools in the Eastern Cape, the average age of onset for sexual activity is 14 (Macleod 2002: p.3). There are, however, ethical issues involving this age group (specifically 14 year olds) and the possibility that some learners may not have been exposed to the relevant issues. This issue will be circumvented by inviting learners to volunteer to participate.
2. Grade 10 reduces the preventative nature of the intervention in that the population exposed is likely to be more academically inclined, but the age of such learners is ethically more acceptable.
3. Grade 11 learners will have had more life experience and exposure to the issues being researched. This age group is likely also to be more cognitively sophisticated and according to cognitive-behavioural theory, more likely to internalize and implement the learnings of the intervention in their own lives. This age group does not really represent a sector of the population in which there is a gap in research, so much as the younger ones do.

PRACTICAL ISSUES:

The number of visits to schools envisaged for this enquiry are:

1. To meet the principal and obtain permission as well as to set a date for a possible group meeting with the relevant grade. A request will be made

that an educator – preferably a senior educator - could be assigned the task of liaising with the research team and the learners. A suitable venue will be requested.

2. To meet with the learners in the grade selected and explain what the research is about, that parental permission will be sought and what is expected of participants. An invitation for volunteers will be extended at such a meeting. Names will be taken down and parental permission forms/information sheets handed out.
3. Subject to the principal's approval, a meeting could be called with parents of the volunteers in order to explain the motivation for the research, what it involves and then seek their informed consent for the participation of the learner. This visit may not be necessary but to ensure that the consent is, in fact, informed, it may be advisable from an ethical standpoint. A research assistant will be available for any interpretation that may be necessary in the event of language difficulties.
4. A visit in which the pre-test questionnaire is presented to participating learners. This will be planned so that, with the school's co-operation, it should not take up more than 45 minutes of the school day.
5. The intervention "Wildfire" itself will be presented a week later. An hour of school time will be requested to allow time for the focus-group discussion/debriefing to be properly administered. The pupils' feedback at this point of the investigation will be crucial and contribute to the richness of the research. An experienced facilitator who is able to communicate in English, Xhosa and Afrikaans will be facilitating the "Wildfire".
6. The post-test questionnaire will be presented to the participants. Again, 45 minutes will be required. It is envisaged that this part of the investigation be conducted approximately one month after the intervention.

The results/findings of this research endeavour are to be used primarily for the following:

1. To inform the current practices of the Small Projects Foundation's use of "Wildfire".
2. To fulfil the requirements of my masters degree. Names of both pupils and schools participating in the research will not be reflected. Should any academic journal publication be produced as a result of this research, to inform the ongoing search for effective interventions, the specific names of the schools will not be reflected.
3. For the information of the Department of Education in the role it plays regarding the ongoing concern over the spread of HIV/AIDS. Should the findings be that "Wildfire" is indeed an effective intervention, it may provide the department, in conjunction with the Small Projects Foundation, with a useful tool for HIV/AIDS interventions in schools.

4.

4. A presentation of the findings of this enquiry will be made to your research committee and the principals of the relevant schools will be invited. This will be after acceptance by the University of Zululand of the mini-dissertation. Should the participants be interested, feedback to them will be given – after acceptance by the University.

In this letter of application, I have outlined the motivation, basic content, practical details and intended uses of this research enquiry. Attached is a copy of the details of “Wildfire”, a letter of support from the Small Projects Foundation, a draft copy of the the questionnaire and a motivation submission. Your input and suggestions will be appreciated.

I therefore seek your permission to proceed with the research. Due to time constraints (a final copy is needed by the university by the end of October and drafts, prior to that) I would appreciate it if you would respond as soon as possible – at the outside, within 21 days. The ideal would be to set at least some of the preliminaries in motion (the visit to the principal, meeting the grade and parental permission) before the end of the first term 2005.

Should you grant permission, I would require the following:

1. Letter of permission to me.
2. Letter of introduction to the Principals
3. Your recommendations as to the grade to target.
4. Suggestions as to schools that can be approached. (A list will be appreciated)

Thank you for your time. I look forward to a reply at your earliest convenience.

Yours faithfully

Julie Cromhout

(University of Zululand Student No: 021486; HPCSA registration as Intern Psychologist : PSIN 0091766)

REFERENCE USED IN LETTER:

Macleod, Dr C., (2002) “Baseline Survey for the Secondary school HIV/AIDS and lifeskills education programme” . The AIDS Directorate Department of Education Eastern Cape.



SMALL PROJECTS FOUNDATION

Reg. T1/88 / 000-319 NPO

Postal: P.O. Box 11208, Southernwood,
EAST LONDON, 5213

Physical: 5 St James Road, Southernwood,
EAST LONDON, 5201

Telephone : (043) 743-9592

Fax : (043) 743-4721

E-Mail: spfinfo@intekom.co.za

Web Site: www.smallprojectsfoundation.com

Our Ref. PBC/zm/720

11th March 2005

THE MANAGER
DEPARTMENT OF EDUCATION

Dear Madam,

Letter of Support for Mrs Julie Cromhout to do Wildfire Research

The Small Projects Foundation together with Phelophepa Primary Health Care Train and the Department of Health is running the AIDS Action Programme in 26 Areas in the Eastern Cape Province. The HIV/AIDS Action Programme is aimed at combating HIV/AIDS through prevention, care and support. Please see our websites www.spf.org.za and // www.aidsaction.org.za

Among the tools we have developed is "Wildfire" which we have been using in communities to great effect (specifically with adults). We would like to use Wildfire especially for youth and high school children but need to do this in the most ethical and informed way.

We have therefore encouraged Mrs Cromhout to assist us with this research in order to investigate wildfire's efficacy, impact and outcome among young adolescents at school. Should the method prove empirically to be highly effective, which we believe is likely, we would like to expand its coverage in conjunction with the Department of Education, Mrs Cromhout and our funders. We therefore commit to supporting the research of Mrs Cromhout with personnel, logistics and materials within our limited resources. We also commit to working with the Department of Education in the initial research and in using the methodology should it be found to be efficacious.

We would be happy to meet or provide any further information that you may require.

Yours faithfully

P.B Cromhout
Managing Director
Small Projects Foundation

Managing Director : P.B. Cromhout, Trustees : E.A. Beaumont, B.N. Henna, Dr H.J.S. Kayser, S.A. Ngonyama, B.A. Radue, Dr T. Thomas



Province of the Eastern Cape
DEPARTMENT OF EDUCATION
EAST LONDON DISTRICT OFFICE
 Private Bag X9007, EAST LONDON, 5200, SOUTH AFRICA

| Reference | Enquiries | Telephone | Fax | Email | Date |
|-------------------|-----------|-------------|-------------|----------------------------|---------------|
| Cromhout Research | HP Greeff | 043-7086200 | 043-7600545 | hpgreeff@stringsight.co.za | 23 March 2005 |

Mrs. July Cromhout
 P.O. Box 19070
 TECOMA
 5214

Dear Mrs. Cromhout

RE REQUEST TO DO RESEARCH

Receipt is acknowledged of your letter dated 23 March 2005.

Kindly be informed that your request is conditionally approved, pending the final approval by Head Office. You are however allowed to start your research if you are prepared to comply with the following conditions:

- The principal and the School Governing Body (SGB) must give permission for the research project to be undertaken in the school.
- No school or individual must be identified.
- Teaching time may not be used for the completion of questionnaires.
- Questionnaires must be sanctioned by the Education Department.
- The school programme must not be disrupted.
- No educator or principal will be under any obligation whatsoever to provide the information required or in any other way be of assistance in the research project.
- Without the prior approval of the Education Department a principal shall, under no circumstances make available for research purposes, any confidential documents or information with regard to learners (e.g. IQ's).
- Where learners are involved, written permission must be obtained from the parent/guardian before they become involved.
- Prospective researchers must show the principal of the school the Education Department's written approval before any research is undertaken.
- The Education Department reserves the right to monitor the research.
- The Education Department must be informed about the outcome of the research.

Yours sincerely

M. P. Greeff
HP GREEFF
 ACTING DISTRICT DIRECTOR

*Approved J. Prapercel
 DOTS Research, Fl.
 6 April 2005*

*Yours for
 Your formal Remarks.*

APPENDIX 5

Dear Principal

My name is Julie Cromhout. I am a student at the University of Zululand. I am also a qualified High School Teacher. I am interested in the situation of teenagers in the face of the problem of HIV/AIDS. The Eastern Cape Department of Education has granted permission for us to conduct this research. Research indicates that teenagers are starting with sexual activity at an *average* age of 14. Young people may be putting themselves at risk of contracting HIV/AIDS without having thought through the issues.

I have an educational tool or a game called "Wildfire" which, I think, helps young people to think about the following things:

- How quickly AIDS spreads.
- That HIV/AIDS is spread through sexual contact with other people.
- That there are choices to be made in relationships – such as not accepting people forcing you to have sex, such as using a condom to have safe sex, such as being faithful to one partner.
- That you can feel alone when you refuse to have sex like the others.
- That if you think you have HIV/AIDS, you need to make a decision about VCT.
- If you test positive you face a life of living positively with AIDS.
- If you test positive you face the issue of disclosure.
- If you test negative, you face the choice of making decisions about sexual practices i.e. abstinence, being faithful or finally, condomising.

I would like to ask for your permission to conduct this research in your school. The name of your school and the names of the learners will be protected by me. These will remain confidential.

Should you grant me permission; I shall need your help with the following:

- To identify a member of staff to liaise with the research team and organise dates and times for visiting the school. There will be three (3) visits in contact with the learners for the actual research, plus one to meet the parents.
- To request that this member of staff be present to witness the parents signatures, when they sign permission slips. Your help in encouraging parents of volunteers to attend the meeting to inform them of the research will be appreciated.
- To provide a suitable venue for this research to take place.

Thank you

Yours faithfully

Julie Cromhout

PERMISSION FROM SCHOOL MANAGEMENT

I understand that the Education Department has given the go-ahead for research on "Wildfire" and HIV/AIDS.

I have taken note of the contents and process of the research proposed by Mrs J.L. Cromhout and am fully informed about the research.

I hereby grant permission for the research to take place, with learners who volunteer to take part.

I undertake to support the project by providing a venue at the agreed times.

Signature of Principal:

Signature of Head of Governing Body:

Name of School:

APPENDIX 6

Dear Parent

My name is Julie Cromhout. I am a student at the University of Zululand. I am also a qualified High School Teacher. I am interested in the situation of teenagers in the face of the problem of HIV/AIDS. The Eastern Cape Department of Education has granted permission for us to conduct this research. Research indicates that teenagers are starting with sexual activity at an *average* age of 14. Young people may be putting themselves at risk of contracting HIV/AIDS without having thought through the issues.

I have an educational tool or a game called "Wildfire" which, I think, helps young people to think about the following things:

- How quickly AIDS spreads.
- That HIV/AIDS is spread through sexual contact with other people.
- That there are choices to be made in relationships – such as not accepting people forcing you to have sex, such as using a condom to have safe sex, such as being faithful to one partner.
- That you can feel alone when you refuse to have sex like the others.
- That if you think you have HIV/AIDS, you need to make a decision about VCT.
- If you test positive you face a life of living positively with AIDS.
- If you test positive you face the issue of disclosure.
- If you test negative, you face the choice of making decisions about sexual practices i.e. abstinence, being faithful or finally, condomising.

I have called you here today to ask your permission for your child to participate in my study. All the Grade _____ have been asked and some have volunteered. Your children are those that have volunteered. In order for them to participate, we need your permission. This permission requires that you are fully informed about this research.

You do not have to give your permission. Should you wish to give your permission, please sign the form allocated. This will be witnessed by a teacher.

Thank you, Yours faithfully
Julie Cromhout

| <u>PERMISSION SLIP</u> | | CODE |
|--|-----------------|------|
| I, _____ (name) | | |
| hereby give permission for my daughter / son | | |
| _____ (name) | | |
| to participate in the research on "Wildfire". I have taken note of the information given about the research. | | |
| Name _____ | Signature _____ | |
| (Parent/Guardian) | | |
| Witnessed by: Name _____ | Signature _____ | |
| (Name of Staff Member) | | |
| Signed: _____ | | |
| School Name: _____ | | |

APPENDIX 7a – QUESTION 1

DEMOGRAPHIC INFORMATION

1. How old are you?

| Age Options | Rural Female | Rural Male | Township Female | Township Male | Ages Total | |
|---------------|--------------|------------|-----------------|---------------|------------|------|
| 14 Years | 11 | 1 | 12 | 1 | 26,3% | 25 |
| 15 Years | 8 | 7 | 18 | 8 | 43,1% | 41 |
| 16 Years | 9 | 5 | 5 | 1 | 21,0% | 4120 |
| 17 Years | 2 | 1 | 2 | 0 | 5,26% | 205 |
| 18 Years | 2 | 0 | 1 | 0 | 3,2% | 5 |
| >18 Years | 1 | 0 | 0 | 0 | 1% | 3 |
| Total Numbers | 33 | 14 | 38 | 10 | | 1 |
| Percentages | 35% | 15% | 40% | 11% | | 95 |

APPENDIX 7b – QUESTION 5

Question 5: How did you hear about HIV/AIDS?

| | RURAL | | | | TOWNSHIP | | | | CONTROL | | | |
|-----------------|---|------------------|------------------------------|------------------|------------------|--|---------------------|------------------|---|-------------------------------------|--|---|
| | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | |
| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| 1 st | Life Orientation Radio | Life Orientation | Life Orientation | Life Orientation | Life Orientation | Life Orientation | Radio | Life Orientation | Life Orientation Radio Youth Group Pastor Friends | Life Orientation Clinic Radio | Radio Youth Group | Life Orientation Clinic |
| | 86% | 85% | 93% | 91% | 90% | 74% | 80% | 89% | 60% | 100% | 80% | 100% |
| 2 nd | Friends | Radio | Radio | Radio | Radio | Radio | Clinic | Radio | Clinic Guest Speaker | Pastor Friends | Clinic | Radio |
| | 43% | 70% | 93% | 70% | 80% | 63% | 70% | 76% | 40% | 50% | 60% | 75% |
| 3 rd | Visitors | Clinic | Pastor, Clinic | Clinic | Clinic | Clinic | Life Orientation | Clinic | Sister Uncle Cousin | Guest Speaker | Guest Speaker Brother Friends Sister | Youth Group Guest Speaker |
| | 36% | 39% | 43% | 48% | 70% | 50% | 60% | 71% | 20% | 25% | 40% | 50% |
| 4 th | Pastor | Friends | Visits | Friends | Youth Group | Friends | Youth Group | Friends | | | Pastor Uncle Cousin | Cousin Friends Pastor Visitors Sister |
| | 14% | 36% | 29% | 45% | 60% | 39% | 50% | 58% | | | 20% | 25% |
| 5 th | Uncle Youth Group Cousin Clinic | Visitor | Friends Brother Sister | Visitors | Friends | Guest Speaker Sister Youth Group | Friends | Youth Group | | | | |
| | 7% | 27% | 21% | 36% | 50% | 26% | 40% | 42% | | | | |

| | RURAL | | | | TOWNSHIP | | | | CONTROL | | | |
|------------------|----------|---------------------------|----------------------------------|----------------------|------------------------------------|----------------|------------------------------------|------------------------------|----------|--------|-----------|--------|
| | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | |
| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| 6 th | | Youth Group 21% | Guest Speaker Youth Group 14% | Youth Group 27% | Pastor Sister 30% | Cousin 18% | Pastor Guest Speaker Sister 30% | Sister 39% | | | | |
| 7 th | | Guest Speaker 18% | | Guest Speaker 24% | Brother Uncle 20% | Brother 16% | Visitors Aunt 20% | Cousin 29% | | | | |
| 8 th | | Brother 12% | | Cousin Sister 21% | Aunt Visitors Guest Speaker 10% | Aunt 13% | Brother Cousin 10% | Guest Speaker 26% | | | | |
| 9 th | | Cousin 9% | | Aunt 18% | | Uncle 11% | | Uncle Pastor Visitors 21% | | | | |
| 10 th | | Aunt 6% | | Pastor 15% | | Pastor 8% | | Aunt Brother 11% | | | | |
| 11 th | | Pastor Sister Uncle 3% | | Brother 9% | | | | | | | | |

APPENDIX 8 – QUESTION 6.1

RESPONSES TO QUESTION 6.1 “Where did you learn this information?”

| | RURAL | | | | TOWNSHIP | | | | CONTROL | | | |
|-----------------|--|------------------------|--------------------------|---------------------------------|---|------------------------|--|--|---|---|--|---|
| | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | |
| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| 1 st | SABC 1 64% | SABC 1 73% | SABC 1 71% | SABC 1 85% | During a lesson 80% | Mother 87% | Xhosa Radio Mother SABC 1 70% | SABC 1 84% | SABC 1 100% | Mother SABC 1 Education Radio During a Lesson 75% | SABC 1 100% | SABC 1 Xhosa Radio 100% |
| 2 nd | During a lesson 50% | Mother 55% | Xhosa Radio 64% | During a lesson 61% | Education Radio 70% | SABC 1 61% | During a lesson Magazines SABC 2 50% | Mother 76% | Direct Talking Xhosa Radio Clinic 80% | Assembly Guest Speakers Clinic Magazines 50% | Xhosa Radio 80% | Mother 75% |
| 3 rd | Xhosa Radio Mother 29% | During a lesson 48% | During a lesson 57% | Clinic Xhosa Radio 48% | Mother SABC 2 Xhosa Radio Clinic 50% | During a lesson 50% | Clinic SABC 3 Education Radio 40% | Xhosa Radio 68% | SABC 3 Mother During a lesson 60% | Over hearing Guardian Direct talking 25% | Over hearing Clinic Education Radio During a lesson 50% | Over hearing Clinic Education Radio Direct talking 50% |
| 4 th | Educational Radio Clinic Assembly Guest speaker 21% | Magazines 42% | Mother 50% | Mother 45% | Direct talking 40% | Xhosa Radio 47% | Over hearing Direct talking Guest speaker Assembly 20% | Magazines During a lesson 66% | Father SABC 2 Magazines 40% | Xhosa Radio 4% | Magazines 25% | Magazines 25% |
| 5 th | Direct talking Magazines 14% | Xhosa Radio 39% | Direct talking 43% | Education Radio 39% | Magazines SABC 3 Father 30% | Clinic 45% | Guardian 10% | Clinic 58% | Education Radio Billboards Assembly 20% | Billboards SABC 2/3 Pamphlets 0% | Billboards Pamphlets SABC 2 Over hearing 0% | Billboards Pamphlets SABC 2/3 Guardian Assembly Guest Speaker 0% |

| | RURAL | | | | TOWNSHIP | | | | CONTROL | | | |
|------------------|---|------------------------------------|---|---|--|---|-----------|-------------------------------|--|--------|-----------|--------|
| | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | |
| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| 6 th | SABC 2 Guardian 7% | Education Radio 36% | Education Radio Clinic 36% | Direct Talking 30% | Guardian Assembly Over hearing 20% | Education Radio 39% | | Education Radio 50% | Pamphlets Over hearing Guest Speaker% | | | |
| 7 th | Billboards Pamphlets Over hearing Father 0% | Assembly Clinic 24% | Assembly 29% | SABC 2 Assembly Magazines 24% | Guest Speaker Billboards 10% | Direct Talking Assembly 32% | | Direct Talking 47% | | | | |
| 8 th | | Guest Speaker 21% | SABC 2/3 Magazines 21% | Guest Speaker 21% | Pamphlets 0% | Guest Speaker 24% | | SABC 2 39% | | | | |
| 9 th | | SABC 3 15% | Guest Speaker 14% | SABC 3 15% | | SABC 2 21% | | Assembly SABC 3 26% | | | | |
| 10 th | | SABC 2 Father 12% | Guardian Over hearing Billboards 7% | Over Hearing 12% | | SABC 3 18% | | Guest Speaker 18% | | | | |
| 11 th | | Billboards 9% | | Father 9% | | Over hearing Billboards Magazines 13% | | Over hearing 16% | | | | |
| 12 th | | Pamphlets Over hearing 3% | | Billboards Pamphlets Guardian 6% | | Guardian Pamphlets 11% | | Guardian 8% | | | | |
| 13 th | | | | | | | | Pamphlets Billboards 5% | | | | |

APPENDIX 9 – QUESTION 7

RANK ORDERING OF RESPONSES TO QUESTION 7 "If you wanted to find out more about HIV/AIDS: Who would you speak to?..."

| | RURAL | | | | TOWNSHIP | | | | CONTROL | | | |
|-----------------|-------------------------------|-------------------------|-----------------------------------|-------------------------------|-------------------------------------|-------------------------|--|-----------------------------------|--|--|--|--|
| | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | |
| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| 1 st | Class Teacher 29% | Class Teacher 58% | Class Teacher 71% | Class Teacher 61% | Mother 80% | Class Teacher 61% | Class Teacher 70% | Class Teacher 79% | Mother 80% | Class Teacher Female 50% | Class Teacher Male 80% | Female 75% |
| 2 nd | Guidance Teacher 21% | Mother 52% | Male 43% | Mother 42% | Male 60% | Mother 53% | Mother 60% | Mother 66% | Male 60% | Guidance Teacher Standard Head Mother Male 25% | Female 60% | Standard Head Mother Male 50% |
| 3 rd | Father Mother 14% | Female 36% | Guidance Teacher Mother 29% | Female 33% | Class Teacher r Father 50% | Female 29% | Male 40% | Female 58% | Guidance Teacher Standard Head Female 20% | Father 0% | Female 40% | Standard Head Mother Male 25% |
| 4 th | Female Standard Head 0% | Guidance Teacher 18% | Father 21% | Guidance Teacher 27% | Guidance Teacher 40% | Guidance Teacher 21% | Female 30% | Father Guidance Teacher 18% | | | Guidance Teacher Standard Head Father 20% | Father 0% |
| 5 th | | Standard Head 15% | Standard Head Female 0% | Male 12% | Standard Head 20% | Father Male 16% | Guidance Teacher Standard Head 20% | Male 13% | | | | |
| 6 th | | Father 9% | | Standard Head Father 3% | | Standard Head 3% | Father 6% | Standard Head 0% | | | | |
| 7 th | | Male 6% | | | | | | | | | | |

APPENDIX 10 – QUESTION 10

Question 10: “How is HIV spread?”

The following is a summary of the basic facts and misconceptions communicated by participants in various ways, in answer to the question. This awareness relates directly to knowledge and information about risk factors”

- ♦ Unsafe sex
- ♦ Blood
- ♦ Not using condoms during sexual intercourse
- ♦ Sharing needles at the clinic or hospital, or when taking drugs
- ♦ Sharing toothbrushes
- ♦ Sharing sharp instruments
- ♦ Sharing ear-piercing needles and tattooing needles
- ♦ Sharing razors
- ♦ Sharing hair-cutting instruments at the barbour’s
- ♦ Sharing towels
- ♦ Being raped
- ♦ Kissing someone with sores in their mouths or on their lips
- ♦ Circumcision – sharing cutting instruments
- ♦ Sexual fluids
- ♦ Blood transfusion
- ♦ Touching an infected person’s rash with an open cut on your hand
- ♦ Mother to baby during breast-feeding
- ♦ By having more than one sexual partner.

Misconceptions:

- ♦ Sharing toothpaste
- ♦ When you smoke drugs
- ♦ “To shoik a hand with other people without clubs” – the “clubs” here are taken to mean “gloves” and if this is the case, this misconception possibly arose from “Wildfire” in which gloves were used to symbolize protection.

APPENDIX 11 – QUESTION 12

“How can HIV/AIDS be prevented?”

A summary of the major points emerging (repetitions not counted) in response to question 12. Those in italics, reflect actual responses.

- By using condoms every time you have sex.
- By using gloves or a plastic bag when there is a car accident.
- By being faithful to your partner.
- By abstaining until you know your partner's status.
- By *“getting a new injection”*.
- Testing before sex with a partner, so as not to affect the baby.
- By no sharing some blades, needles, toothbrushes, razors.
- By abstaining from sex.
- Wait until you get married.
- *NO UNDER AGES*
- *By using these alphabets A-abstain, B-be faithfull, C-condomise, D-delay from sex.*
- *By eating fruit and vegetable by excising.*
- *Radios, posters of warning. Television.*
- *Use of contraception methods dual protection is recommended.*
- *Parent must be faithfull to their partners.*
- *Can be prevented by telling people must sleep with one partner or telling them they must be careful to touch other people blood.*
- *It will be prevented by using a condom with your partner if your one did not want to use it don't sleep with him.*
- *NOT have to many sexual partners.*
- *Respect our bodies.*
- *A mother should be treating herself with nevirpin to protect her unborn baby and by making sure that every needle you use is clean.*
- *Cover up your cuts.*

APPENDIX 12 – QUESTION 13

Question 13: “What are other young people saying about HIV/AIDS, and how it is spread?”

In this question, the intention was to gauge the volunteer participants’ views of their peers’ perceptions constructions of HIV/AIDS. Most of the responses dealt with information related to prevention eg: “Abstain”, “Be faithful (honest with your partner)”. As a result, only those responses that explicitly relate to others’ views will be recorded here. No shifts from pre to post test were notable, so this can be considered to be a time-trend monitoring, response – a view into adolescents’ construction of the views of their peers.

| | Pre-Test | Post-Test |
|--|--|--|
| <p>School A 15 Year Old Female</p> | <p>a) Other young people even our boyfriend di not care about that. b) My friends says to me it’s a disease that is like other disease so even if you have a sugar, high blood you can die even cancer, and I say no you can’t die at the same way”.</p> | <p>a) Others young people are not scared they did not want condom they say meat to meat, they say this is our disease its not for animals liked dogz and cats so its not unfair or its not an embarasement most of people live with this disease”.</p> |
| <p>School B 14 Year Old Female</p> | <p>They are saing is a dangerous disease. It cannot be cured. Many people dies because of AIDS. They also says it attack youth. Because youth do not protect. They are saying there are orphans because of AIDS. Others are saying AIDS does not kill.</p> | <p>“They are saying it doesn’t kill. They are saying they never heard about it. Some are underst anding it. They are saying people are dying. There are orphans because of AIDS.</p> |

| | Pre-Test | Post-Test |
|-----------------------------------|--|--|
| School C 16 Year Old Male | Some they afraid of it. Some say if he/she got its god who gave him/her. Some say if I can get I will kill myself. Some say they can't use protection they want skin on skin | Unprotected sex. Sharing needles Touching someones blood with a cut. |
| School D 14 Year Old Female | Making youself a sex slave. Girl who love mean easily get infected. Use a raid coat you'll be infected. Foreigner brought this disease especially ankwerekwere (black foreigners). A person who has open cuts will infect you. Having many partners will give HIV/AIDS. | HIV/AIDS kills so protect yourself. Don't sleep with foreigners they are the one who brought this disease to SA. HIV/AIDS is dangerous because it is inside you but still sleeping so when you're having sex you are giving it power to wake up and kill you, so stop having sex with anyone. |
| School D 16 Year Old Female | They are saying HIV is killing our nation. Where do we think we are going to get the next generation. People are spreading it because they don't care. Old people are spreading it by raping young children and they say that you can cure AIDS by having sex a young kid. We as young people we are saying they don't think about the future because these kids were going to be leaders of the nation. | They are saying it is a disaster like tsunami. They say it spread by having sex without a condom. Others are saying that god is coming back again because before the were no uncurable disease like this one AIDS. They say that we must abstain from having sex. Others are saying that they don't want to abstain. |

APPENDIX 13 – QUESTION 14

Question 14: “What questions do you have about the disease HIV/AIDS?”

- Can the baby have HIV when you are pregnant?
- Will you have HIV if you don't condomise?
- Will you die if you don't join support groups?
- Where did AIDS come from?
- Where can we get some pills for helping this?
- Why do government give HIV+ people money?
- Can you help someone (under age) have sex and get HIV+?
- Is it truly possible that you musn't have a boyfriend without reaching (21 years)?
- Why does it kill someone? Why it effect your immune system?
- Why people get it by having sex?
- Why blacks are most infected people?
- When will it be cured?
- Why it makes a person to be this like a scorpion?
- How can it be helped?
- Why do people make it a big business?
- Why people if you have this disease are not have many years?
- Why the doctor do not work with the traditional healer?
- Why many people hide that they are HIV+?
- When you stay with person who HIV do you get it?
- Why is it making our live a living hell?
- How can we prevent it. Why its for people only?
- Do you get it from mosquitos?
- Did the black monkey come with it?
- Did the white man come with it?
- Do other countries have it?
- Do Americans cure it?
- How does it affect you?
- ?is HIV/AIDS the same or they are different and how are the different
- Can you die from HIV?

- Is it spread by sitting next to an infected person?
- Is it spread by abstaining?
- How can I talk to others like support group?
- How can I talk to my parents about it?
- Is there anything government has done to help except the ARV's?
- Is it the punishment from God?
- And I know HIV is not something that we born with?
- How can a small baby get?
- What it like? What is its colour?
- Does aids affect you by saliva?
- Where do you come from AIDS I hate you?
- What does you think because you have many brothers and sisters maybe and children?
- Why people do not talk abut this?
- When you slip in one bedroom with some who have it e.g. your sister?
- When you had AIDS how can you fill?
- Could you get AIDS from someone's urine?
- If a doctor touch the blood of the persionate will the doctor be affected?
- Do nurse have the medicine?
- What does this disease do in your body?
- How can I test my blood with out a blood test?
- Condom is safe 100% yes or no?
- Do you get it when you're using concetreptives?
- How many yrs you can live with HIV/AIDS?

Note: A basic summary reflective of questions asked by participants has been made. All entries are direct quotes of words used. No significant decrease in pre- to post-test questions was noted.

The questions reflect emotional responses, fear of those living with HIV, misconceptions about the origins of HIV/AIDS and practical "how-to" questions. The responses raise questions as to how much knowledge and information can be empowering enough for personal preventative action to be taken and when overwhelming saturation and a sense of powerlessness sets in.

APPENDIX 14 – QUESTION 15

Question 15: Is there anything that you know/or have heard about HIV/AIDS, that:

- a) You do not understand
- b) You do not believe?

| Do Not Understand | Do Not Believe |
|--|---|
| Where does HIV come from? | When I eat from her plate I will be HIV+. |
| If I have a girl friend who is HIV+ and I kiss her would I be HIV positive? | I don't believe that you can have a baby that is not infected when you are infected. |
| TB is the most thing that you are HIV/AIDS. | How do the doctors know that they disease destroy you immune system. |
| I don't understand that HIV+ people get money. | I don't believe that HIV is everywhere. |
| I don't understand why it kills so many people. | It came from a monkey. |
| Do animals get it? | That some herbalist can cure it. |
| Where did it come from? | There's nothing that I don't believe because there are many people that are died with this in front of me. |
| Who had it first? | I don't believe that at about million people are diagnosed with this disease even in America. |
| Why can't we cure it? | If a person was fat it makes person to be thin like a scorpion. |
| By sleep nex to him / doing nothing. | I think it's a lie. |
| By sharing the same sit. | Sharing the same spoon will not affect u. |
| Why don't you see AIDS for the 1 st time? | Eating in the same dish you won't have it. |
| Why don't you become positive when you share toilet seats with an affected person? | You take other one like it not a person. |
| When you are in a swimming pool with someone who is HIV/AIDS you will get infected. | You make someone to feel angry. |
| That it can be stopped within 72 hours | You make someone to feel disappointed. |
| Is a punishment from God. | By using the same plate and hair product |
| AIDS is the disease that is coming with many diseases like TB, cansa, fever. | There's nothing I cannot believe cause I see many people die with this disease so also afraid of it and also know my status all the time. |
| AIDS can harm your body. | His the punishment from God. |
| I understand that HIV/AIDS is the dealy disease nothing that I don't understand in AIDS. | Moisqiuto is coming from America. |
| Animals are spreading it. | Animals come with people who have sex with animals. |

| Do Not Understand | Do Not Believe |
|---|---|
| I did'nt understand that how didi it kill human immune system. | White people cannot get AIDS. |
| We can not see a HIV/AIDS. | AIDS is for blacks only, |
| If aids get you never live like each other. | I don't believe that theres no medication for it. |
| If aids get you never feel like other people. | If you have HIV/AIDS you can loss by going in Church. |
| That mosquitos not spread it. | Animals are spreading it. |
| When people have head ache. | I do not believe AIDS in Africa. |
| When people have a stretch in her body. | I don't believe AIDS kill children. |
| If people cough she/he have this. | I don't believe AIDS is in Africa. |
| That you cannot get it from sharing toilets. | You use the same mug u can found it. |
| By washing with the same water you do not get germs. | I don't believe can have AIDS at age of 2. |
| That you can only see it in the blood. | I don't believe HIV/AIDS spreading with sex by not using a condom. |
| If a person have this disease and go to an church will Jesus help him. | I don't believe that AIDS is coming from cold e.g flue. |
| If I'm abstaining from this when do we start having sex? | Yes I don't cause in the olden years I've never head my grandparents talking about this in there day. |
| Yes because they say most of the people who get AIDS easy are female so I don't understand. | That it has a 3 month period. |
| More responses in post test, from School C. | It is still the punishment of god. |
| | It have devil. |
| | I do not believe condom is 100%. |

APPENDIX 15 – QUESTION 16

Question 16: “If a new person came to join your class at school, and said they had HIV/AIDS, what would you:

- a) think about him/her? (What thoughts?)
- b) Feel about him/her? (What emotions?)
- c) Say about him/her? (What would you tell other?)
- d) How would you act toward him/her?

| | | | | |
|--------------------------------------|---|---|--|---|
| 14 Year Old – Female Post-test | Offer to be his/her friend Offer an advice | Feel very sad | We musn’t gossip about him/her We musn’ laugh at him/her because he/she is HIV+ | I would act as friendly as I can |
| 14 Year Old – Female Pre-test | I will treat the person the way I would like to be treated by other people | I will feel sorry for that person | I would tell others they must not make fun of that person what would they do if it was their parents | I would tell her/him that she is not the one. There are people who love her like now. |
| 15 Year Old – Male Pre-test | I would first ask him/her how did she get it. I would encourage her to move on with her life. The what did she thought when she find out that she has it. | I will feel very sad because she/he won’t be similar to me. I won’t feel great because she/he will think to kill or do another thing to him or herself. | I will tell my friends to no make some thing that is not good. An als tell them to take this person as part of our friends. I can tell them to play with hi/her making funnie having fund. | I can be someone who is very kind to this person. I won’t let him/her donw I can take him/her to places or so we can have fun |

| | | | | |
|--|---|---|---|--|
| 15 Year Old – Male Post-test | At first I cannot like to do something with him/her. As time goes o and start understanding I ill think for him. I would think he does not feel well because other insult him | I can feel guilty if I don't like him/her. Some times feel sad because he is not in like playing | I can tell the to treat him as others. The other thing tell them to accept him as a friend. Tell them to not worry about anything | I would take to play some nice stuff take him to town if he feel like going to. Keep telling him that you care for him |
| School E Pre-test 15 Year Old – Female | I will love him or her like I love other I will be violent to him/her I will play will them and take them like people | They a human being just like us no matter what? It is just that they HIV and we must love then people who have it must be treated greatly | They must not giate them about being sick They must give them a change to enjoy their lives | I will always be grateful to him/her and I will always play with him/her we will always be friends. |
| School E Post-test 15 Year Old – Female | I would treat them like others. I would share everything with them. I would support them | I feel like they people and they just like us. | To be benevolent and love them and take them like one of them | I would to kind and helpful I would act like a friend and sister |

APPENDIX 16 – QUESTION 17

Question 17: “If a new person came to join your class and said they have AIDS, what do you think he/she would be:

- a) Thinking about AIDS?
- b) feeling about AIDS?
- c) Saying about AIDS?
- d) How would this person expect you to act towards him/her?

| | | | | |
|--|---|--|---|--|
| 15 Year Old – Male Pre-test | I think she will be unhappy all the times she have a few time to be happy | She would feel like she has no one in her side and some time wanting to kill herself | I would say that AIDS is not good to everyone | He/she would want you to show that you care about him because if you don't show that anything can happen |
| 15 Year Old – Male Post-test | He/she will think that we are not going to accept them | They will feel like they are alone no one luvs them and they have no value | They will say that they are nothing and end up doing some crazy thing | |
| 14 Year Old – Female Pre-test | I think, it is very painful | I feel worried and sad | AIDS is very dangerous | Nice, friendly and happy towards him/her |
| 14 Year Old – Female Post-test | I would think of him/her there on the bed sick ling | I would feel scared and sad of seeing someone with AIDS | I would say its very dangerous and killing | To act friendly, nice and care of him/her |
| School E Pre-test 15 Year Old – Female | No | No | No | Treat him or her the way you treat others and to be kind to him/her |
| School E Post-test 15 Year Old – Female | (No-entry) | (No-entry) | (No-entry) | Act like a friend not just a friend a kind one. |

APPENDIX 17 – QUESTION 18

Question 18

| | |
|---|--|
| <p>a) What personal strengths do you have, that can help you to protect yourself from HIV/AIDS?</p> | <p>b) What practical things can you do to protect yourself from HIV/AIDS?</p> |
| <p>I know how it spread I can protect myself</p> | <p>I will not have sex without a condom. Not touch someone's blood Not use somebody's raser.</p> |
| <p>By not having sex at this age until I am married. By taking care of myself.</p> | <p>If I had a boyfriend, I would make sure that we are honest with each other even if boys ain't honest but I would make sure I find Mr Right even though they are not all Mr Right.</p> |
| <p>I chose to wait or abstain from sex. I am me and I don't want to be other person. I love myself God didn't make any mistake.</p> | <p>I must have a self-esteem/confidence. I must take care of myself and say no to anythings no matter what I can make myself happy without a boyfriend because boyfriend can change your minds and change who you are so that you can do what he like you to do. He can make your life hard.</p> |
| <p>My personal strengths to stay strong. I believe in myself.</p> | <p>If I have a partor and I am ready sexually I will use condom to prevent HIV/AIDS and preneny or abstain from sex and be faithful to one parter.</p> |
| <p>My brain.</p> | <p>Running. Eat healthy food.</p> |
| <p>Yes I can protect myself with HIV/AIDS.</p> | <p>I will condomise when I'm having sex and I will wear gloves if some one has a blood, and if I'm in a clinic I will check that doctor or nurse will change the neggle.</p> |
| <p>To protect my baby from any one who wants to take advantage of it. SAY NOT TO PEER PRESSURE.</p> | <p>I can do as many things as I can to keep me busy and have no time to do stop things like going to bars, drinking alcohol and</p> |

| | |
|--|---|
| a) What personal strengths do you have, that can help you to protect yourself from HIV/AIDS? | b) What practical things can you do to protect yourself from HIV/AIDS? |
| | selling my body to strangers. |
| Say no to strangers who want to have sex with me. When I have sex make sure I use condom. | Is to do beads to keep me busy at home so that I can stay away from peer pressure that will lead me on having sex with strangers just to get money and drink alcohol and get raped and strangle with the rest of my life. |
| I can scream. I can run. I can fight. | Cover up my open wounds. Report at the police station if I've been raped or tell my mother. |
| Do not have sex until I have twenty years. Do not have a girl friend until I twenty years. Do no kiss a girl until twenty years. | Staying in home. Do not go to the tavern. Do not have sex. |

The response to Question 18 reflect a thorough knowledge of protective measures. Above is a collection of some of the more personal responses i.e.: those that do not use too much AIDS-jargon.

APPENDIX 18 – QUESTION 21

Question 21: “What can you and your friends do to combat/fight HIV/AIDS? (including prevention, care and support)”

The following is a summary of main points (repetitions not included) and unusual responses that show a range of adolescent “voices”. No significant difference in pre and post tests were found, except in School C where there were: 26 no-entries in pre-test and 14 no-entries in post-test – showing that the intervention encouraged thought around these issues.

To stop behaving like older people or run to the things of the above ages.

Talk about it to others.

To say people those who had IV and AIDS they must stop spreading AIDS to the people who doesn't have that deses.

I will take care of children who had HIV/AIDS and support them.

Support with food.

We must share with others what we know, so they can think positively.

Singing about it.

Make a TV or radio programme on young people getting infected with HIV/AIDS try to encourage young people to protect their bodies from HIV/AIDS.

Righting poems about it.

Playing games.

Getting information from those who are HIV.

Fight AIDS do not have sex in your stage we are young to have sex and we must fight rapest do not rape child do not spread AIDS.

We will try to form a support group in my community and to her communities as well.

We would have a grop where we can talk about things that we can do without having to sex or even thinking about it.

We can also have a playing ground where we can play games and we would teach other about AIDS.

We can act dramas or do speeches about AIDS we can try to voice our views to the government and the government will try to find shelter for HIV orphans.

We should make sure that we do not sleep with our girl friends and our parents know about our relation with those girls.

We will help people to get in shape and tell them that they must feel proud about there self and don't feel down about they self.

We need to show support to the infected people. Showing love because love is a strong weapon and love is about showing how you care for somebody. To make friends with them because nobody else will do it is our responsibility. Working together and not focusing on the past but it is our problem we must look forward and no matter what together we can. Nothing impossible on willing hearts.

To stop asking girlfriends. By not sleeping with our girl lovers. If unmarried person have sex he/she must go to jail.

Help children that their parents may be they die may be we can do something or tell the social worker about him/her.

Counsel people and tell them about or generation of today which is dying of AIDS and ask them about generation of tomorrow.

Research from different people's view on this disease.

We would teach people (especially girls) to fight back.

My first thing that I would do is to build homes for the poor one's that a HIV/AIDS and give them what they need and want.

APPENDIX 19 – QUESTION 22

Question 22: Section 5 : Sexual Contact

“Have you ever had full penetrative sexual intercourse?”

| Responses to Sexual Contact | RURAL | | | | TOWNSHIP | | | | CONTROL | | | |
|-----------------------------|----------|---|-----------|----|----------|---|-----------|----|----------|---|-----------|-----|
| | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | |
| | M | F | M | F | M | F | M | F | M | F | M | F |
| YES | 0 | 0 | 57 | 30 | 0 | 0 | 20 | 20 | 0 | 0 | 80 | 0 |
| NO | 0 | 0 | 21 | 30 | 0 | 0 | 40 | 40 | 0 | 0 | 0 | 0 |
| No Answer | 0 | 0 | 21 | 39 | 0 | 0 | 40 | 40 | 0 | 0 | 20 | 100 |

Question 22: Section 5: Sexual Contact

| Responses to Sexual Contact | RURAL | | | | TOWNSHIP | | | | CONTROL | | | |
|-----------------------------|----------|---|-----------|----|----------|---|-----------|------|----------|---|-----------|-----|
| | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | | PRE-TEST | | POST-TEST | |
| | M | F | M | F | M | F | M | F | M | F | M | F |
| YES | 0 | 0 | 50 | 21 | 0 | 0 | 10 | 18,4 | 0 | 0 | 40 | 0 |
| NO | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 29 | 0 | 0 | 0 | 0 |
| No Answer | 0 | 0 | 50 | 79 | 0 | 0 | 90 | 52,6 | 0 | 0 | 60 | 100 |

APPENDIX 20 – QUESTION 24

Question 24: “How many partners have you had?”

| Responses to Numbers of Partners | RURAL | | TOWNSHIP | | CONTROL | |
|--|-----------|-----|-----------|-----|-----------|-----|
| | POST-TEST | | POST-TEST | | POST-TEST | |
| | M | F | M | F | M | F |
| One | 43% | 21% | 20% | 37% | 40% | 50% |
| Two | 14% | 15% | 10% | 13% | 40% | 0% |
| Three | 7% | 3% | 10% | 5% | 0% | 0% |
| Four | 7% | 3% | 0% | | 0% | 0% |
| Five | 0% | 0% | 0% | | 0% | 0% |
| More than Five | 7% | 6% | 0% | | 20% | 0% |
| No Answer | 21% | 52% | 60% | 45% | | |
| Responses to having a regular partners | | | | | | |
| YES | 14% | 21% | 20% | 21% | 40% | 0% |
| NO | 57% | 3% | 0% | 3% | | |
| No Answer | 29% | 76% | 80% | 76% | | |

APPENDIX 21 – QUESTION 25

Question 25: “What age is or was your latest sexual partner?”

| Ranking of Age of Latest Sexual Partner | RURAL | | TOWNSHIP | | CONTROL | |
|---|-----------|-----|-----------|-------|-----------|-----|
| | POST-TEST | | POST-TEST | | POST-TEST | |
| | M | F | M | F | M | F |
| 10-13 Years | 21% | 9% | 40% | 3% | 60% | |
| 14-15 Years | 30% | 9% | 10% | 18,4% | 20% | |
| 16-17 Years | 14% | 18% | 0% | 21% | 20% | |
| 18-20 Years | 14% | 12% | 0% | 16% | | 25% |
| 21-23 Years | 0% | 0% | 0% | | | |
| 23-25 Years | 0% | 0% | 0% | | | |
| 26-30 Years | 0% | 0% | 0% | | | |
| Over 30 Years | 0% | 0% | 0% | | | |
| | 21% | 52% | 50% | 42% | | |

APPENDIX 22 – QUESTION 26

Question 26: “Where do these sexual activities take place?”

| Ranking Order of Site of Sexual Activities | RURAL | | TOWNSHIP | | CONTROL | |
|--|-----------|-----|-----------|-----|-----------|-----|
| | POST-TEST | | POST-TEST | | POST-TEST | |
| | M | F | M | F | M | F |
| In your house | 36% | 12% | 40% | 12% | 60% | |
| In your partners house | 14% | 30% | 0% | 39% | 40% | 25% |
| Car | 0% | 0% | 0% | 3% | | |
| Bar/Shebeen | 0% | 0% | 0% | 3% | | |
| School | 0% | 3% | 10% | 0% | | |
| Sports Field | 0% | 0% | 0% | 3% | | |

Question 27: “At what time of day do sexual activities take place?”

| Responses to time of day of sexual activities | RURAL | | TOWNSHIP | | CONTROL | |
|---|-----------|-----|-----------|-----|-----------|-----|
| | POST-TEST | | POST-TEST | | POST-TEST | |
| | M | F | M | F | M | F |
| Day | 7% | 3% | 20% | 3% | 0% | 0% |
| At School | 0% | 0% | 10% | 5% | 0% | |
| After School | 14% | 9% | 20% | 26% | 20% | |
| Night | 36% | 27% | | 13% | 40% | |
| Day and Night | 21% | 6% | | 5% | 40% | 25% |

APPENDIX 23 - QUESTION 35

RANK ORDERING OF ACTIVE INTENTIONS

| TOWNSHIP: FEMALE | | TOWNSHIP: MALE | |
|--|-----|--|-----|
| Talk to friends | 63% | Talk to friends | 80% |
| Talk to parents | 61% | Talk to parents | 50% |
| Visit a clinic | 50% | Talk to a teacher | 50% |
| Talk to a teacher | 47% | Visit a clinic | 50% |
| Talk to someone at church | 29% | Form a support group for people living with HIV/AIDS | 40% |
| Go for VCT | 29% | Talk to someone at church | 30% |
| Form a support group for people living with HIV/AIDS | 26% | Collect money for AIDS orphans | 20% |
| Collect money for AIDS orphans | 21% | Start an HIV/AIDS club at school/Church | 20% |
| Start an HIV/AIDS club at school/Church | 16% | Go for VCT | 10% |

| RURAL: FEMALE | | RURAL: MALE | |
|--|-----|--|-----|
| Talk to friends | 70% | Talk to a teacher | 57% |
| Talk to parents | 48% | Talk to friends | 50% |
| Visit a clinic | 27% | Visit a clinic | 50% |
| Talk to a teacher | 24% | Talk to parents | 43% |
| Go for VCT | 24% | Form a support group for people living with HIV/AIDS | 36% |
| Collect money for AIDS orphans | 18% | Start an HIV/AIDS club at school/Church | 36% |
| Form a support group for people living with HIV/AIDS | 15% | Go for VCT | 14% |
| Talk to someone at church | 12% | Talk to someone at church | 14% |
| Start an HIV/AIDS club at school/Church | ? | Collect money for AIDS orphans | ? |

