

**KNOWLEDGE, ATTITUDE AND PRACTICES SURVEY
(KAP)**

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GLOSSARY OF ABBREVIATIONS USED

AIDS	- Acquired Immunodeficiency Syndrome
HIV	- Human Immunodeficiency Virus
HDI	- Human Development Index
ICESCR	- International Covenant on Economic, Social and Cultural Rights
LRA	- Labour Relations Act
NACOP	- National AIDS Co-ordination Programme
NIP	- National Integrated Plan
PCR Tests	- Polymerase Chain Reaction Tests
UNDP	- United Nations Development Programme

CHAPTER 1: HIV/AIDS IN PERSPECTIVE

INTRODUCTION

HIV/AIDS is probably the deadliest enemy Africa has ever faced. The global magnitude of the epidemic is estimated at 42 million people living with HIV/AIDS based on the UNAIDS estimates of December 2002. The total cumulative AIDS death is 24.9 million and new infections are estimated at 5 million for 2002. The majority of new infections occur in sub-Saharan Africa. This has been so particularly in sub-Saharan Africa where the disease is threatening to wrack the economic and social structure of many countries (Marunda & Chamme, 2003:250). It is estimated that 2.4 million Africans died of AIDS during 2002. The high toll is blamed on the failure of many African governments to take steps to eradicate the disease (McQuillan.2003:1). It seems further that current efforts to eradicate the disease are simply not equal to the need as the threat posed to Africa continues to increase.

McQuillan (2003:1) quoted in Table 1.1 the following statistics from the World Health Organisation of people living with AIDS in the most-infected regions of the world:

Table 1.1: People living with AIDS

Most-Infected Regions	Numbers (In millions)
Sub-Saharan Africa	29.4
Latin America	1.5
Eastern Europe/Central Asia	1.2
East Asia/Pacific	1.2
North America	1.0

Source: World Health Organisation. 2002. AIDS Epidemic Update. December.

More country specific, are the data provided van Rensburg et al (2002:19) giving a breakdown of those countries with the largest number of HIV infections and the

highest adult HIV-positive prevalence rates. The data reveals the awkward position of developing countries in respect of these issues (See Table 1.2).

Table 1.2: Countries with the largest number of HIV infections and highest adult HIV-positive prevalence rate (December 2000)

NUMBER OF INFECTIONS (MILLIONS)	ADULT PREVALENCE RATE (%)*
South Africa (4.7)	Botswana (36)
India (3.7)	Swaziland (25)
Ethiopia (3.0)	Zimbabwe (25)
Nigeria (2.7)	Lesotho (24)
Kenya (2.1)	South Africa (22)
Zimbabwe (1.50)	Zambia (20)
Tanzania (1.3)	Namibia (20)
Mozambique (1.2)	Malawi (16)
Democratic Republic of the Congo (1.1)	Kenya (14)
Zambia (0.875)	Central African Republic (14)
United States of America (0.850)	Mozambique (13)

* The percentage of the population between the ages of 15 and 49 who are HIV-positive.

McQuillan (2003:1) also quoted International health experts claiming that in South Africa's neighbouring country, Botswana, already 40% of the population is infected with HIV, the virus that causes AIDS. For people ages 15-49 years, the average life expectancy is only 39.9 years. Fabricius (2003:16) quoted UNDP as calculating that Aids will take 35 years off the life of the average Zimbabwean by the year 2005. This implies that the average life expectancy at birth will be just above 33 years. Without the devastating impact of AIDS, the life expectancy of the average Zimbabwean would have been over 68 years in the year 2005. The same report calculated that in **South Africa** the life expectancy at birth of the average South African will have dropped to 47.7 years in 2005. Steinitz (2000:21) estimated an overall HIV prevalence of about 20% among sexually active adults in Namibia another neighbouring country to South Africa. The same author indicated 75 383 officially reported cases in Namibia between 1986 and June 2000 and also that since 1995, AIDS has been the leading cause of death in Namibia.

Lehohla (2002:10) stated that more infants are born HIV positive and that UNAIDS reported that in Southern Africa at least 20% of people aged 15-49 are already infected. With regards to **South Africa** van Rensburg et al (2002:20) indicated in Table 1.3 that in 1999 already 27.1% of young women between the ages 15-24 years are HIV infected. The same authors reported that 1 700 South Africans are being effected with HIV each day.

Table 1.3: HIV prevalence in South Africa (December 1999)

Country	Adult prevalence rate	Prevalence rate in young women (15-24 years)	Prevalence rate: Women in antenatal clinics – urban areas	Prevalence rate: Women in antenatal clinics – rural areas
South Africa	19.9	27.1	19.2	21.3

Noteworthy is that the number of South Africans that died because of AIDS before they reached the age of 50, almost doubled since 1990. According to the president of the Medical Research Council, Professor Malegapuru Makgoba, AIDS is devastating South Africa's most economically productive citizens – those aged between 15 and 49 – with more men aged between 35 and 40 dying than in any other age group in the 1999-2000 period. The death rate has risen despite better access to health care and improvements in the quality of life of most South Africans in the ten years since 1990. This has devastating implications both for the economy and the social structure of families and for their quality of life (Sunday Times, 23 July 2000: 14).

In a study conducted by Grundling, de Jager, Fourie, Ras, and Grundling (2002), it was clearly indicated that on a community and individual level, pending the development of an effective vaccine or cure for HIV/AIDS, sexual behaviour change is the only means of averting the continuous spread of the disease. This also implies that higher education institutions in South Africa have a social responsibility to contribute to the managing and prevention of the epidemic in a strategic manner.

EPIDEMIOLOGY AND TRANSMISSION

HIV (Human Immuno-deficiency Virus) is a virus that is only found in human beings which attacks and slowly damages the body's immune system so that the body cannot defend itself against infections and diseases. HIV causes AIDS (Acquired Immune Deficiency Syndrome) which represents a group of particular medical conditions called "AIDS-defining conditions or illnesses" (like "cold sores", swollen lymph nodes, shingles, skin rashes and irritations, occasional fevers, nail infections, weight loss, brain infections and Tuberculosis (Barrett-Grant, Fine, Heywood & Strode. 2001:10). HIV is transmitted through infected blood or body fluids. According to the same authors the following bodily fluids are applicable:

- Blood;
- Semen;
- Vaginal and cervical fluids; and
- Breast milk.

The HIV virus is usually transmitted when one of these fluids goes into another person's body. Most transmission occurs during unprotected anal or vaginal penetrative sexual intercourse or injection of infected blood or blood products, such as drug users sharing the same injecting equipment. Perinatal transmission can also occur from an infected mother to her baby during pregnancy or delivery. There is no risk of contracting the infection through human contact or through kissing, touching or handling objects used by an infected person or through sharing offices or toilets. There are also no known cases of AIDS having been transmitted by mosquitoes, the sharing of public baths or swimming pools, water or food, according to du Pisani (2000:52).

Types

The diversity of HIV epidemics around the world is becoming more apparent. It also seems that the epidemic does not follow the same course in all societies. In 1983, French researchers discovered a new virus "HIV-1 That causes AIDS. In 1985 a second type namely HIV-2 was discovered in West Africa (Senegal) which seems to

be less easily transmitted and harmful than HIV-1. Scientists later discovered that there are also many different strains or subtypes of HIV. In South Africa, subtype C is most common (Barret-Grant et al. 2001:11).

Stages

HIV infection typically takes many years to develop into symptomatic illness and therefore the impact of the epidemic is not seen for some time after infection levels begin to rise. The importance of deriving models which could estimate and project the illness can not be underestimated. One important model needed is to understand HIV in terms of the stages in which it operates. According to Barrett-Grant et al (2001:30) the following stages can be identified:

- **The window period** – This is defined as the short period between infection by HIV and when the person first develop antibodies that can be picked up by standard HIV tests. Because it can take up to three (3) months for some people to develop antibodies for HIV after infection, a person may test HIV negative during this time.
- **Sero-conversion** – This happens when a person changes from being HIV negative to HIV positive. This is when there are enough HIV antibodies in the blood to be seen in a standard HIV test.
- **Asymptomatic stage** – This is the period between becoming infected with HIV and becoming ill. This stage can range from weeks to many years – typically from 8 to 10 years.

NORMATIVE AND ETHICAL CONSIDERATIONS

According to du Pissani (2000:53) HIV infection raise complex normative and ethical issues that include amongst others:

- Human dignity;
- Human rights;
- Prejudice against the infected person;
- Sex;

- Human sexuality;
- Drug use;
- Disability; and
- Death.

All the above issues are highly emotive subjects that requires institutions of higher education to explore the ethical and policy issues that they raise. While there is much emphasis on the rights of persons who are HIV antibody positive, persons with HIV also have ethical and moral duties towards society at large. These moral responsibilities should occur and encouraged by a non-discriminatory, supportive environment.

HIV INFECTION VULNERABILITY

Sex is considered to be the main risk factor to consider that placed a person at risk of HIV infection (Barrett_Grant et al. 2001:32).

Grobler (2000:35) stated that the youth – especially teenagers – are still in the stage of “identity formation”. This time period is characterised by discovery and excitement in which the youth is in need of love, care and a commitment in individual relationships. If the need for emotional gratification is not fulfilled, a gap develops in a person’s emotional accoutrement, which can place the person in a predisposition for sexual relationships to fill the gap.

According to Van Rensburg et al (2002:31) youth is also the time when gender roles, sexuality and attitudes towards women are formed. Further, apart from physiological vulnerability, adolescents in particular are very susceptible to peer pressure, are more inclined to engage in risk-taking behaviour, are less able to negotiate safe sex practices, and have difficulties accessing health services and information.

Further, according to Steinitz (2000:22) strong gender imbalances exist in the age-specific profile of HIV infections. Of these, younger women and girls are the most vulnerable. Van Rensburg et al (2002:24) indicated that women are at highest risk

between the ages of 15 and 20, while men achieve their highest incidence approximately five years later, i.e. between the ages 20 and 24. HIV Insight (2001) is of the opinion that the reason why women are infected at an earlier age can be attributed to both biological and cultural reasons. For these authors age mixing is a critically factor. It seems that one can expect to see young girls having sex with older men, who have been sexually active for many years to a much larger extend than young men having sex with older women. Young girls are thus more likely to be infected than young men.

COMMUNICATION AND OPENNESS TO DISCUSS HIV/AIDS

Marunda & Chamme (2003:256) is of the opinion that the reluctance of elderly people to discuss sex and condom use with youngsters denies young people very good advice and should be considered a serious stumbling block against AIDS.

It is of extreme importance that knowledge about HIV/AIDS is conveyed in such a way that the target group understands the message because knowledge is only useful if it is understandable (Grobler. 2000:40). Thus, if prevention campaigns is not being placed in the context of the lives of the youth, the youth will not relate to the message. Knowing the facts may be a required pre-requisite but definitely not a sufficient pre-requisite to change the sexual behaviour of the youth. Lehohla (2002:11) is of the opinion that although young women are exceptionally vulnerable to the disease, millions of young African women are dangerously ignorant about HIV/AIDS. This statement is supported by Katjire, Langa, Siwa, Mbuche and Tjongarero (2000:75) which stated "... information about a disease and how it spreads does not necessarily increase the likelihood that one will take preventive action or change one's behaviour". According to Grobler (2000:40) a solution may be to involve the youth in translating the planned messages into understandable concepts. These researchers would add that over and above the understanding principle, understanding the motivations behind demonstrating certain behaviours is also required.

MANAGEMENT AND PREVENTATIVE METHODS

Indicators to be used in HIV surveillance – In an unpublished document the South African Department of Health (2001) provides information of indicators used in HIV surveillance in the last couple of years which allow for comparison across time and between geographical areas. Most of these indicators according to the department should be presented by age and sex, and some could be presented by other variables such as risk category. In Table 1.4 the major indicators are summarised.

Table 1.4: Major indicators used in HIV surveillance

<p>1. Biological Indicators</p> <ul style="list-style-type: none">• HIV prevalence• STD prevalence• Hepatitis B and C prevalence• Number of adult AIDS cases• Number of paediatric AIDS cases
<p>2. Behavioural Indicators</p> <ul style="list-style-type: none">• Sex with non-regular partner in the last six months• Condom use at last sex with a non-regular partner• Youth: age at first sex• Drug injectors: Reported sharing of unclean injecting equipment• Sex workers: Reported numbers of clients in the last week
<p>3. Socio-demographic indicators</p> <ul style="list-style-type: none">• Age• Sex• Socio-economic or educational status (occupation or years of schooling)• An indicator of residency or migration status• Parity (for antenatal sites)• Marital status

Normally HIV and STD prevalence will be reported for the youngest sexually active groups namely 15-24 years of age.

Public finances and HIV/AIDS in South Africa – The trends in social expenditure in general and in conditional HIV/AIDS grants in particular represent some indication of the extent to which government is reprioritising expenditure so as to cope with the impact of HIV/AIDS. One has to realise that social expenditure consists mainly of the allocations to the Departments of Education, Health and Social Development. Other social expenditure includes allocations for housing to the Department of Local Government and Housing. Social expenditure constitutes close to 60% (58.2%) of total government expenditure. Social expenditure by government has continued to increase in the recent past years, reflecting a continued concern with improved social delivery. Trends in social delivery also suggest that government will be prioritising expenditure so as to cope with the HIV/AIDS epidemic, with increasing allocations going towards the Departments of Health and Social Development, which will have to cope most directly with the epidemic. However, future increases in these allocations are relatively small in real per capita terms. Further, in the first year of the National Integrated Plan (NIP) the focus was largely on prevention. The emphasis, however, is now shifting away from prevention towards treatment, care and support. (Van Rensburg et al, 2002:93-109).

HIV testing – HIV prevention and treatment depends largely on people **wanting** to have an HIV test. The aim of HIV testing is to pick up HIV antibodies in the person's blood. Currently two categories of tests can be identified (Barrett-Grant et al. 2001:20-21):

- Rapid tests – These tests are cheap and rapid, easy to use and very accurate, can pick up whether there are HIV antibodies in blood or saliva, and the result is available within about 15 minutes.
- PCR tests (Polymerase Chain Reaction tests) – These are very sensitive tests that test for HIV rather than HIV antibodies, and can be used to find HIV even when the sample of body fluid is very small. The PCR test is very useful for emergency situations like a sexual assault because one can test even a tiny sample of blood to determine if the assaulter is living with HIV and because one can find out if the person who has been assaulted has HIV in the blood.

Protecting the fundamental rights of people living with HIV or AIDS – The South African Bill of Rights has a list of the fundamental rights of all people living in South Africa. In addition to the right of equality under the equality Clause (s9 of the Bill of Rights), these rights are also extremely important for people living with HIV or AIDS (Barett-Grant et al. 2001:83-85). These rights are summarized in Table 1.5.

Table 1.5: Fundamental rights of people living in South Africa

SECTION IN THE BILL OF RIGHTS	RIGHT	WHAT THIS MEANS FOR PEOPLE WITH HIV OR AIDS
10	<u>Human dignity</u> Everyone has the right to have their dignity respected and protected.	A person or institution may not insult or damage any person’s self-respect, by their words or actions.
12	<u>Freedom and security of the person</u> Includes the right to: <ul style="list-style-type: none"> • Make decisions on reproduction • Security and control over their body • Not to be subjected to medical or scientific experiments without informed consent. 	A person has the right to take their own decisions about medical treatment and pregnancy; e.g. a person cannot be forced to test for HIV. A person cannot be treated in a cruel or degrading way by any person or institution.
14	<u>Privacy</u> Everyone has the right to privacy.	If a person has HIV or AIDS the person has the right to keep the information to him or herself. An employer or

		hospital cannot force the person to tell them, or force the person to have a blood test to find out this private information.
16	<u>Freedom of expression</u> Everyone has the right to freedom of expression, which includes freedom to receive or give out information or ideas.	The right is important, particularly as a way to ensure that proper information about how to prevent HIV is available in schools or prisons.
18	<u>Freedom of association</u> Everyone has the right to freedom of association.	A person can join any organisation he or she choose. One cannot be forcefully separated from other people.
21	<u>Freedom of movement and Residence</u> Everyone has a right to: Freedom of movement, and to leave the country. All citizens have the right to enter, to remain in and to live anywhere in the country.	If a person has HIV or AIDS the person is free to move around the country. The person cannot be forced to live in a separate place, away from the rest of society.
22	<u>Freedom of trade, occupation and profession</u> Every citizen has the right to choose their trade, occupation or profession freely.	People with HIV or AIDS can choose what kind of work they want to do, e.g. a doctor, a teacher or a health care worker.
23	<u>Labour relations</u>	No person may be unfairly

	Everyone has the right to fair labour practices.	discriminated against at work.
24	<u>Environment</u> Everyone has the right to an environment that is not harmful to their health or well-being.	The right is important for people with HIV who are living in state institutions such as prisons or psychiatric hospitals.
26	<u>Housing</u> Everyone has the right to have access to adequate housing. No person may be evicted from their home, or have their home demolished, without an order of court made after considering all the relevant circumstances.	People living with HIV or AIDS may not be refused a subsidy or loan to buy a house. Evicting a person from a house or flat because of their health is also unlawful.
27	<u>Health care, food, water and social security</u> Everyone has the right to have access to: <ul style="list-style-type: none"> • Health care services, including reproductive care. • Social security, including, if they are unable to support themselves and their dependants, suitable social assistance. 	No person may be refused emergency medical treatment. Hospitals or doctors cannot refuse to treat a person with HIV or AIDS. People with HIV or AIDS have the right to disability grants if they are too ill to support themselves or their families.
29	<u>Education</u>	If a person has HIV or

	Everyone has the right to a basic education, including adult basic education.	AIDS, the person has the same right as all people to education. A school cannot refuse to educate the person or the person's child because the person has HIV or AIDS.
32	<u>Access to information</u> Everyone has the right to have access to any information that is held by another person and that is needed to carry out or protect your rights.	If the person feels there are being discriminated against him or her because of a policy, the person can demand to see that the policy, and then challenge it in a court. The person has the same right with private institutions, and information that is kept of the person.
33	<u>Just Administrative Action</u> Everyone, whose rights have been negatively affected by administrative actions, has the right to be given written reasons.	If the person feels that he or she is being refused a social service for unjust administrative reasons, the person can demand these reasons in writing.
35	<u>Arrested, Detained and Accused Persons</u> Everyone who is detained, including every sentenced prisoner, has the right to conditions of detention that protect their dignity.	Prisoners cannot be treated in a discriminatory or undignified way just because of their HIV status.

According to Barret-Grant et al (2001:103) the Constitution of South Africa limits the right to health by:

- Linking it to available resources; and
- Accepting that this right can be fulfilled as long as the State shows that it is taking meaningful steps to deliver on this right.

This is somewhat different from the standpoint of the International Covenant on Economic, Social and Cultural Rights (ICESCR) which recognises the right of everyone to the enjoyment of the **highest attainable level of physical and mental health**.

It is also of utmost importance that the rights and laws protecting a person living with HIV or AIDS been fully understood. In this regard the summary provided by Barret-Grant et al (2001:177) provides valuable information (See Table 1.6).

Table 1.6. The rights of employees living with HIV or AIDS

Right	Law
Right to fair labour practices	Constitution and Labour Relations Act (LRA)
Right not to be unfairly dismissed because one is infected with HIV	LRA
Right not to be unfairly discriminated against on the basis of a person's HIV status	Employment Equity Act (EEA)
Right not to be tested for HIV unless the employer has applied to the Labour Court for authorisation	EEA
Right to a safe working environment	Occupational Health and Safety Act, and Mine Health and Safety Act
Right to compensation if infected with HIV at work	Compensation for Occupational Injuries and Diseases Act (COIDA)
Right to certain basic standards of	Basic Conditions of Employment Act

employment, including 6 weeks of paid sick leave over a 3-year period	(BCEA)
Right to no unfair discrimination in giving employee benefits	Medical Schemes Act
The right to privacy about one's HIV status at work	Common law right

Condom use – According to Marunda & Chamme (2003:250) countries that have embraced the use of condoms have found a significant drop in the rate of AIDS and other sexually transmitted diseases rate of infection. The authors quoted that in Uganda the HIV incidence dropped from 8.0 per 1000 in 1990 to 5.2 per 1000 in 1999. In Thailand “a 100% condom” campaign resulted in a significant reduction in HIV prevalence among sex workers from 30% in 1993 to 18% in 1995.

The condom stands a better chance of success because it does not call on people to change their sexual behaviour as such. People could still have sex as often as they used to, the only change being on how they do it (Marunda & Chamme, 2003:251). However, research by Nasheya (1999:31) as quoted by Grobler (2000:39) indicated that sexually active people may experience technical problems with condoms. In the mentioned research the respondents indicated the following:

- A condom can get lost inside a woman;
- Condoms can fall off;
- Condoms often burst;
- Condoms make sex less enjoyable;
- Condoms are against God's will;
- People are ashamed and embarrassed to use condoms;
- Women who initiate using a condom are trying to gain power;
- Women who carry condoms are loose; and
- If a women wants to use a condom, a man should give the final decision.

Abstaining from sex – Supporters of this view believe that the elimination of HIV/AIDS requires a moral rather than a medical or condom solution. Preaching of

abstaining rather than putting the emphasis on condom use should be emphasised. The view from religious leaders is often that promoting condom use encourage sins like adultery and practising sex at an early age (Marunda & Chamme, 2003:255-256).

Educating sexually active youth – The biggest challenge in education according to Lehohla (2002:11) is the disturbingly high rate of sexual activity among teenagers in secondary and intermediate education. This will bring decision-makers face-to-face with the reality that while there may be moral questions about teaching safe sex to children, whether or not one approve that they are sexually active.

THE ECONOMIC CONSEQUENCES OF HIV INFECTION

NACOP (2000:16) stated categorically that the consequences of HIV infection are loss of economic productivity and income, social liability, loss of family member and an emergence of an army of orphans. The Futures Group, as quoted by Steinitz (2000:21), indicated for example that in Namibia the direct and indirect cost between 1996 and the end of the year 2000 for Namibia would have been approximately US\$6 billion.

Lehohla (2002:8) indicated the following effects of HIV/AIDS on human development in the SADC region:

- The pandemic has multiple and negative effects on the demand for education, the supply for education, the quality and management of education in individual learning posts and the whole region is undisputable.
- There exists uncertainty about the future demand for education in the light of possible and apparent declines in the number of school-going-age children. Enrolments in secondary, intermediate and tertiary education may also be negatively affected by the demise of breadwinners in households.
- The quality of learning outcomes and education will be affected by several confounding factors, which will emerge as the pandemic takes a deeper hold in the region. In the 2001 AIDS epidemic update, UNAIDS reported that in 1999 alone, an estimated 860 000 children lost their teachers to AIDS in sub-Saharan Africa. Fabricius (2003:16) quoted UNDP that indicated that in 1998

Zambia lost 1 300 teachers to the disease – two-thirds of those trained each year. The education systems also have begun to experience problems of loss of inspectors, teachers, education officers, planners and management personnel. UNAIDS estimated that there will be a less qualified teaching force in time, as trained and experienced teachers are replaced with younger and less qualified teachers.

As a group of countries, the life expectancy figures for Southern Africa are the lowest in the world, and are having a major impact in each country on the UNDP Human Development Index (HDI). The HDI compares the quality of life in the different countries of the world. It is reported that South Africa had fallen 27 places in the HDI rankings since 1990, to its present 111th position – mainly because of AIDS (Fabricius. 2003:16).

CONCLUSION

HIV/AIDS infection rates continue to rise in the sub-Saharan African countries and in South Africa. It is therefore important that decision makers take note of how communities and individuals respond to the disease. This includes the student population of the Technikon of Pretoria. It is accepted that, until an effective vaccine or cure for HIV/AIDS is found, sexual behaviour change is the only means of averting the continuous spread of the disease.

CHAPTER 2: RESEARCH METHODOLOGY

INTRODUCTION

Evaluation of the sexual behaviour, understanding the behaviour patterns and the information needs of students is an integral part of this research. To achieve the objectives of the research, it was necessary to use multi-dimensional criteria to measure and identify the sexual behaviours of the students.

STATEMENT OF THE PROBLEM

Whereas HIV and AIDS are in their nature health-related problems, it is common knowledge that the fight against the epidemic and its manifest effects has to be based on partnerships by all of society. Relatively little research has been done on the impact of AIDS on the education sector and the implications of its effects on the current and future supply of education (Lehohla. 2002:5-6). Further, it is important that institutions of higher education adopt policies regarding HIV/AIDS that corresponds with the Constitution of South Africa and the basic rights of its people.

Further, the fact that HIV predominantly affects people between the ages of 14 and 35 years means that students at tertiary institutions are directly affected. In a survey conducted among 3000 students in KwaZulu-Natal in May 2000, it was found that 1 in 2 students are HIV positive. An immediate response to this would be to ask the question – “What could tertiary education institutions do to make students more aware of prevention strategies and care available to those infected with HIV?”

MOTIVATION FOR THE STUDY

Lehohla (2002) stressed at a meeting of the SADC Ministers of the Human Resource Development Sector that the SADC member countries should join efforts to commission studies on the impact and implications of HIV/AIDS in education, build capacity for teaching, research and management of HIV/AIDS programmes,

strengthen multi-sectoral initiatives, and ensure the infusion of HIV/AIDS issues in all Human Resource Development Strategies under the protocol on Education and Training at national and regional levels. Otaala (2000:3) provides three principal reasons why institutions of higher education should take the phenomenon HIV/AIDS seriously and why these institutions should act and react on it:

- The vulnerability of these institutions to the many adverse impacts of HIV/AIDS;
- Because of this vulnerability, these institutions need to take these impacts into account in its planning, while at the same time taking steps aimed at AIDS prevention and control;
- It is the responsibility of institutions of higher education – through knowledge dissemination, research and advisory services – to contribute to stemming the spread of the disease and to mitigating its impact within the larger society of which these institutions are part.

The aim of this investigation is primarily to determine firstly, who of the registered students studying at Technikon Pretoria is most at risk to become HIV infected, secondly to determine which behaviours put them at risk, and thirdly to determine their understanding of their basic rights as humans, in the workplace and in a relationship. Finding answers on these issues will enable the institution to generate an appropriate response to HIV in order to contribute in keeping the epidemic low, and to direct efforts to slow the spread of HIV.

SCOPE OF THE RESEARCH

This research provides both socio-demographic, knowledge and behavioural information regarding registered students of Technikon Pretoria as it relates to various aspects concerning HIV and AIDS. The specific aspects to be analysed are described in Table 2.1.

Table 2.1: Aspects analysed in the survey

<p>1. Knowledge profile of students</p> <ul style="list-style-type: none"> • Understanding the difference between HIV and AIDS • Perceived highest age risk groups • Identification of a HIV positive person • Knowing one's HIV rights
<p>2. Sex intercourse profile of students</p> <ul style="list-style-type: none"> • Engagement in sex profile of students • Enjoyment profile • Expectations of partner • Popularity profile
<p>3. Condom use</p> <ul style="list-style-type: none"> • Condom use with last sex partner • Reasons for not using condoms • Decision node in condom use • Condom use as it relates to type of sexual behaviour • Ease of introducing condom use into relationships • Sourcing for condoms
<p>4. HIV testing</p> <ul style="list-style-type: none"> • Awareness of the AIDS centre on Campus • Information requirements

THE POPULATION

The population under investigation were all registered students registered at the Technikon of Pretoria, South Africa and its satellites during 2003. The number of registered students amounts to 25 529 students.

DESCRIPTION OF THE SAMPLE FRAME

According to Martins, Loubser and Van Wyk (1999:252) the sample frame represents a record of all the sample units available at a given stage in the sampling process. In

the case of this sample a list of registered students were obtained from the Management Information System of Technikon Pretoria. Respondents were randomly selected from the Arcadia campus, Arts campus, Technikon Pretoria Main Campus and the Witbank Campus. No respondents were considered from the campuses of Pietersburg and Nelspruit as they were not available during the time of the investigation. This represents a total sample frame size of 25 529 from which the final sample was selected. The sample frame constitutes the following numbers as explained in Table 2.2:

Table 2.2: The Sample Frame

Population	Female	Male	Total
Asian	103	228	331 (1.3%)
Black	9 221	8 682	17 903 (70.1%)
Coloured	146	199	345 (1.4%)
White	2 820	4130	6 950 (27.2%)
Total	12 290 (48.1%)	13 239 (51.9%)	25 529 (100%)

It is clear from the table that the Black and White population groups constitutes most of the registered students studying at the Technikon of Pretoria.

SAMPLING

The aim of sampling is always to ensure that the actual acquired statistics will be as close as possible to the population parameters in order to be able to make generalisations (Black. 2002:59).

SELECTING THE SAMPLING METHOD

Stratified sampling

The stratified sampling method, which forms part of the family of probability sampling methods was used. Black (2002:52) explains this method of sample selection as "...taking random samples from various strata in society, such as men and

women. Different subpopulations are thus defined within a larger population”. The result is that the researchers are able to divide the target population into relatively homogeneous subgroups (Hair et al. 2003:216). According to Martins et al (1999:257) this holds the big advantage that in a probability sample the sample error for a given sample can be calculated statistically. In this stratified sample the population of registered students were divided into mutually exclusive stratum according to campus, race and gender. Simple random sampling was conducted within each stratum. The stratified sampling method also allowed the researchers to:

- Draw the actual sample in a disproportional manner so as to ensure that each respondent has a known chance to be selected in each stratum yet, the chance to be selected in one stratum differs from the chance to be selected in another stratum. However, the chance is equal for all elements in a specific stratum.
- Study the heterogeneous registered student population of Technikon Pretoria in terms of the qualities to be investigated by dividing the population into more homogeneous groups with regards to these qualities and in so doing enhances the precision or reduces the sample error in two ways namely:
 - Firstly, making sure that that the various elements of campus, race and gender are included in the sample in their correct proportions.
 - Secondly, variability of the qualities being investigated decreases within the various strata as the qualities of the elements in a specific stratum corresponds with the stratum qualities.

Sample size

The next aim was to ensure that the sample is representative of the Technikon Pretoria registered student population. The number of respondents selected from each strata was proportionate to the size of each strata relative to the overall sample size. The formula $n = \text{SQR}(20*N)$ was used to determine the sample size for each stratum, where N is the total obtained in a specific stratum. For example:

1. total number of female Asian students is 103 (for all 3 campuses).
2. to find out how many should be included, the researchers used
$$n = \text{SQR}(20*103) = 45.38722 = 46 \text{ (rounding up)}$$

3. lastly, 46 was proportionally divided among the campuses.

Using the stratified sampling method provided the following advantages according to Hayes(1997:90):

- Better precision with the same overall sample size;
- Estimations of population parameters can be obtained for each stratum; and
- One can focus on a particular sample in which one is interested.

Table 2.3 indicates the specific sample size selected. The selected sample represents 6.28% of the sample frame.

Table 2.3: Composition of the selected sample

	Asian		Black		Coloured		White		Total
Campus	F	M	F	M	F	M	F	M	
Arcadia	7	5	51	32	5	4	44	20	168
Arts	6	2	9	12	5	2	64	25	125
Technikon Rand	33	61	370	373	44	58	130	242	1311
Total	46	68	430	417	54	64	238	287	1604

DESCRIPTIVE RESEARCH METHOD

The main purpose of the research was to describe the behaviour patterns and preferences of Technikon Pretoria students. According to Zikmund (2003:55) the descriptive research method in this case provides an excellent opportunity to the researchers to find answers on questions relating to who, what, when, where, and how questions. It also enables the researchers to segment and target specific markets. In this research it was amongst others important to differentiate between age groups and the male and female populations. This research approach was also appropriate as the researchers could build on some previous understanding of the research problem. The main purpose therefore was to find conclusive evidence of differences in the behaviour, perceptions, expectations and characteristics of specified sub-groups.

DATA COLLECTION

Survey – A structured survey method was used to collect the data. According to Black (2002:44) the survey method allows one to describe the characteristics of a single group of subjects in terms of pre-described characteristics. The design of the survey can be described as follows:

RS \longrightarrow O_a, O_b, O_c,.....O_n

Where:

RS = Random selected respondents

O = The different observations/measurements made of each member of the group corresponding to the prescribed HIV/AIDS characteristic

Administration – The first step was to ensure confidentiality, anonymity and ethics in the conduct of the research. The measuring instrument was presented to the Ethical Committee for advice, evaluation and approval to ensure that the survey complies with all ethical considerations and provide the necessary protection to all respondents involved. Secondly, confidentiality was guaranteed implying that no respondent could be identifiable and by so doing protect respondents from any adverse consequences. Allowing respondent to complete the questionnaire anonymously and ensuring that no respondents could be identified through any coded numbers or names on the questionnaires achieved this.

In light of the sensitivity of study and the questionnaire, it was decided that trained field workers would be used to collect the data. The Technikon has a Peer Education Programme, as a component of its HIV and AIDS strategy. These Peers have been trained and skilled with knowledge to render HIV/AIDS services, hence their understanding of the many dynamics surrounding HIV, was a critical asset to this process.

The field workers were interviewed and selected by the researchers and exposed to a three-day training session. The training was aimed at acquainting them with the purpose of the study, enabling the understanding of the sampling exercise and role-

plays to prepare for possible resistance/sensitivities raised by respondents. The field workers were exposed to a process of continuous assessment during the course of the training and upon completion of this phase, 10 were selected.

A further two individuals were recruited (post graduate students) to serve in the capacity of supervisors. Hence, the group was divided into 2, with each supervisor being allocated 5 field workers.

These supervisors were also responsible for quality checking the questionnaires on completion. Various other checks were put in place to ensure the quality of the data received. The research team and the field workers met on daily basis to discuss and resolve any difficulties that arose in the course of data collection.

Upon completion of the Knowledge, Attitudes and Practices (KAP) survey, a session was held with all 12 fieldworkers to reflect on their experiences of being involved in a survey of this nature. This information was ascertained to assist researchers in follow-up research projects or those planning similar research. Field workers agreed that, in most instances there was no hesitation among respondents when approached to fill out the questionnaire. However, the following points were highlighted as problematic:

- Asian and Coloured respondents were difficult to find - possibly because of their small number in terms of the total student population.
- Some Asian and Coloured students had religious objections against filling out the questionnaire.
- It was found that black female students were particularly shy when filling out the questionnaire. Some thought the questionnaire was a “sex quiz,” while others, incorrectly, assumed that being approached implied that they are HIV-positive. In some instances, this misconception, led to verbal abuse.
- Students across the board indicated that the questionnaire was too long. In terms of the questionnaire.
- It seems as if open-ended questions are problematic in the sense that it is often not completed.
- The cover letter, in which the Rector of Technikon Pretoria briefly explained the survey and motivated students to participate, was often not read. Some

respondents were offended by the word “unmarried” in the biographical details section of the questionnaire and said that they would have preferred “single.” The same applied to “White” – some White respondents said that they also regard themselves as “African.”

- Although being told not to do so, some students wanted to discuss the questionnaire with one another. Some respondents – especially males – joked about the age at which they became sexually active. Students who had been approached once, complained when targeted for a second or third time. This especially occurred towards the end of the survey.
- Field workers cited uncertainty among – especially white - students on how one contracts HIV/Aids as a concern. There was some confusion and arguing whether, in fact, kissing, sharing of cutlery and toothbrushes etc. could lead to one becoming HIV-positive.

Many respondents expressed the need for more HIV-positive people to disclose their status and called it the “real stuff.” Respondents at the Arcadia and Arts Campuses felt left out with regards to HIV/Aids activities and expressed the need to become peer helpers and peer educators. Some respondents at Technikon Pretoria’s main campus said that the AIDS Centre should be more visible.

Most of the field workers said that being involved in the survey was a “great” experience.

The field workers and supervisors were given incentives in terms of payment, but their commitment to the study was unquestionable.

This process is recommended for future studies, in light of the fact that there was a 100% response rate recorded.

DATA ANALYSIS

Descriptive analysis – The first form of analysis that was used was in the form of a descriptive analysis whereby the researchers tried to transform the raw data into a form that was easy to understand and interpret. The most common methods that was utilised include frequency distributions and cross-tabulations. The frequency

distribution approach was followed to allow the researchers to find answers on questions based on a single variable. The objective of a frequency table is to display the number of responses associated with each value of a specific variable (Hair et al. 2003:232).

The purpose of the cross-tabulations were to allow for inspection of differences among groups trying to spot differences and make comparisons between the groups. Zikmund (2003:476) is of the opinion that cross-tabulations is an excellent way to help determine the form of relationship between two variables.

Measuring reliabilities - In general, the concept of reliability refers to how accurate, on the average, the estimate of the true score is in a population of objects to be measured. Thus, broadly speaking reliability is the degree to which measurements are free from error and therefore yield consistent results (Zikmund, 2003:300). A Cronbach Alpha reliability analysis was conducted to determine the internal consistency reliability of the analysis between the motivations for sex (Section 21) and engagement in different forms of sex (Section 20) of the questionnaire. The researchers based the analysis on the following assumptions:

- Observations made for section 20 and 21 were independent;
- Each pair of items would have a bi-variate normal distribution;
- Item scales were additive, so that each item is linearly related to the total score; and
- Data were dichotomous.

Hair, Babin, Money and Samouel (2003:173) provides the following rule of thumb to interpret alpha reliability values:

>0.6	=	Poor strength of Association
0.6 to < 0.7	=	Moderate strength of Association
0.7 to < 0.8	=	Good strength of Association
0.8 to < 0.9	=	Very good strength of Association
0.9	=	Excellent strength of Association

Measuring relationships – The phi coefficient, Cramer’s V coefficient and the Contingency coefficient were calculated to determine the association between

condom use and sexual transmitted infections. All three measures are chi-square based measures of association in which a value of zero (0) indicates no association between row and column variables whilst a value of 1 is indicative of a high degree of association.

Discriminant Analysis – This analysis was done to determine which variables are associated with best explaining:

- Condom use;
- Profiles of those involved in sexual activities with regard to enjoyment of sex, perceived coolness and popularity and lastly, expectations of partner.

Factor Analysis – Factor analysis was used a data reduction tool and as a technique to establish the construct validity of the measure of three reasons (the underlying variables) for having sex namely because of 1) the enjoyment of it, 2) it makes one looks cool or popular and 3) the partner expects it. Dancey and Reidy (2002) as quoted by Gbadamosi and Francis (2003:127) had noted that when performing a factor analysis, at least 100 participants should be used in the analysis and the study should have five times as many participants as variables. For this reason two questions (variables) were excluded from the analysis namely:

- Sex for money or gifts as only 41 respondents were engaged in this activity.
- Homosexual relationships as only 47 respondents were engaged in this activity.

Both criteria were met by this study with a five-item measure and between 111 to 1211 respondents engaged in different types of sexual activities. The Principal Components Analysis Methods and the Varimax rotation (an orthogonal rotation) methods were applied. In the Principal Component Analysis all of the variance in the data sets are used, while in common factor analysis only the common variance is used (Hair et al. 2003:361). Thus, the Principal Component Analysis includes the common, unique and error variance. In this study the researchers assumed that that the unique and error variance would be small, thus making the Principle Component Analysis suitable. The rotation method was then used to get another view of the factor structures and to obtain evidence of a simple structure in which each original variable

has a high loading on only one factor and relatively low loadings on the other derived factors. Hair et al (2003:362) mentioned that if such a simple structure can be achieved then it provides some evidence of convergent and discriminant validity. Thus, achieving a simple structure will be indicative that an original variable in the measuring instrument is highly related to only one latent factor.

In deciding how many factors to select the latent root criterion described by Hair et al (2003:363-364) was followed. According to Hair et al (2003) the latent root is a measure of the amount of variance a particular factor represents. This criterion states that with principle components analysis factors that have a latent root (eigen value) of one or higher is retained. Factors with a latent root of less than one are considered insignificant and are therefore not retained. Further, as a general rule of thumb Hair et al also proposed that the final factor solution should explain at least 60% of the total variance.

The researchers opt for three criterion to determine the final factor solution namely:

- The size of the latent root (eigen value);
- The total variance accounted for by the factors should be more than 60%; and
- The rotated factors should be able to be assigned a logical name.

To determine which factor loadings to include in naming a factor the guidelines provided by Hair et al (2003:366) were used namely:

+/- loadings of 0.3 were considered acceptable;

+/- loadings of 0.5 were considered moderately important; and

+/- loadings of 0.7 were considered very important.

DATA EDITING

Data was manually keyed into the database directly. The researchers also checked 15% of the coded questionnaires, as well as the actual database for possible coding or data entry errors. The questionnaires and data entries to be checked were selected on a systematic, random sampling process.

Missing data was not replaced in the data analysis phase. In the factor analysis and in the discriminant analysis observations with missing values were excluded from calculations. This procedure is allowable according to Hair et al (2003:231).

CONCLUSION

A survey was conducted amongst 1604 students from three facilities of Technikon Pretoria. The sample is considered as being representative of the composition of the student population. Great care was taken to ensure the validity and credibility of the data due to the sensitivity of the subject matter.

CHAPTER 3: DATA ANALYSIS AND INTERPRETATIONS

INTRODUCTION

This chapter summarises research results based on the data obtained from the survey. With regards to the variables where significant differences were found with regard to the responses, such differences are illustrated by means of tables and figures. For variables where no significant differences were found in response distributions of the respective groups, a breakdown of results into different groups is omitted.

DATA ANALYSIS

DEMOGRAPHIC PROFILE OF RESPONDENTS

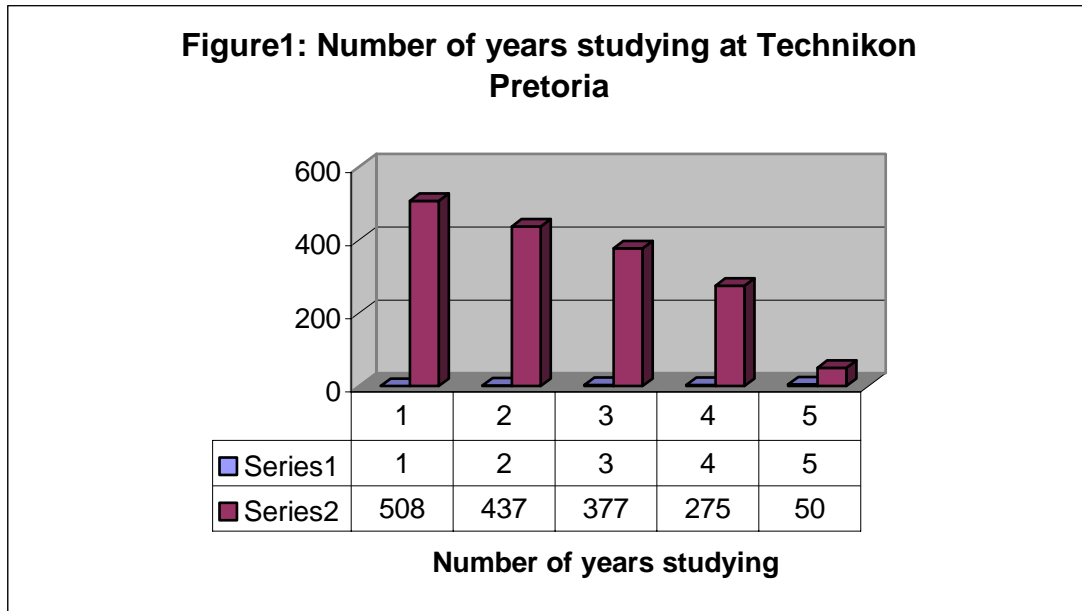
Table 3.1: Composition of students studying at Technikon Pretoria

	V2	No of years studying				Total
		1	2	3	4	
V1: No of 1 years studying	70	56	44	23	7	200
2	46	27	33	28	3	137
3	392	354	300	224	40	1310
Total	508	437	377	275	50	1647

A total of 1647 respondents were willing to complete the questionnaire. This represents a response rate of 102.6 %. Of the respondents 79,5% (n=1310) were studying at the main campus, 12,14% (n=200) at the Arcadia campus and 8,3% (n=137) at the Arts campus. Of these students 30,8% (n=508) were first year students, 26,5% (n=437) second year students, 22,9% (n= 377) third year students, 16,7% (n =

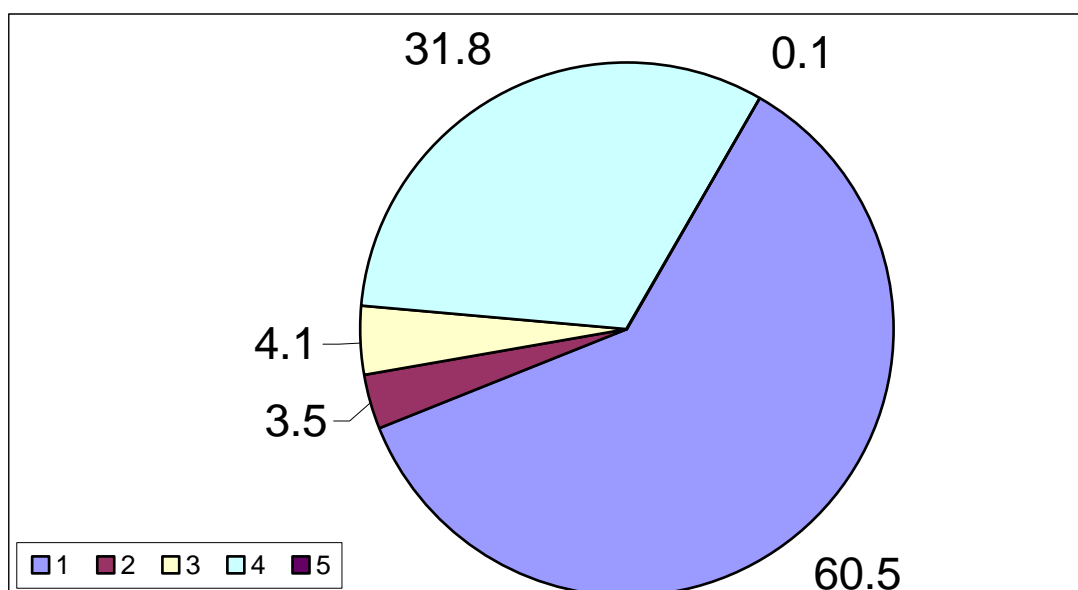
275) fourth year students and 3,0% (n= 50) in there fifth year of study at Technikon Pretoria. Figure 3.1 provides a profile of the number of years students studied at Technikon Pretoria.

Figure 3.1: Number of years studying at Technikon Pretoria



Most of the respondents, 98% (n=1637) were unmarried whilst just 2% were either married or divorced (n1= 28; n2 = 2) implying that this sample is primarily a representative description of **unmarried student youth**. The racial composition of the sample is representative of the population composition on the campus. Figure 3.2 provides insight into the racial sample composition.

Figure 3.2: Racial Composition of sample



Where:

1 = African

2 = Asian

3 = Coloured

4 = White

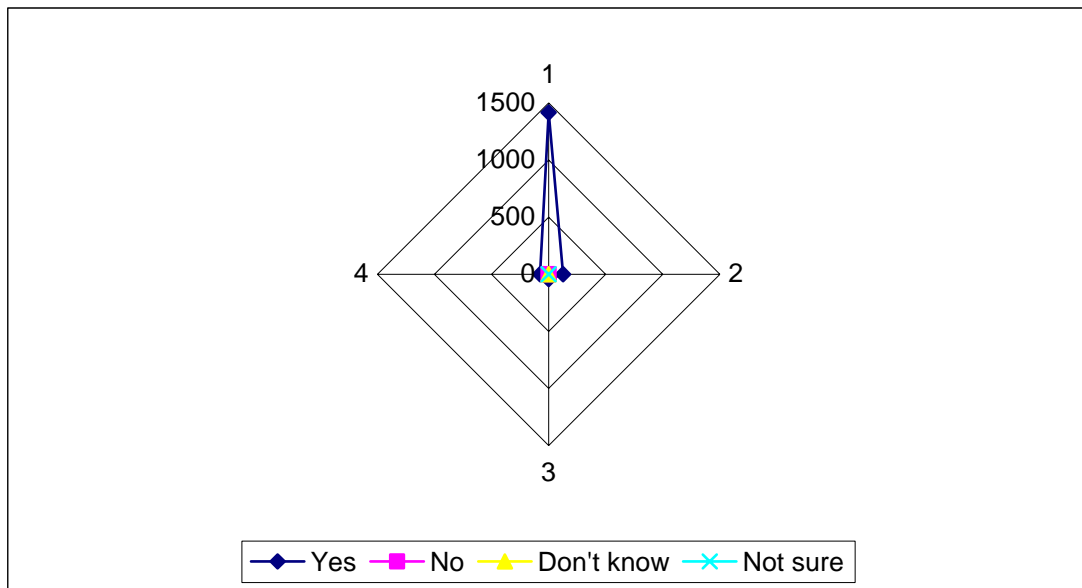
5 = Missing values

KNOWLEDGE PROFILE OF RESPONDENTS

Understanding existence of a difference between HIV and AIDS

The vast majority of respondents (84.9%; n=1418) indicated that there exists a difference between HIV and AIDS. Only 7.5% (n=126) of the respondents were of the opinion that there is no difference between HIV and AIDS while the rest of the respondents (7.1%; n=118) did not know or were unsure (See Figure 3.3).

Figure 3.3: Knowing the difference between HIV and AIDS



Where:

1 = Yes**

2 = No

3 = Don't know

4 = Not sure

Perceived highest age risk groups

A total of 92.2% responses indicated that people younger than 35 years of age has the biggest change to be infected by the HIV/AIDS virus, with the biggest vulnerability between the age group 15 years to 30 years. This perception was consistent between all the race groups. The age group up to 19 years old can be considered as a moderate potential, moderate risk age group if the data is related with Table 3.2: Sexual intercourse at different ages. On the other hand, the age groups above 20 years should be considered high potential, high risk age groups to be infected by the virus.

Table 3.2: Cross-tabulation between race and perceptions of HIV/AIDS age vulnerability

	-15 Y	15Y-19Y	20Y-25Y	26Y-30Y	31Y-35Y	36Y-40Y	41Y-45Y	+45Y	Total
African	76 (3.0%)	592 (23.5%)	822 (32.7%)	504 (20.0%)	293 (11.6%)	126 (5.0%)	64 (2.5%)	40 (1.6%)	2517 (100%)
Asian	4 (3.6%)	29 (26.2%)	43 (38.7%)	22 (19.8%)	9 (8.1%)	2 (1.8%)	1 (0.9%)	1 (0.9%)	111 (100%)
Coloured	6 (3.7%)	37 (22.8%)	52 (32.1%)	35 (21.6%)	15 (9.3%)	7 (4.3%)	5 (3.1%)	5 (3.1%)	162 (100%)
White	82 (7.9%)	247 (23.7%)	411 (39.6%)	182 (17.5%)	68 (6.5%)	26 (2.5%)	12 (1.2%)	11 (1.1%)	1039 (100%)
Total	168 (4.4%)	905 (23.6%)	1328 (34.7%)	743 (19.4%)	385 (10.1%)	161 (4.2%)	82 (2.1%)	57 (1.5%)	3829 (100%)



These perceptions differs somewhat from the realities of the South African situation. Van Rensburg et al (2002:27) founded on the contrary that of the 4.7 million South Africans infected with HIV by the end of 2000, with a prevalence rate of 16%, more than 50% were aged 15-24, with a prevalence rate of 16% in the 15-19 years group in 2000. Thus Table 1 may be indicative of the existence of denial amongst the youth respondents that they are a high risk or vulnerable group. On the other hand, the same authors also reported (2002:27) that the annual zero-prevalence survey among women attending antenatal clinics has shown that HIV prevalence among teenagers has not increased over the past three years, which suggests a more positive change in sexual and reproductive health behaviour among teenage women than among any other age category. As the awareness campaigns have mostly targeted the youth category up to now it may well be that it is beginning to bear fruit – at least in the 15 to 19 years category. This may also provide some evidence why respondents see the older youth groups as higher risk groups.

Identification of an HIV positive person

A total of 90.8% (n=1517) of the respondents indicated that one can not identify an HIV positive person by simply looking at the person (See figure 3.4). This reflects a good understanding of the fact that it is not possible to identify an HIV positive person by visual appearance. However, this percentage increases slightly to 91% when it is compared with the question “Do you have a friend or family member, who is HIV positive?” The change in percentage is however not significant (See Table 3.3).

Figure 3.4: Identification of an HIV positive person by visual appearance

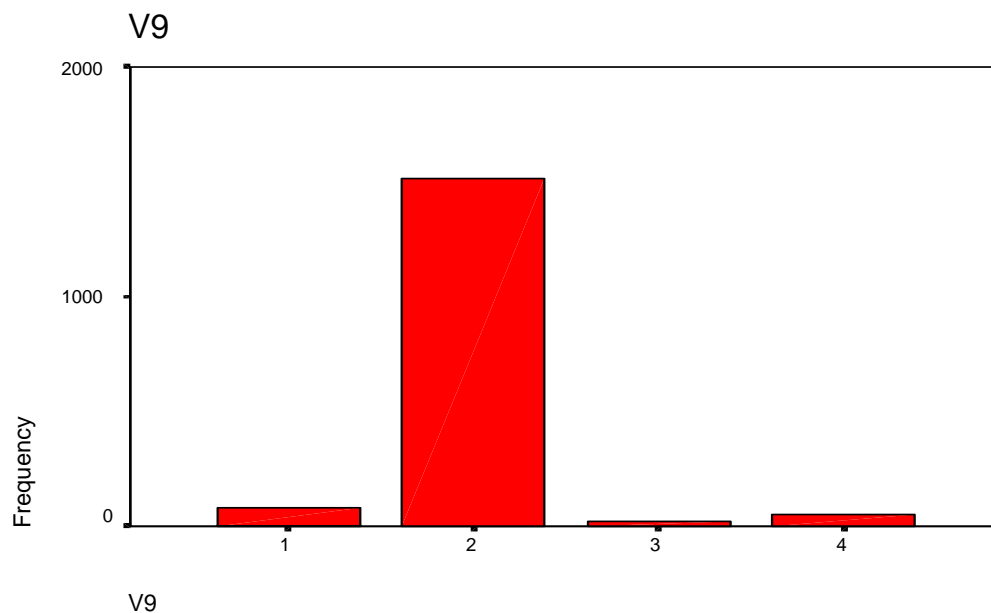


Table 3.3: Cross-table of Visual appearance of HIV infected person and having an HIV positive friend/family member

		V9				Total	
		1	2	3	4		
V76	1	Count	11	199		4	214
		% within V76	5.1%	93.0%		1.9%	100.0%
		% within V9	14.3%	13.2%		7.7%	13.0%
		% of Total	.7%	12.1%		.2%	13.0%
	2	Count	58	868	13	36	975
		% within V76	5.9%	89.0%	1.3%	3.7%	100.0%
		% within V9	75.3%	57.8%	68.4%	69.2%	59.1%
		% of Total	3.5%	52.6%	.8%	2.2%	59.1%
	3	Count	8	435	6	12	461
		% within V76	1.7%	94.4%	1.3%	2.6%	100.0%
		% within V9	10.4%	29.0%	31.6%	23.1%	27.9%
		% of Total	.5%	26.4%	.4%	.7%	27.9%
Total	Count	77	1502	19	52	1650	
	% within V76	4.7%	91.0%	1.2%	3.2%	100.0%	
	% within V9	100.0%	100.0%	100.0%	100.0%	100.0%	
	% of Total	4.7%	91.0%	1.2%	3.2%	100.0%	

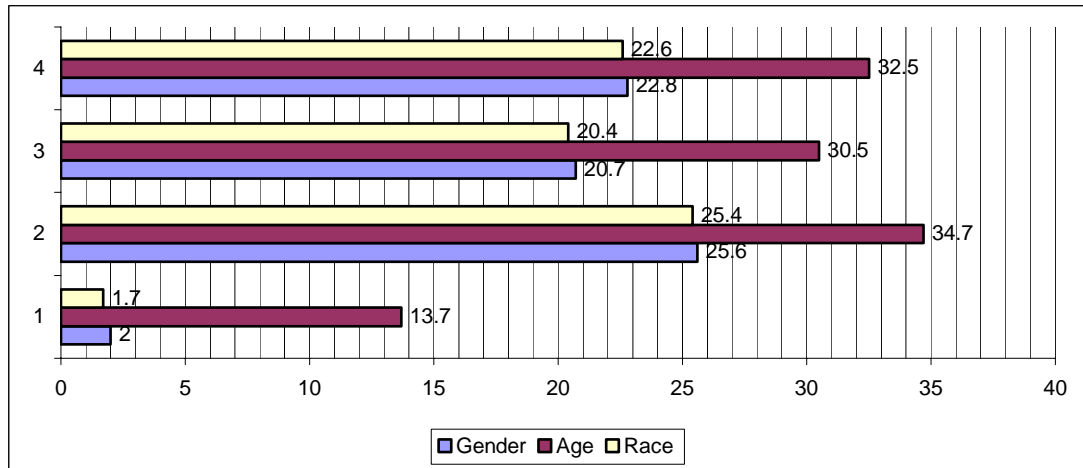
A total of 13% (n=214) of the respondents indicated that they do have a friend or family member, who is HIV positive. This percentage is below the estimated HIV infection rate in South Africa. This percentage is probably an underestimation of the true infection rate as 27.9% of the respondents (n= 461) indicated that they do not know whether they have a friend or family member, who is HIV positive.

Knowing one's HIV/AIDS rights

A significant percentage of respondents did not answer the questions relating to knowing their HIV/AIDS rights. The category knowing your HIV/AIDS rights as a potential employee received the highest non-response on all the categories i.e. gender, age and race, whilst knowing your HIV/AIDS rights received the lowest non-response

rate on all the categories. The factor contributing to the highest non-response rate was age, whilst no significant difference between gender and race could be detected. The non-respondents on all for questions were primarily of the age group below 23 years.

Figure 3.5: Percentage respondents not answering question on HIV/AIDS rights

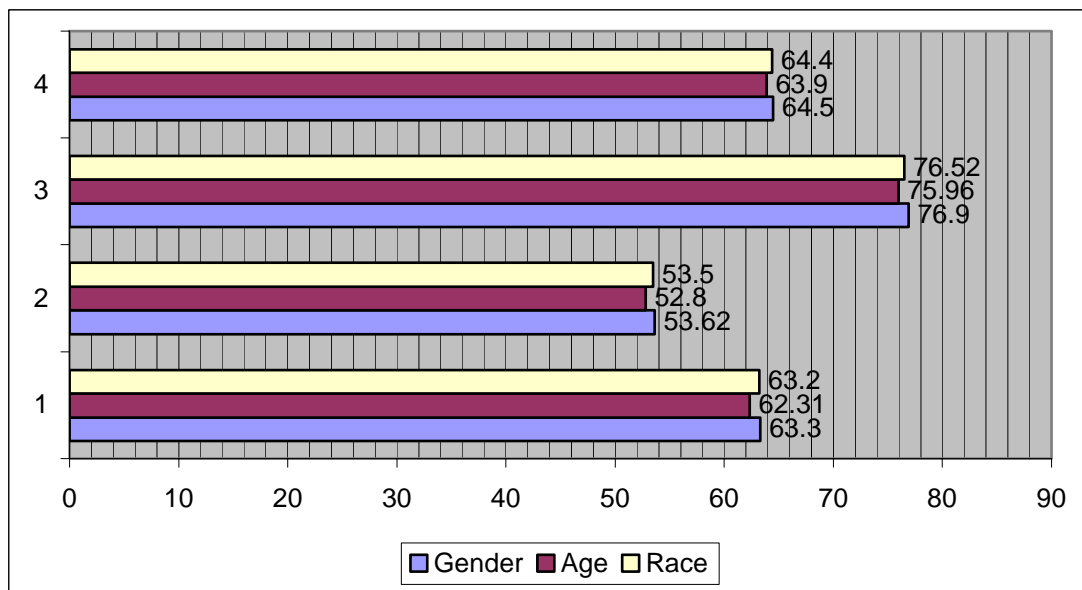


Where:

- 1 = Know your HIV/AIDS rights as a student
- 2 = Know your HIV/AIDS rights as a potential employee
- 3 = Know your HIV/AIDS rights in a personal relationship
- 4 = Know your HIV/AIDS rights as a member of civil society

No significant differences could be found between gender, age and race with regards to knowing their HIV/AIDS rights of those respondents able to answer the questions (See figure 3.6). It is interesting to note that all three categories of respondents understand their rights in a personal relationship the best, whilst understanding their rights as a potential employee the worst. It seems much can be done to improve respondents understanding of their HIV/AIDS rights in all spheres of life, but especially in spheres that extends further from the personal area.

Figure 3.6: Knowing HIV/AIDS rights



Where:

- 1 = Understanding rights as a student.
- 2 = Understanding rights as a potential employee
- 3 = Understanding rights in a personal relationship
- 4 = Understanding rights as a member of civil society

SEXUAL PROFILE OF RESPONDENTS

A total of 68.3% (n=1140) indicated that they already have had sexual intercourse. Only 31.1% (n=520) indicated that they never had sexual intercourse before. (See Table 3.4).

Table 3.4: Sexual intercourse profile of respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1140	68.3	68.7	68.7
	2	520	31.1	31.3	100.0
	Total	1660	99.4	100.0	
Missing	System	10	.6		
Total		1670	100.0		

Figure 3.7 indicates that the Indian respondents appear to abstain more from sexual intercourse than the other race groups. As the sample size of this group is relatively

small no conclusive conclusions could be made about this aspect. The White population is more or less evenly spread between no sexual intercourse and sexually active with percentages of 47% and 53% respectively. The Black and Coloured respondents show a clear tendency to being sexually active with percentages of 79% and 74% respectively. A significant low Phi-correlation of 0.290 was calculated indicating some degree of relationship between race and the sexual activities of respondents.

Figure 3.7: Sexual Intercourse of different race groups

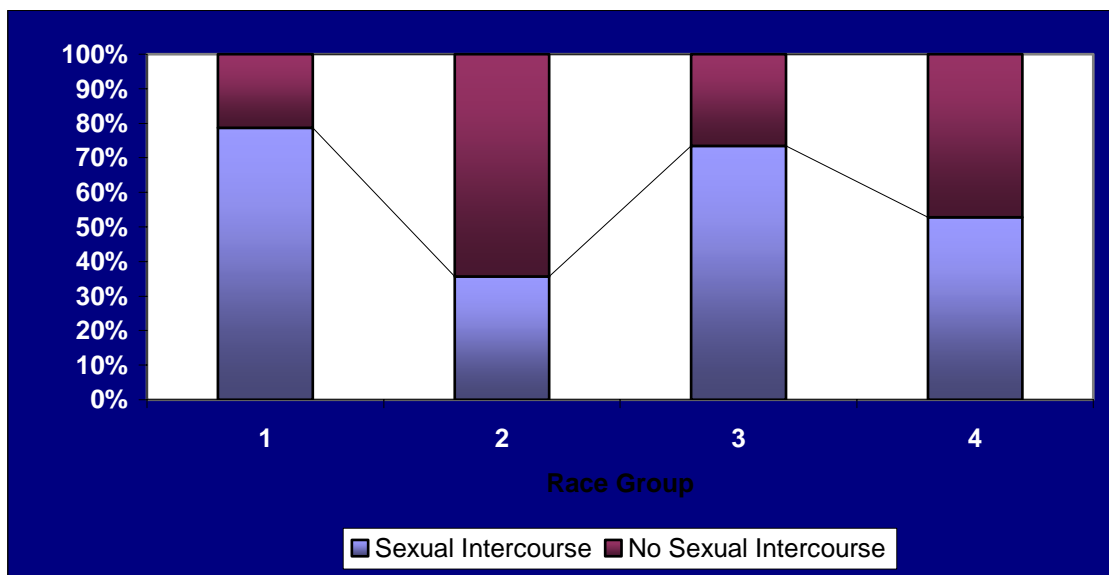
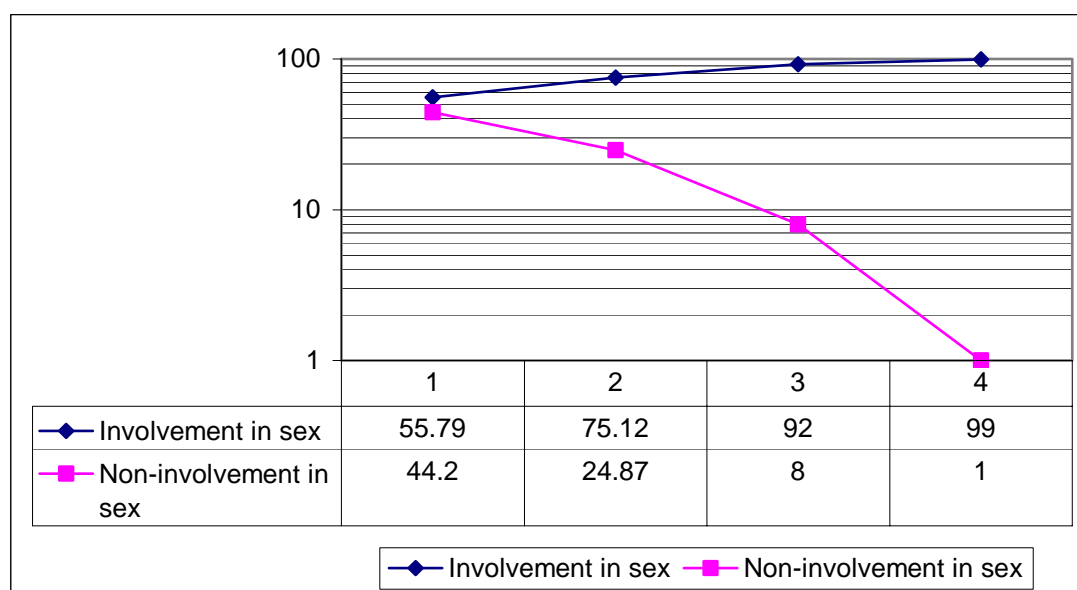


Table 3.5 and figure 3.8 provides an indication of sexual activity for the different age group respondents. It is clear that a positive relationship exists between sexual intercourse and an increase in age. On the other hand, an inverse relationship exists between abstaining from sex and an increase in age. Thus, the potential for sexual intercourse increases as the age of respondents increases. One can deduce that the chances of having sex between the ages of 15 to 19 years are moderate, whilst the chances of having sex when twenty years and older are extremely high.

Table 3.5: Sexual intercourse at different age groups

Age	Yes	No	Total
15-19	332 (55.79)	263 (44.20)	595 (100%)
20-25	625 (75.2%)	207 (24.87%)	832 (100%)
26-30	23 (92%)	2 (8%)	25 (100%)
31-35	3 (100)	0 (0%)	3 (100%)

Figure 3.8: Sexual intercourse at different age groups (Logarithmic scale)



CONDOM USE

A total of 57.2% (n=955) of the respondents indicated that they did use a condom with their most recent sexual partner, whilst 11.3% (n= 189) did not make use of a condom. Figure 3.9 and Table 3.6 provide insight in the use and not use of condoms with the most recent sexual partner.

Figure 3.9: Condom use with last sexual partner

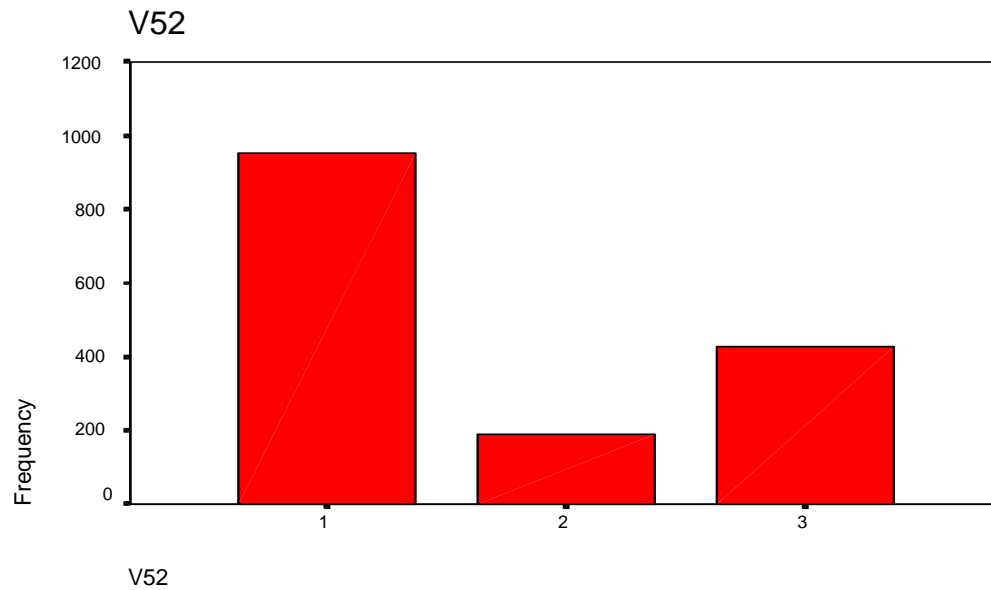


Table 3.6: Condom use with last sexual partner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	955	57.2	60.7	60.7
	2	189	11.3	12.0	72.7
	3	430	25.7	27.3	100.0
	Total	1574	94.3	100.0	
Missing	System	96	5.7		
Total		1670	100.0		

The percentage condom users with last sexual partners is significantly higher than condom use statistics provided by the Department of Health in 1998, as quoted by Van Rensburg et al (2002: 23) in Table 3.8.

Table 3.8: Condom Use in the different provinces during 1998

Province	% Women (15-49 years) using a condom during last sex with any partner
KwaZulu-Natal	6.7
Mpumalanga	9.5
Gauteng	10.4
Free State	10.9
North West	9.0
Eastern Cape	6.1
Limpopo	6.4
Northern Cape	5.0
Western Cape	8.1
National Average	8.2

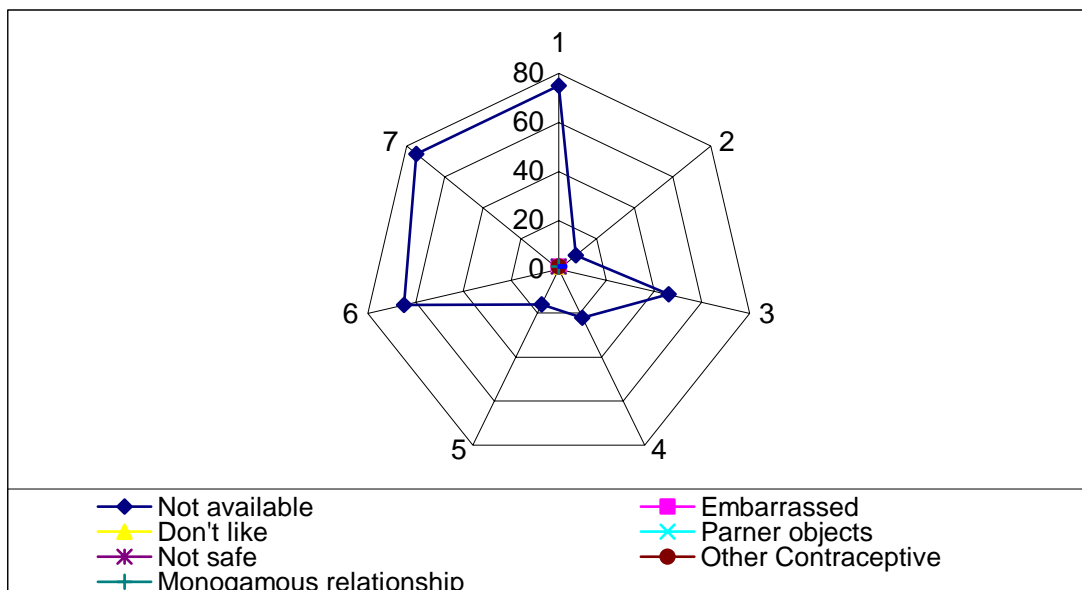
The differences between these averages may be indicative that publicity programmes promoting condom use did indeed have an impact to change the sexual behaviour in the population towards the practising of safer sex. On the other hand, the higher condom use amongst students may also be due to better access to information than the population in general.

The major reasons provided by respondents for not using a condom as indicated by figure 3.10 are:

- Condoms were not available;
- I am in a monogamous relationship;
- Used other contraceptive; and
- Don't like condoms.

One can speculate that it seems that respondents are not embarrassed to buy condoms, nor do they think that condoms are not safe as suggested by Grobler (2000:39).

Figure 3.10: Reasons for not using condoms



Where:

- 1 = Condoms not available**
- 2 = Embarrassed to buy
- 3 = Don't like them*
- 4 = Partners objects
- 5 = Didn't think it was safe
- 6 = Used other contraceptive**
- 7 = In a Monogamous relationship**

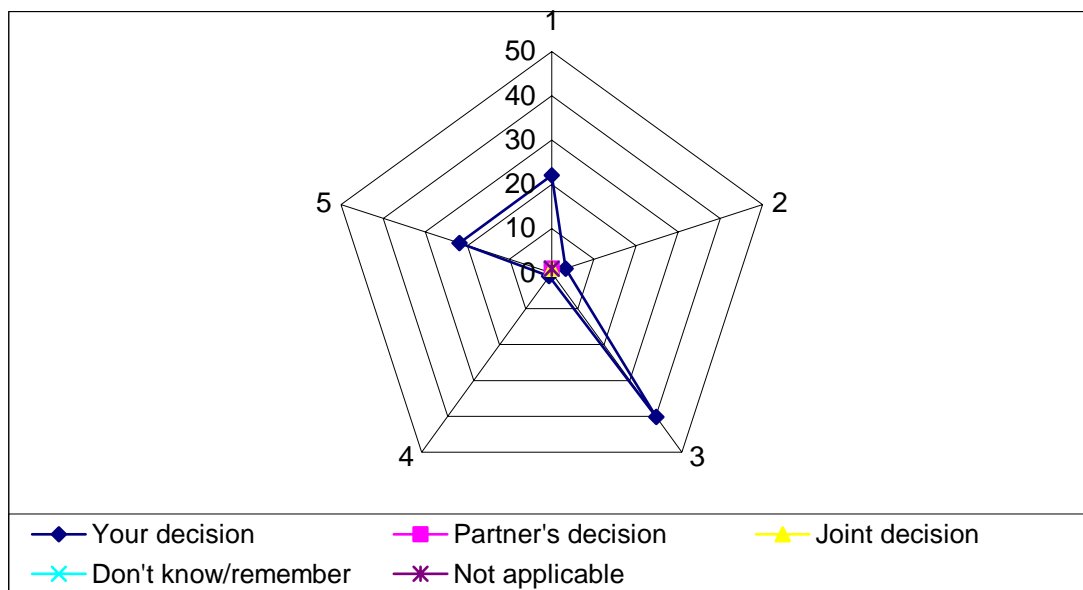
An aspect that was not researched is the regularity of condom use. In Namibia Grobler (2000:45) found that 50% of respondents use condoms inconsistently. This is an aspect that also needs to be investigated.

Amongst the users of condoms with their most recent sexual partner the following results were revealed as indicated by Table 3.8 and Figure 3.11:

Table 3.9: Decision node in condom use

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	367	22.0	24.9	24.9
	2	53	3.2	3.6	28.5
	3	672	40.2	45.6	74.0
	4	17	1.0	1.2	75.2
	5	366	21.9	24.8	100.0
	Total	1475	88.3	100.0	
Missing	System	195	11.7		
Total		1670	100.0		

Figure 3.11: Decision node in condom use



Where:

1 = Own decision*

2 = Partner's decision

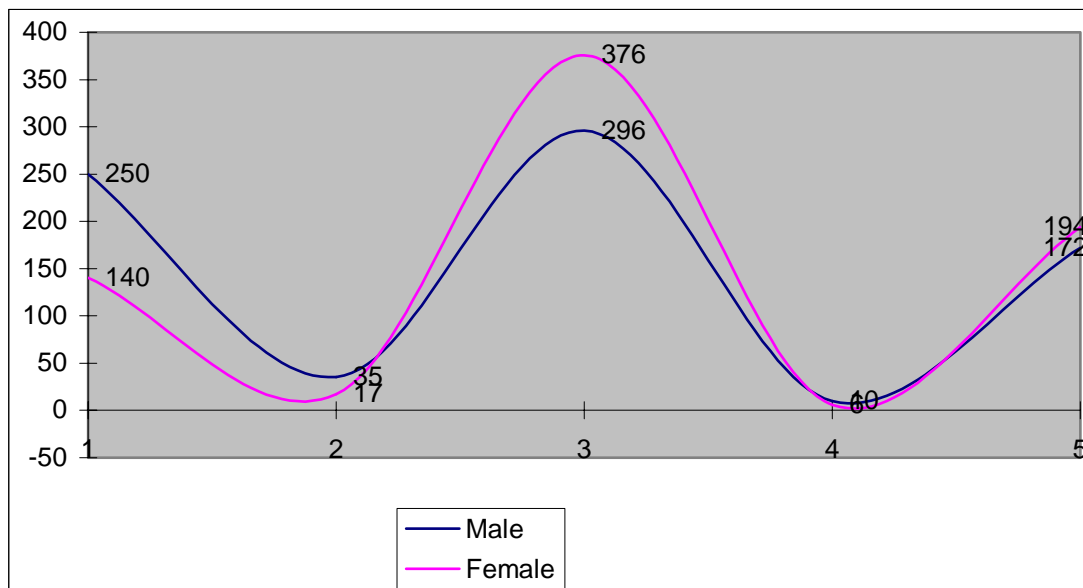
3 = Joint decision***

4 = Don't know/remember

5 = Not applicable*

The data revealed that condom use was primarily based on a joint decision (40.2%) made by both partners whilst 22% was of the opinion that they made the decision. It is interesting to realise that 33.6% (n= 561) respondents did either not answer the question or indicated that the alternatives provided did not explain their reasons for using a condom during sexual intercourse. Figure 3.12 indicates that female respondents have a greater tendency than the male respondents to base their decisions on own decisions and vice versa. Both genders deny that the decision to use condoms is made by the other partner. One can therefore deduct that condom use has the best chance to be implemented if it is a joint decision by both partners. It is assumed that responses allocated to value 1 (Own decision) may share a high communality with response 3 (Joint decision).

Figure 3.12: Gender decisions on condom use.



Where:

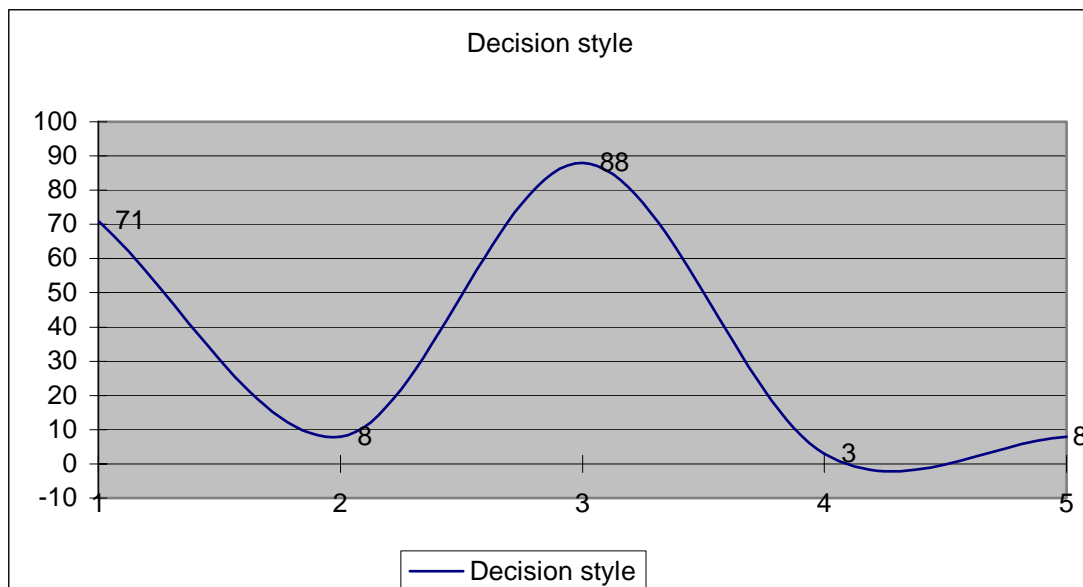
- 1 = Own decision
- 2 = Partner's decision
- 3 = Joint decision
- 4 = Don't remember
- 5 = Not applicable

A discriminant analysis was conducted to determine which variables explained best condom use as it relates to the variety of sexual activities in which the respondents engaged (Section 20) in. The following equation best explains condom use:

$$\text{Condom Use} = 0,754 \text{ Sex for money} + 0,665 \text{ Multiple Sex Partners} + 0,586 \text{ Homosexual Relationships} + 0,464 \text{ Sex without consent} + 0,317 \text{ Casual Oral Sex}$$

This implies that most people engaging in sex for money, having multiple sex partners, having homosexual relationships, having sex without consent, or who are involved in casual oral sex have a tendency to use condoms. Those people involved in steady relationships and those having casual sexual intercourse have a less tendency to use condoms. Thus, people involved in high-risk sexual activities are more inclined to use condoms. The study also revealed that 89.78% (n=186) respondents engaging in multiple sexual partner activities indeed use condoms through joint decision-making or by own decision indicating an understanding of the risks involved in multiple sexual relationships. This is indicated by figure 3.13.

Figure 3.13: Decision-making style of condom users amongst multiple sexual partners.



Where:

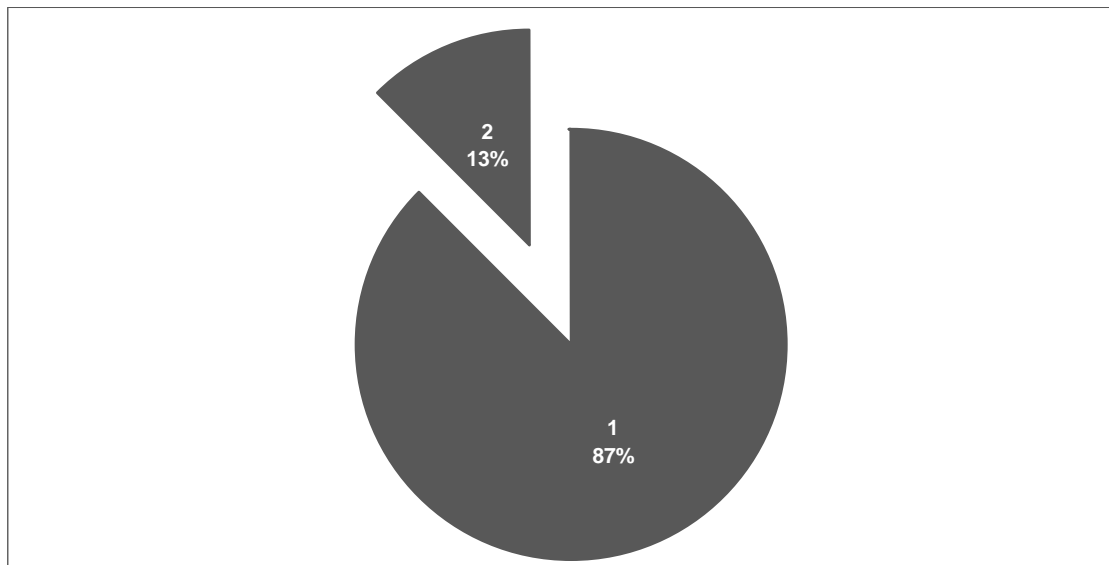
- 1 = Own decision
- 2 = Partner's decision
- 3 = Joint decision

4 = Don't know/remember

5 = Not applicable

A total of 87% of respondents (n=978) indicated that they found it easy to introduce a condom into their relationship. Only a small proportion of respondents found it not so easy. (See figure 3.14).

Figure 3.14: Ease of introducing the use of condoms



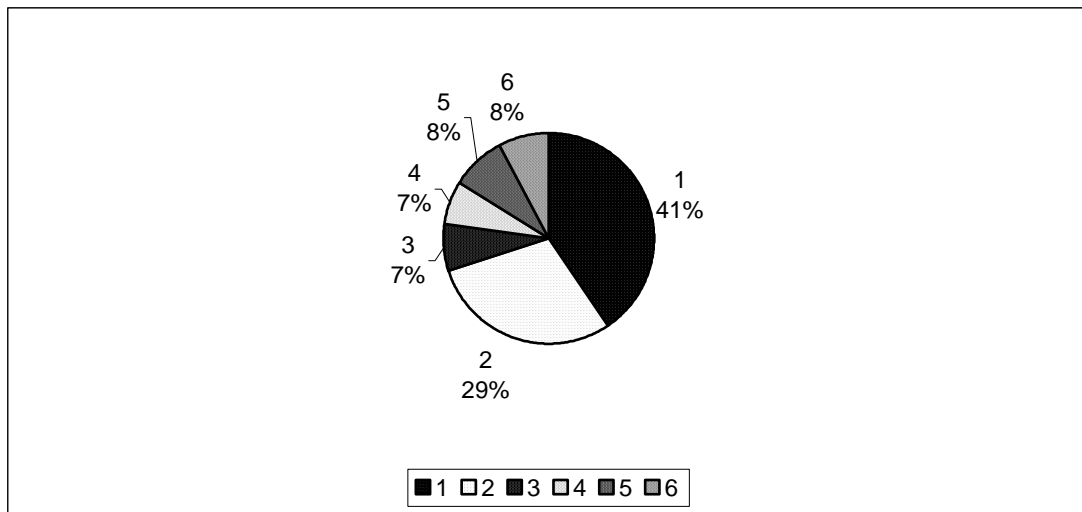
WHERE:

1 = Easy to introduce a condom into relationship

2 = Not so easy to introduce a condom into relationship

A total of 41% (n=1118) of the respondents indicated that they obtained their condoms from a pharmacy, followed by 29% (n=808) obtained condoms from the Campus AIDS Consultancy Centre. Only 7% (n=181) used the Campus Clinic to obtain condoms. The rest of the respondents (23%) indicated that they obtained condoms from a private doctor, a family planning centre or from other sources. It is interesting to realise that the majority of the respondents are thus willing to pay for obtaining condoms. The relatively high percentage (29%) of respondents indicating that they obtained condoms from the Campus AIDS Consultancy Centre may be indicative of the trust relationship already established between the students and the Consultancy Centre (Figure 3.15).

Figure 3.15: Condom Sources



WHERE:

1= Pharmacy

2 = Campus AIDS Consultancy Centre

3 = Private Doctor

4 = Campus Clinic

5 = Family Planning Centre

6 = Other

Table 3.9 provides information regarding the use and non use of condoms and how it relates to having experienced an Sexual transmitted infection (STI). Three coefficients of associations were determined namely the Phi coefficient, Cramers'V and the Contingency coefficient. No significant relationship could be found between condom use and the experiencing of a sexual transmitted infection. Table 5 provides an indication of the insignificant associations. No evidence thus exists in this sample that the use of condoms reduced or had an effect on transmission of sexual infections.

Table 3.9: Cross tabulation between Condom use and STI

		V61: Experienced STI			Total
		Yes	No	Not sure	
V52: Condom use	Yes	4	856	53	953
	No	17	158	14	189
	Not Applic.	6	405	8	419
Total		67	1419	75	1561

Table 3.10: Association between Condom use and STI

Association Measure	Value	Significance
Phi	0.143	0.000**
Cramer's V	0.101	0.000**
Contingency Coefficient	0.141	0.000**

ENGAGEMENT IN SEXUAL RELATIONSHIPS

It is clear from Table 3.11 and figure 3.16 that the majority of respondents (58%) indicated they were not involved in any casual sexual intercourse, whilst 42% of the respondents indicated seldom to regular casual sexual intercourse. A total of 121 respondents did not indicate whether they had any casual sexual intercourse relationships. However, these figures seem to be an under estimate of sexual behaviour as 60.6% (n=955) responded, “yes” to condom use.

Figure 3.16: Engagement in casual sexual intercourse

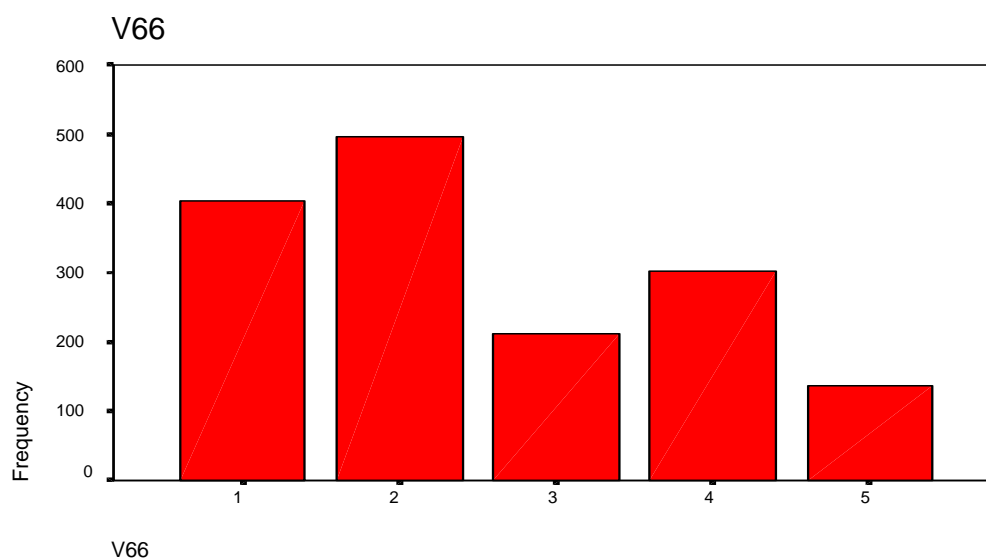


Table 3.11: Engagement in casual sexual intercourse

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	403	24.1	26.0	26.0
	2	496	29.7	32.0	58.0
	3	211	12.6	13.6	71.7
	4	302	18.1	19.5	91.2
	5	137	8.2	8.8	100.0
	Total	1549	92.8	100.0	
Missing	System	121	7.2		
Total		1670	100.0		

A total of 39.3% of the respondents indicated that they were engaged in a steady relationship while a total of 22.4% were never involved in a steady relationship. A total of 33.1% of the respondents were at some stage involved in a steady relationship. One can thus deduct that at least 72.4% of the respondents were at some stage in their lives involved in a steady relationship.

Figure 3.17: Steady Relationships

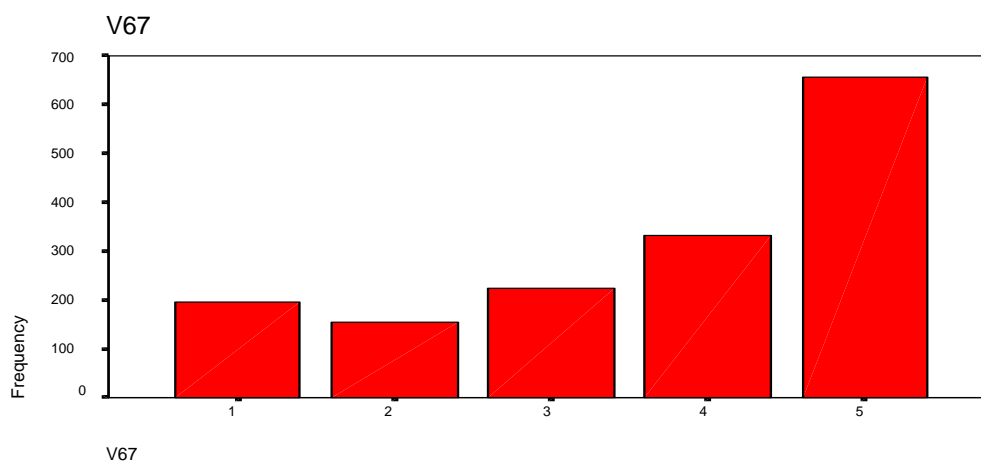


Table 3.12: Steady Relationships

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	195	11.7	12.5	12.5
	2	154	9.2	9.9	22.4
	3	223	13.4	14.3	36.7
	4	331	19.8	21.2	57.9
	5	657	39.3	42.1	100.0
	Total	1560	93.4	100.0	
Missing	System	110	6.6		
Total		1670	100.0		

The majority of respondents (61.5%) – both sexually active and not sexually active – indicated that they are not involved in casual oral sex. A total of 38.5% however indicated that they were involved in casual oral sex activities. As 138 respondents did not answer the question one can assume that this might be an under-estimation (See Figure 3.18 and Table 3.13).

Figure 3.18: Engagement in casual oral sex

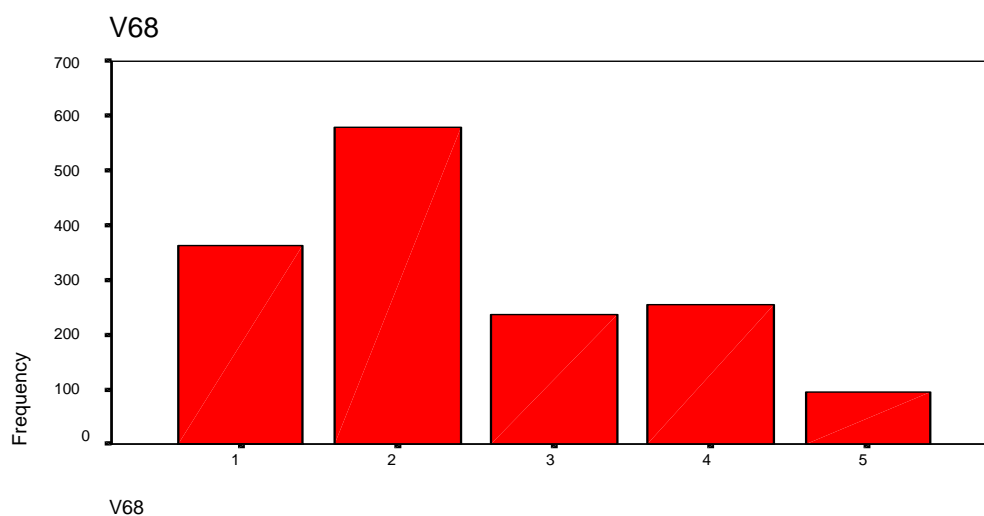


Table 3.13: Engagement in casual oral sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	362	21.7	23.6	23.6
	2	579	34.7	37.8	61.5
	3	238	14.3	15.5	77.0
	4	256	15.3	16.7	93.7
	5	96	5.7	6.3	100.0
	Total	1531	91.7	100.0	
Missing	System	139	8.3		
Total		1670	100.0		

A total of 92.8% (n= 1436) of the respondents indicated that they never had sex without their consent. Only 7.2% indicated that at some stage in their lives had they had sex against their will. A total of 123 respondents did not answer the question.

Figure 3.19: Having sex without consent

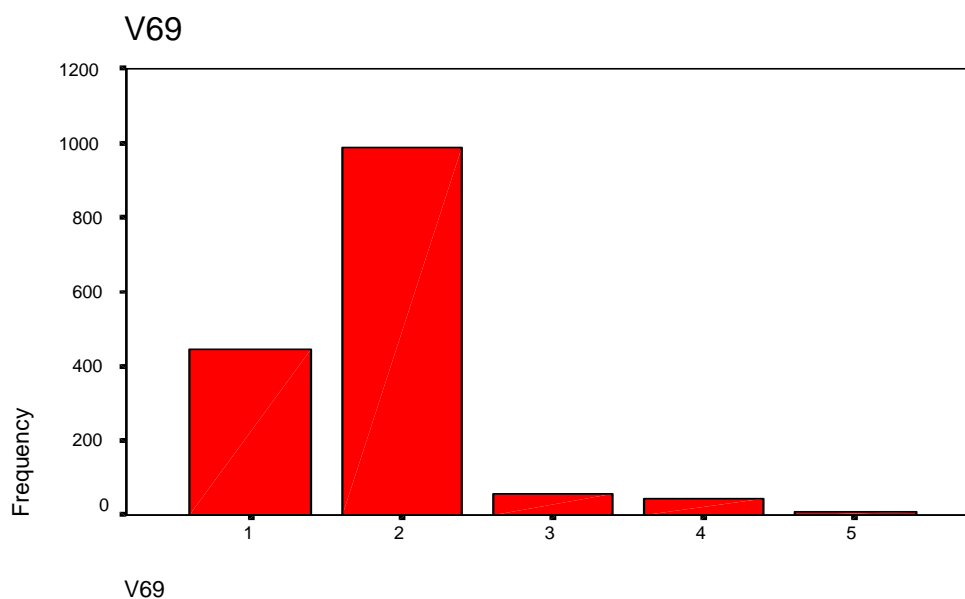


Table 3.14: Having sex without consent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	447	26.8	28.9	28.9
	2	989	59.2	63.9	92.8
	3	59	3.5	3.8	96.6
	4	44	2.6	2.8	99.5
	5	8	.5	.5	100.0
	Total	1547	92.6	100.0	
Missing	System	123	7.4		
Total		1670	100.0		

A total of 98% of the respondents indicated that they were never engaged in sex for money or gift purposes. The remaining 2% (n=31) of the respondents indicated engagement for money or gift purposes. A total of 113 respondents did not answer the question. (See Figure 3.20 and Table 3.15).

Figure 3.20: Engagement in sex for money or gifts

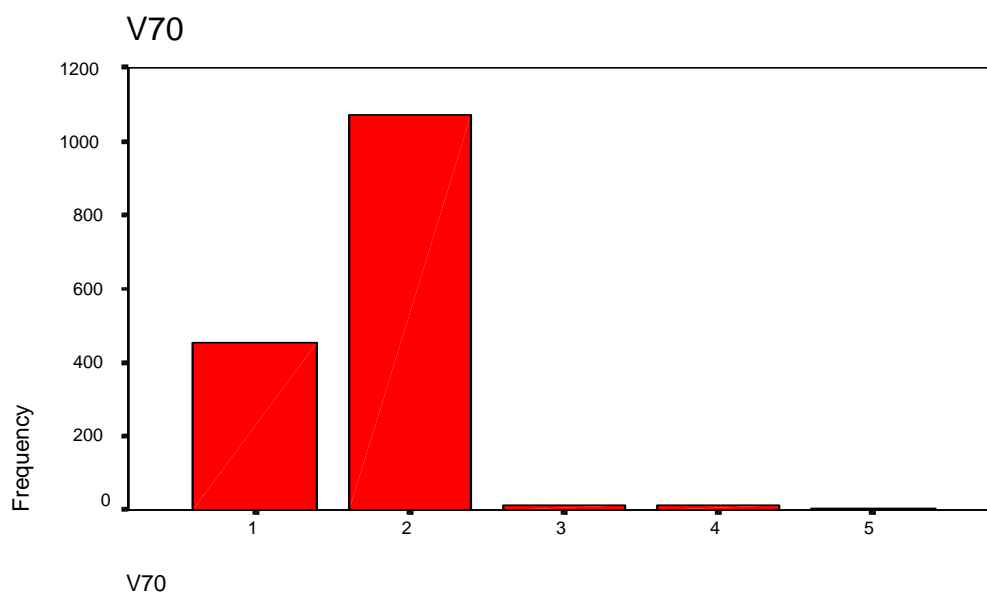


Table 3.15: Engagement in sex for money or gifts

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	456	27.3	29.3	29.3
	2	1070	64.1	68.7	98.0
	3	13	.8	.8	98.8
	4	13	.8	.8	99.7
	5	5	.3	.3	100.0
	Total	1557	93.2	100.0	
Missing	System	113	6.8		
Total		1670	100.0		

The majority of respondents (87.2%; n=1352) indicated that they were not involved in multiple sexual partner activities. The remainder of the respondents (12.8%; n=198) on the other hand indicated are thus involved in poly-paternism (the custom to have more than one sexual partner). A total of 120 respondents did not answer the question.

Figure 3.21: Engagement with multiple sex partners.

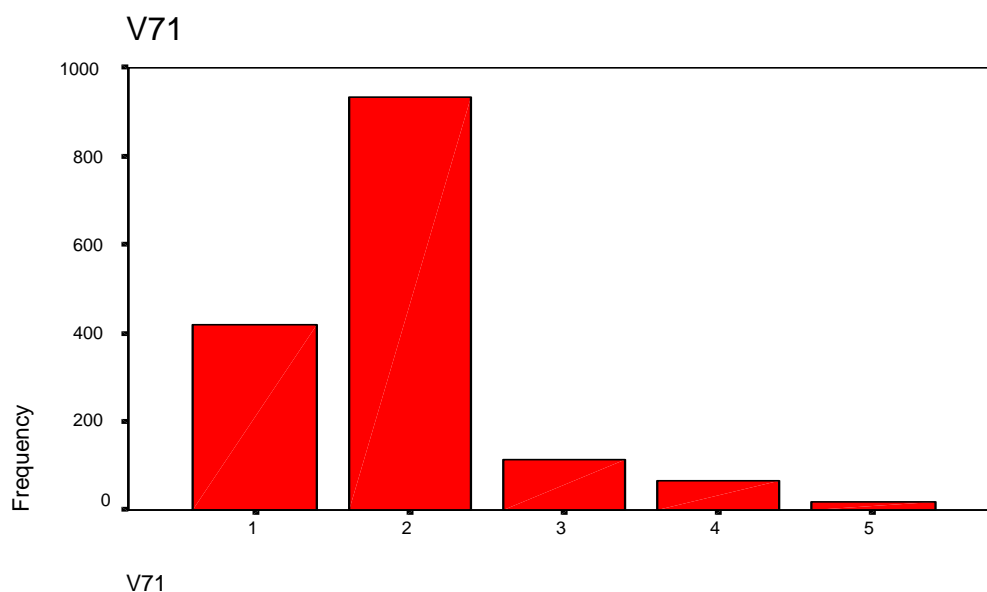


Table 3.16: Engagement with multiple sex partners.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	419	25.1	27.0	27.0
	2	933	55.9	60.2	87.2
	3	113	6.8	7.3	94.5
	4	66	4.0	4.3	98.8
	5	19	1.1	1.2	100.0
	Total	1550	92.8	100.0	
Missing	System	120	7.2		
Total		1670	100.0		

The vast majority of students (97.0%; n=1502) indicated that they are not involved in any homosexual relationships. Only 2% (n=47) of the respondents demonstrated an inclination towards homosexual activities. A total of 121 of the sample respondents did not answer the question.

Figure 3.22: Engagement in homosexual relationships

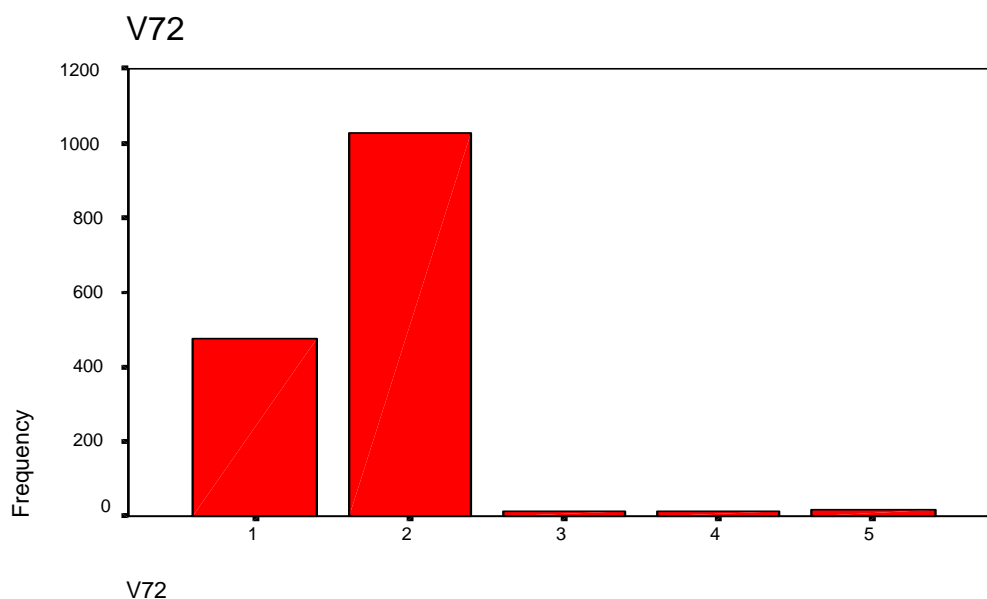


Table 3.17: Engagement in homosexual relationships

V72

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	476	28.5	30.7	30.7
	2	1026	61.4	66.2	97.0
	3	14	.8	.9	97.9
	4	15	.9	1.0	98.8
	5	18	1.1	1.2	100.0
	Total	1549	92.8	100.0	
Missing	System	121	7.2		
Total		1670	100.0		

PROFILES OF THOSE INVOLVED IN SEXUAL ACTIVITIES

Reliability of data

A Cronbach Alpha coefficient of 0.6272 was obtained for section 21 and 0.8103 for section 22 implying a moderate level of internal consistency, based on the average inter-item correlations.

Enjoyment of sex: The activities

The enjoyment of sex of those respondents whom were sexually active can best be attributed to the following four factors through the discriminant analysis:

- Casual sexual intercourse (0.755)
- Casual oral sex (0.476)
- Multiple sexual partners (0.415)
- Steady Relationships (0.394)

This clearly indicates that students at tertiary institutions approach the sexual experience and the enjoyment they get from it in more adventurous and experimental ways. Steady relationships as prerequisite for enjoyment were only rated fourth. This statement is supported by the factor analysis conducted indicating that 65.573% of the variance can be explained in terms of two factor components (Table 3.18) namely 1) that respondents involved in sex found the most enjoyment by having casual multiple sexual intercourse or by 2) having oral sex in a steady relationship as indicated by Table 8. The percentage of 65.573% is indicative of a relatively high construct validity for the measurement of enjoyment of sex.

Table 3.18: Factors explaining sex enjoyment.

FACTOR	FACTOR STRUCTURE
Factor1: Casual multiple sexual intercourse.	Q71) Multiple sexual partners Q66) Casual sexual intercourse Q66) Sex without consent
Factor 2: Oral sex in steady relationship	Q67) Steady relationships Q68) Casual oral sex

It makes me feel look cool/popular

Two distinct function structures could be identified that explain the coolness/popularity motivation for sex namely:

- a. Function 1 which explains 68,3% of the variance and consist of the following variables:
- Multiple sexual partners (0,616 correlation with the discriminant function).
 - Casual sexual intercourse (0.540 correlation with the discriminant function).
 - Steady relationships (-0.337 correlation with the discriminant function).

The three variables indicated contribute to a positive view of looking cool and popular. Thus having multiple sexual partners, casual sexual intercourse and not having steady relationships is perceived as making one cool and popular.

- b. Function 2 which explains 24.9% of the variance and consist of the following variables:
- Sex for money or gifts (0.869 correlation with the discriminant function).
 - Sex without consent (0.555 correlation with the discriminant function).

However the latter two variables contribute to a negative perception of looking cool and popular. Thus, the respondents disagreed that sex for money or without consent can contribute to a cool and popular image.

The functions that best describes coolness and popularity are:

$$F1: \text{Coolness/Popularity} = 0.671\text{MSP} + 0.387\text{SCR} - 0.402\text{SR}$$

WHERE:

MSP = Multiple Sex Partners

MSP = Casual Sexual Intercourse

SR = Steady Relationships

$$F2: \text{Coolness/Popularity} = 0.854\text{SFM} + 0.161\text{SWC}$$

WHERE:

SFM = Sex for Money/Gifts

SWC = Sex without consent

The factor analysis conducted again supported this view. The two components extracted explain 58.93% of the total variance. Table 3.19 provides some insight on the factor structure of each component which was labelled as 1) intimate relationships and 2) denied multiple intimate relationships. The latter factor may be indicative of unconscious consent or pretended denial. The 58.93% explanation of the variance is indicative of moderate evidence of construct validity of the measurement “It makes me look cool/popular. It is advisable that this component requires a more rigorous investigation to confirm the findings.

Table 3.19: Factors explaining coolness or popularity

FACTOR	FACTOR STRUCTURE
Factor 1: Intimate relationships	Q68) Casual oral sex Q66) Casual sexual intercourse Q67) Steady relationships
Factor 2: Denied multiple intimate relationships	Q69) Sex without consent Q71) Multiple sexual partners

Expectations of partner

The following variables explain 87,2% of the variance of the motivation for sex of respondents based on the expectations of partners:

- Multiple Sex Partners (0.671 Correlation with the Discriminant function)
- Casual Sexual Intercourse (0.647 Correlation with the Discriminant Function)

These two variable contribute to an agree to strongly agreement that partners expect of respondents to engage in Multiple Sex Partners activities and having Casuaul Sexual Intercourse.

The function that best describes the expectations of partners is:

$$F3: \text{Expectation of Partner} = 0.630\text{MSP} + 0.458\text{CSI}$$

WHERE:

MSP = Multiple Sex Partners

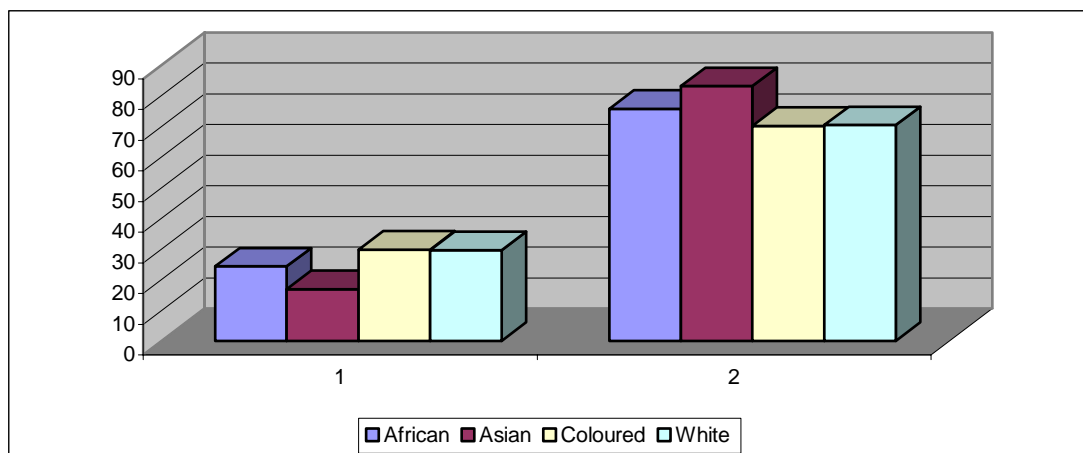
CSI = Casual Sexual Intercourse

However, the factors explaining the expectations of partners are the same as the factors explaining coolness and popularity, namely intimate relationships and denied multiple intimate relationships. The 55.939% explanation of the variance is indicative of moderate evidence of construct validity of the measurement “My partner expects it of me”. It is advisable that this component requires a more investigation to confirm the findings.

TESTING FOR HIV/AIDS

The majority of respondents never had an HIV test. Yet, a substantial percentage (On average 26%) in all race groups had themselves tested indicating a growing awareness of HIV/AIDS amongst the youth. A slight increase in percentages is also observed when the sexually active respondents are compared to the not sexually active respondents (See figure 3.23). This may be indicative of a greater awareness of HIV/AIDS amongst the sexually active respondents.

Figure 3.23: HIV/AIDS testing amongst race groups

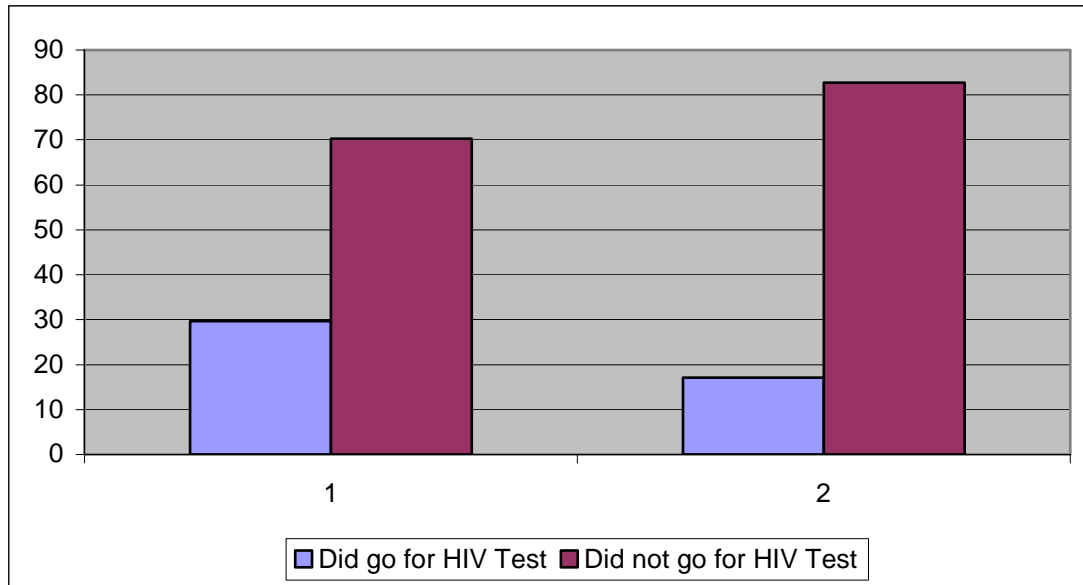


Where:

1 = Respondents had have an HIV test

2 = Respondents hah not have an HIV test

Figure 3.24: HIV/AIDS testing according to sexual activity status



Where:

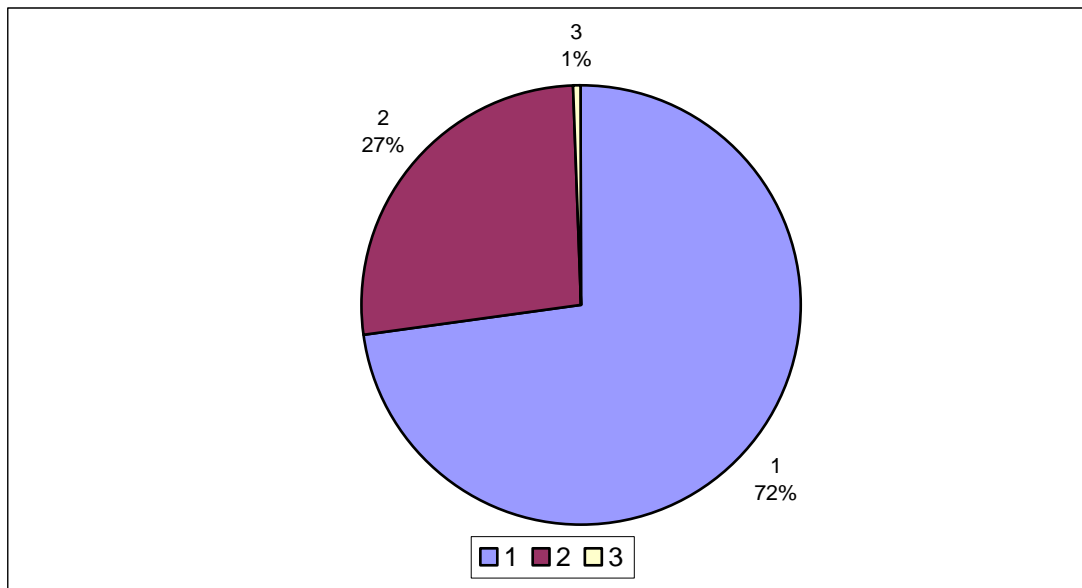
1 = Sexually active respondents

2 = Sexually not active respondents

AWARENESS OF TECHNIKON PRETORIA AIDS CENTRE

A total of 72% (n= 1215) of the respondents indicated that they are aware of the AIDS Centre at Technikon Pretoria, whilst only 27% (n= 445) were not aware of the AIDS Centre. Only 10 respondents (1%) did not answer the question (See Figure 3.25). However, of the 72% respondents indicating an awareness of the AIDS Centre only 17% (n= 209) have made use of the services offered by the Centre as indicated by figure 3.26.

Figure 3.25: Awareness of AIDS Centre at Technikon Pretoria



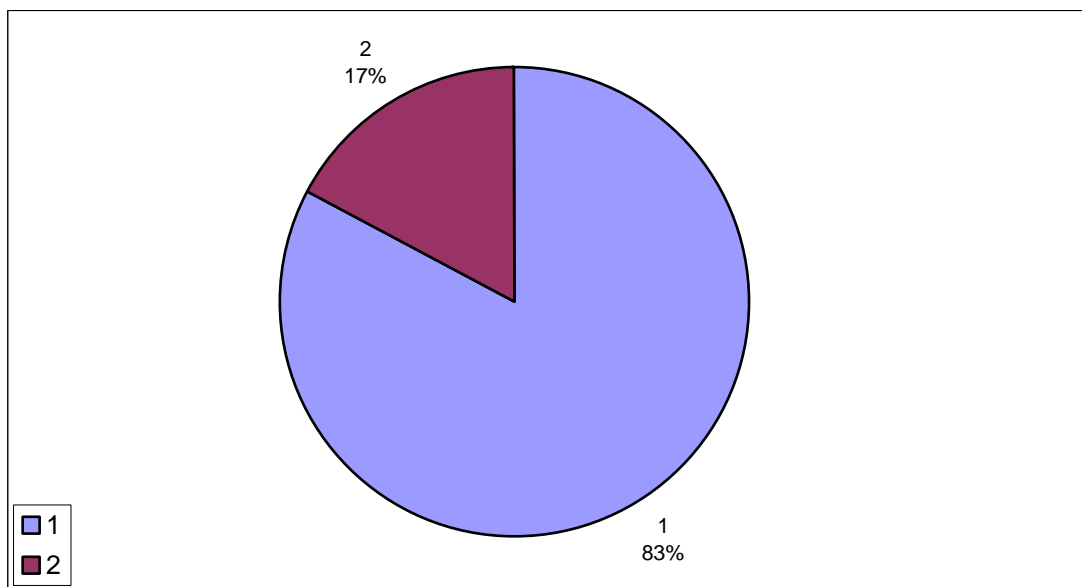
Where:

1 = Yes

2 = No

3 = Missing responses

Figure 3.26: Utilisation of the services of the services offered by the AIDS Centre



Where:

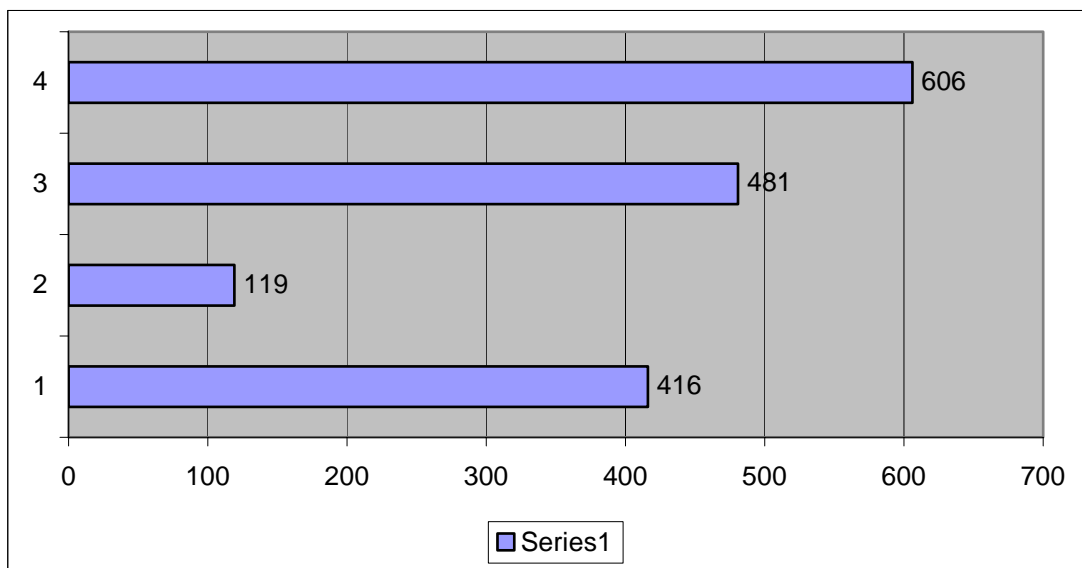
1 = Made use of the services offered by the Centre

2 = Made not use of the services offered by the Centre

INFORMATION REQUIREMENTS

A disturbing fact is that the majority of respondents are still ignorant about how regularly they receive information on HIV/AIDS. The majority 37.3% (n= 606) indicated that it does not really matter. The other two dominant groups represent a dichotomy between a weekly and a monthly requirement.

Figure 3.27: Regularity of information required



CONCLUSION

Research results was summarised and represented with discussion in Chapter 3. Differences between groups were identified and discussed. The sexual profile of students was also described.

CHAPTER 4: RECOMMENDATIONS

INTRODUCTION

Institutionalising HIV and AIDS as a response is far more complex than just offering counselling services on campus or establishing research programmes. It involves a recognition that HIV and AIDS are threats to both the technikon and society as a whole and thus it also challenges the relationship that exist between the technikon and society (Crew. 2000:118). From this the following questions derived:

- How can infected students be supported on and off campus? ;
- How can students who are not infected remain so? ;
- What can be done to minimise the effects of this epidemic on the technikon? ;
and
- What can be done by Technikon Pretoria to prepare the students to take their professional role in society that is radically affected by HIV and AIDS?

COMPLICATING FACTORS

Social cohesion

The concept social cohesion refers to the degree of homogeneity to which a society operates as a social, ethnic, linguistic, religious and cultural unit. The larger the diversity of ethnic, language and religious groups for instance, the smaller the chance that the society will function as an all-inclusive system, and thus the weaker the level of social cohesion. The Jaipur-paradigm contends that societies with strong social cohesion and high median income will suffer less from HIV/AIDS than societies divided by culture, ethnicity and income disparities such as India and **South Africa**. The argument then reads as follows (Van Rensburg et al. 2002:35): “*Societies with high levels of social cohesion as well as high median income (UK, France, Japan, Germany and Sweden) will not experience a serious epidemic and will be best place to fight the spread of HIV. Intermediate societies with high levels of social cohesion*

but inequitable wealth distribution and low median income (Brazil, Mexico, Senegal, North African Countries) will see only a slow growing epidemic and will be less well placed to fight the epidemic. Those countries with low levels of social cohesion and relatively high incomes (India, Uganda, Rwanda, Sub-Saharan Africa) will experience a serious epidemic, but it takes time to develop. It is, however, countries with low levels of cohesion and relatively high incomes that face the most rapid spread in and highest levels of HIV infection. South Africa belongs to the last category of countries”.

RECOMMENDATIONS

The first recommendation deals with the development and implementation of an HIV/AIDS policy at Technikon Pretoria entailing the following stages:

- Consultation of the content with Management, student councils and the Trade Union;
- Establishment of a Committee on HIV/AIDS;
- Committee gets expert advice and continuously refers back to the Code of Good Practice;
- Development of a draft policy that includes aspects like non-discrimination, HIV testing, confidentiality and disclosure, a safe working environment, compensation, benefits, grievance procedures, and management of HIV/AIDS in the workplace.
- Consultation on draft policy between Management, the Trade Union and the Student Council;
- Development of the final policy document;
- Implementation of the Policy; and
- Ongoing evaluation of policy

Students at institutions of higher education fall squarely into the category of the sexually active population. This demands for the implementation of **life skill programmes** educating learners with regards to practising safe sex, their human rights, treatment of sexually transmitted diseases, voluntary HIV testing, nutrition, etc. However, to align the programmes of Technikon Pretoria with the National

Integrated Plan (NIP) programmes should also implemented focussing on **mitigation, treatment, care and support** of those already HIV infected. Funds should also been made available to **research the HIV/AIDS** phenomenon and its manifestations on campus on an annual basis.

Also important is ensuring HIV/AIDS **knowledge transfer** utilising the curriculum requirements of Academic departments to ensure that the public in general and students specifically get access to correct information. A journalist academic department can for example analyse articles in terms of the way the pandemic is spreading or in terms of ethical writing such as judgemental writing and the implications thereof or in terms of reporting myths. It may even be possible for academic departments to consider the subject matter from a career role point of view and building the information into a global, regional, or community perspective.

Crew (2000:119) is of the opinion that institutions of higher education has to address the problem of HIV/AIDS through a *collective response* underpinned by a strong *human rights ethos* that will recognise the legitimate concerns and angers of the infected people, but that would also address the more complex complex issues that a disease of this nature and magnitude raises. In this the Technikon of Pretoria can –

- Providing intellectual leadership that will develop an understanding of the epidemic in South Africa. Introducing new obtained knowledge into the curricula of students can do this.
- Develop a culture of critique that will address the role of the state, private sector, NGO's and educational institutions.

Create an increase awareness and institutional commitment to fight HIV/AIDS - It is of outmost importance that considerable mention is made of the AIDS pandemic by senior managers in official communication publications of the Technikon of Pretoria. All key stakeholders need to recognise that that both a community-based and a multi-disciplinary approach is required to reduce the HIV/AIDS incidence in South Africa and also to increase the understanding of the phenomenon amongst all population members and specifically the youth.

Promote the idea of stable sexual relationships within the institution of a marriage

– According to Santorum (2003:9) empirical evidence indicates that the formal union between a man and a woman has unique benefits for children and society. According to Santorum healthy societies are characterised by giving marriage special protection as they consider it to be the key building block to ensure a society's future.

Provide all new students a brochure of “safe sex lessons”

– The best model one can provide to the students is a guide explaining safe sex principles. The students need to know and understand the dangers of sex and that it can ruin one's life. Yet, they also need to understand that a fulfilled life is in need of sex. Therefore, they need a proper understanding of both sides so that if they cross to an active sex life, students will know how to do it safely. One of the critical goals of “safe sex lessons” should be to promote condom (Both male and female condoms) utilisation, not merely informing the youth about the availability of condoms. The “safe sex lessons “ material should be produced in various languages taking into account cultural sensitivities.

Promote an understanding of basic human rights

– It is important that Technikon Pretoria determines to what extent real or perceived discrimination prevails in the work-place and in other social settings on campus. This is important to ensure that the basic rights of the HIV infected person is protected and understood by all students and personnel.

Support for human rights and legal issues

– The research indicated a general lack of understanding amongst respondents about their basic HIV/AIDS and human rights. The activation of an advice centre operated by trained paralegals and supported by public-interest law is considered a major strength in the promotion of HIV/AIDS rights and human rights. The advice centre can serve both the student community but its work can be extended to also serve the Tshwane community.

Develop a communication strategy on healthy relationships

– A successful sex life is a result of many things. It is influenced amongst others by who the partner is, friendships, upbringing in the family, and the people one mingle with or were able to avoid. A communication strategy providing some guidance on social interaction and building healthy relationships can provide tremendous support to install healthy

behaviour on the campus. Technikon Pretoria is ideally positioned and structured to make use of live music and drama as a means of teaching people about HIV and AIDS. The presentations can be used as a means of starting discussions.

Determination of the youth's attitudes toward life-style alternatives – The researchers support the view of Campbell and Chela (1990:428) that if behaviour needs to be changed then it is important to be able to present the youth with choices and not to proceed with control strategies without proper knowledge of the lifestyles of the youth within the contexts of the communities from which they come.

Counselling service expansion – One can deduct from the research that HIV infection and AIDS prevalence will continue to increase on the campus of Technikon Pretoria. This means that now more than ever, HIV/AIDS needs to be looked at as a chronic disease in which patient management is important. It may require a combination of therapies and protease inhibitors to improve the health care of HIV+ patients. Schneiderman (1999:8) indicated for example that patients going on highly active antiretroviral therapy, including protease inhibitors, missing surprisingly few doses can reportedly lead to viral escape and mutations that result in drug resistance and ineffective therapeutic response. Side effects are common, and may include not only nausea, diarrhoea, and other discomforts, but also changes in habitués. Social support to patients may facilitate adherence to medication protocols. This would also set the tone for synergistic psychosocial and pharmacological treatments. This combination of therapy, both on intervention and standard care may lead to improvements in the health care of HIV+ patients. The key areas in which the clinical psychologist can play a vital role includes amongst others relaxation therapy, adaptive coping, social support, psychological appraisal and the patient's attitude towards health care aimed at influencing the patient to medication adherence, patient's distress and reducing risky sex and drug use.

Telephone counselling is a possibility that should be considered, as many individuals are not prepared to go public.

The Manager of the AIDS Centre should report directly to one of the vice-rectors of Technikon Pretoria and be accountable to an interfaculty committee that is representative of all faculties for research and curriculum innovation.

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