

THE KNOWLEDGE OF HIV/AIDS
AND
THE SEXUAL ATTITUDES AND BEHAVIOUR
OF ADOLESCENTS WITH LEARNING
DIFFICULTIES/DISABILITIES

by

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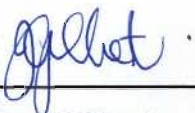
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DECLARATION

I, INDIRA GILBERT (PILLAY), declare that this dissertation is my own work. It is submitted for the Degree of Masters in Social Work at the University of KwaZulu-Natal (UKZN).

This dissertation has not been submitted before for any degree or examination at any other university.

Signed 
Indira Gilbert (Pillay)

Date 03/04/2008

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DEDICATED

To

The memory of my late parents

and to

my husband

and our children

Emmeleen and Esteleen

Quinlin and Arlton

ABSTRACT

The focus of this study was to assess the level of knowledge of HIV/AIDS, and to examine the sexual attitudes and behaviour of adolescents with learning difficulties/disabilities.

The sample was obtained from a secondary school in Chatsworth that caters for learners with learning difficulties/disabilities. The study used quantitative methods of data collection. Sixty adolescents with learning disabilities completed questionnaires.

The findings indicate that adolescents with learning difficulties/disabilities have good knowledge of HIV/AIDS and subsequently the majority is not engaging in sexual activity.

The findings can be used to inform future research on adolescents with learning difficulties/disabilities, as well as to inform future intervention strategies.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

The HIV/AIDS epidemic is one of the great challenges experienced to date. It is unique in comparison to any other phenomenon which has affected people at all social levels at any time in history. It presents a great challenge for South Africa, which has the highest HIV/AIDS rates in the world.

Adolescents today seem to be engaging in pre-marital sexual activity at younger ages than ever before. An increasing number of young people in South Africa are sexually experienced by the age of 20 and premarital sex is common among the 15-19 year-olds (WHO, 2001). In South Africa, HIV/AIDS is spreading at an alarming rate. Half of the youth in South Africa are not expected to reach adulthood, since sexually transmitted infections, including HIV/AIDS, are most common among young people aged 15-24 (WHO (2001). It has been estimated that half of all HIV/AIDS infections in South Africa have occurred among people aged less than 25 years (World Health Organisation, 1995).

As a result adolescence has become a traumatic phase of development in modern times. Previously, various cultures afforded special status and paid attention to the onset of puberty, thus, easing the transition from childhood to adulthood.

Today, however, the young person is left to cope with this transition often without guidance or support. This transition period is complicated by diverse societal pressures such as television programmes that glorify sex by the nature and content of the majority of the programmes aired during periods of peak viewing.

For adolescents with learning disabilities these issues are intensified, in that in addition to the typical adolescent concerns, they often despair over their learning problems.

At the onset of the adolescence years, young people with learning disabilities often become aware of their disabilities that make them different from other adolescents. They struggle to come to terms with their 'differences'. They see their school friends and siblings participating in activities in which they cannot be part of, and assuming responsibilities of which they are not capable. This can be a very frustrating time for adolescents with learning disabilities (Australian Learning Disability Association, 2006).

1.2 PROBLEM IDENTIFICATION

Global statistics reveal that at the end of 2004, there were approximately 39 million people living with HIV/AIDS in the world. The epidemic has created 13.2 million orphans (unaids.org/epidemic, 2004). According to the global summary of the HIV/AIDS epidemic (unaids.org/epidemic, 2004):

- Children below the age of fifteen and who were newly infected with HIV/AIDS was recorded as 600 000.
- Children below the age of fifteen and who were living with HIV/AIDS was recorded as 1.4 million.
- Deaths resulting from HIV/AIDS among children below the age of fifteen years was recorded as 500 000.

The majority (25.3 million) of the world's HIV/AIDS infected population is from the Sub-Saharan region. It is of great concern that 11 million are between the ages of 15 to 24. This number indicates that the highest risk groups are adolescents ([aids-bells.org.Org/health-care.html](http://aids-bells.org/Org/health-care.html) 2000).

LoveLife (2002), reported that South Africa has 4.9 million recorded cases of

HIV/AIDS. It concluded that the rate of infection in South Africa is presently the highest in the world and that the most vulnerable groups are adolescents. Most of the data in the LoveLife publication on the South African HIV/AIDS epidemic was obtained from an annual survey of pregnant women attending public sector antenatal clinics. According to Smith (2000), the HIV prevalence among antenatal attendees in KwaZulu Natal was recorded as 36.5% for the year 2000. In addition, KwaZulu Natal has the highest prevalence of HIV infection in the country, and since 1999, an increase of 3.7% has been noted (Smith, 2000).

The fact that HIV/AIDS virus has, and can develop many strains has prevented scientists from developing a vaccine against the virus. In keeping with the proverb that "*prevention is better than cure*", the best option in the prevention of HIV/AIDS among all ages, is *education*.

The HIV/AIDS epidemic has far reaching implications for the infected person, the family, the community and society at large. As highlighted in a report in the Daily News (1/5/2001), the epidemic will have a devastating effect on the economy of South Africa as people in their most productive years are infected. The health care system has to bear the cost of providing treatment for the millions of infected people as they become increasingly sick with HIV/AIDS and related illnesses. The welfare system will have to provide financial, emotional and other support for the increasing number of orphans and elderly (Daily News, 1/05/2001).

These statistics on the prevalence of HIV/AIDS supports the urgent call for the planned, organized, structured action in addressing the issues which contribute to the increase in HIV/AIDS infection rates. HIV/AIDS education programmes are seen as an extremely important form of intervention in both the prevention and treatment of the disease. During the XI International Conference on HIV/AIDS and STD's in Africa (ICASA), held in Lusaka in September 1999, 10 heads of state (including South Africa) declared

HIV/AIDS as a national disaster, which requires emergency response (Sichone, ICASA).

The impact of the epidemic is being felt in most countries. Globally 39 million people are living with the virus (unaids.org/epidemic, 2004), and generally life expectancy has been significantly reduced. Many people in the 15–49 year age group are now dying of AIDS. Many countries in Africa have taken urgent steps to curb the epidemic with varying success rates. In South Africa, despite our efforts, the HIV/AIDS infection rate has increased significantly over the past five years. The increase in the infection rate calls for a renewed commitment from all South Africans to make lifestyle changes and to educate the younger generation to make wise choices.

The way HIV/AIDS is spread clearly indicates that the virus can be contained by a change in sexual behaviour, which may be influenced by the development and inculcation of life skills through education. The high incidence of HIV/AIDS infections among adolescents has prompted the implementation of school-based HIV/AIDS education programmes nationally and internationally.

Despite the HIV/AIDS education programmes at the school many of the learners with learning disabilities seem to be engaging in sexual activity. Those with learning disabilities have the same sexual needs and desires as those without learning disabilities. Adolescents with a learning disability may look and feel mature physically, but they function at a lower cognitive age and lack the social judgment of their peers. Not only does this create conflict within them, but their physical appearance may also lead others to expect them to be more mature than they really are.

According to Broatch (as cited in Charles & Helen Foundation, 2006), children with learning disabilities often have problems that extend beyond their problems with reading, writing, mathematics, memory, or organization.

Strong feelings of frustration, anger, sadness, or shame can lead to psychological difficulties, such as anxiety, depression, or low self-esteem for many. Often this leads to behavioural problems, such as substance abuse and other juvenile delinquency, which in turn could lead to sexual promiscuity and/or sexual exploits. Adolescents with learning disabilities will want to explore their sexual feelings, some of which may be quite confusing (SchwabLearning.org, 2006).

An adolescent with a learning disability may act impulsively, without considering or planning for consequences e.g. engaging in spontaneous and unprotected sex (SchwabLearning.org, 2006). According to Christen (2002, as cited in SchwabLearning.org, 2006), adolescents with learning disabilities are especially vulnerable to sexual exploitation. Many lack the social competence to recognize individuals they shouldn't trust. An abuser might be an older adolescent, an adult, a stranger or a trusted adult, such as an uncle, youth group leader, or coach.

Each year at the school involved in the research, at least one learner falls pregnant. The concern of educators at the school prompted the researcher to focus on the level of knowledge of HIV/AIDS, and the sexual attitudes and behaviour of adolescents with learning difficulties at the school.

In its efforts to educate learners at public schools about HIV/AIDS, the Department of Education has introduced into its curriculum a new subject; Life Orientation, of which HIV/AIDS education is a part. From 2006, the learning area of Life Orientation was made compulsory in school up until matric (grade 12). Life Orientation includes HIV/AIDS education and awareness.

Despite the introduction of Life Orientation into the school curriculum, some five years ago, the researcher observed that the adolescents at school do not seem to have changed/modified their sexual behaviour in relation to the

life skills education. Pregnancies of female learners continue, and male learners continue their 'sexual exploits' with female learners.

1.3 CONTEXT OF THE STUDY

Damorosa Secondary School, previously known as Chatsworth Prevocational School, is situated in Moorton, Chatsworth, 20 km south of Durban, a town in the Province of KwaZulu-Natal. The school caters for just over 300 learners.

The need for a school like Damorosa arose from the lack of a bridge between special classes at primary school level and the demands at the work place. In 1986 the school came into being and was subsequently called the Chatsworth Prevocational School. Initially, the school catered for the vocational training of mildly mentally handicapped youth of Indian origin. However, with the changes in the country laws in 1994, learners from all ethnic groups were admitted. Hence, the school caters for learners from Chatsworth and surrounding areas that are able to access the school.

Learners from special education classes over 13 years old and are mild or moderate intellectually impaired/challenged are accepted. Learners that are 14 years old and older who have experienced consistent failure at mainstream schools are also considered for placement. The learners are assessed by an educational psychologist who recommends their placement at Damorosa Secondary School.

The curriculum provides for the vocational training of both boys and girls on five levels viz. grades six to ten. Besides the vocational training offered the curriculum includes Functional English, Functional Mathematics, and Life Orientation.

Approximately 80% of learners that graduate from the school are gainfully employed in various types of jobs e.g. workshops, supermarkets, and some have started their own businesses and are making good progress.

1.4 RATIONALE FOR THE STUDY

A survey of the literature on the HIV/AIDS pandemic indicated that the control of the virus among adolescents is linked to the need for greater awareness. Education on prevention and transmission, and the development of life skills to check irresponsible sexual behavioural patterns should be seen as a necessity.

While there has been research into the sexual attitudes and behaviour of adolescents from mainstream education, the researcher found that there was no available research into the sexual knowledge, attitudes and behaviour of adolescents with learning difficulties. As an educator (and a qualified social worker) at a school for learners with learning difficulties, my observation indicates that HIV/AIDS information given to learners has no impact on their sexual attitudes and behaviour. It was observed that adolescents with learning difficulties continue to behave promiscuously and at least one learner, from a female population of approximately 60, falls pregnant each year. Educators at the school are concerned that despite the knowledge imparted to the learners, they continue the risky sexual behaviour.

Since there has been no such research undertaken at the school relating to the knowledge of HIV/AIDS and the sexual attitudes and behaviour of learners, the researcher thought it appropriate to undertake research on this aspect. Review of literature indicates that there are no available research into the sexual behaviour and attitudes of adolescents with learning difficulties in South Africa. Although the literature on adolescent health-risk behaviours and negative health outcomes is extensive, relatively little

research has been devoted to adolescents with disabilities (Blum and Kelly, 2002). It is therefore crucial to pursue research in this aspect in order to plan more effective programmes both at educational and community level.

The findings from the present study can contribute towards developing and/or improving and sustaining the current HIV/AIDS education programmes for those with learning difficulties. The information would also serve to facilitate further research in the planning of strategies towards sustainable behaviour changes among the youth with learning difficulties.

1.5 AIM OF THE RESEARCH

The aim of the Research is to examine the sexual attitudes and behaviour, and the level of awareness of HIV/AIDS amongst adolescents with learning difficulties.

1.6 OBJECTIVES OF THE STUDY

- To ascertain the current knowledge of HIV/AIDS of adolescents with learning difficulties.
- To ascertain the sexual attitudes and behaviour of adolescents with learning difficulties.
- To identify the different sources and contexts from which adolescents with learning difficulties acquire their knowledge and understanding of sex and HIV/AIDS.
- To make recommendations to the Department of Education in respect of gaps in HIV/AIDS programmes for adolescents with learning difficulties.
- To make recommendations to the Social Work profession concerning their planning of appropriate programmes/interventions for adolescents with learning difficulties.

1.7 RESEARCH QUESTIONS

The key questions addressed in this study are:

- What is the level of knowledge of HIV/AIDS among adolescents with learning difficulties?
- What are the attitudes of adolescents with learning difficulties towards sex?
- How do adolescents with learning difficulties behave sexually?
- Where do adolescents with learning difficulties obtain their knowledge of sex and HIV/AIDS?

1.8 RESEARCH METHOD

The researcher chose a quantitative method for this study using structured questionnaires to gather the data. According to Babbie (1995), quantitative research is designed to produce data that tell us how many people do, or think about, a specific issue, and to be statistically reliable. It is a type of method that emphasizes the numerical measurement of variables. Personal experiences are quantified, measured on some scale before they can be scientifically studied. It excludes qualitative research which is focused on the meanings of experiences that are individual/personal to the people who lived them. According to Yegidis and Weinbach (2002), quantitative methods are also employed in descriptive research.

1.9 RESEARCH DESIGN

The study undertaken was descriptive in nature. Kumar (1999), asserts that a study classified as descriptive research attempts to describe systematically a situation, problem or phenomenon. According to Royse (2004), descriptive studies are larger-scale efforts that attempt to characterize a population group.

The information was primarily obtained to describe the level of knowledge of, and the attitudes toward HIV/AIDS of learners with learning problems.

Descriptive research can provide the researcher with in-depth information about knowledge, attitudes and behaviour, and the sources of the knowledge, attitudes and behaviour. Descriptive research does not limit the researcher to any one method of research: almost all methods of data collection can be used e.g. questionnaires, interviews, direct observation. This design best suited the research questions.

1.10 METHODS OF DATA COLLECTION

A quantitative method of data collection was used. The use of information-gathering methods was kept to the strict minimum requirement to gain access to appropriate information on sensitive issues, in accordance with the basic ethical principles. Adolescents with learning disabilities are not able to analyse their own thoughts and opinions, or to sit for an extended interview. They have a short attention span (Schwablearning.org, 2006), and therefore a structured questionnaire was used.

The questionnaire was divided into six categories: demographic data of the respondents, support systems, knowledge of HIV/AIDS, attitudes towards sex, sexual behaviour, and recommendations.

The questionnaire contained both closed and open-ended questions and were personally administered by the researcher.

1.10.1 Pilot Study

A pilot study is a trial run of the study, using the chosen instrument and randomly selected participants, similar to those in the final study (Cooper and Schindler, 2002).

Six adolescents with learning difficulties were randomly selected for the pilot study. The designed questionnaire was administered to the six volunteers.

The pilot study assisted in rephrasing certain questions and excluding others.

1.11 SAMPLING

Damorosa Secondary School was chosen as the population to be studied since it is the only school that caters for adolescents with learning problems. The geographical area of study was Chatsworth and the surrounding areas.

The total population at Damorosa Secondary School is 300 learners. A total of 60 respondents were chosen. Five strata or subgroups according to gender, grade and race were identified. This allowed the quota for the study to be obtained through the process of stratified and quota random sampling representing both genders and all the five grades at the school.

1.12 UNDERLYING ASSUMPTIONS

The researchers underlying assumptions were:

- The knowledge of HIV/AIDS, and the sexual attitudes and behaviour of adolescents with learning difficulties are shaped by multiple influences.
- Adolescents with learning difficulties are not able to retain sufficient knowledge on HIV/AIDS obtained at school for it to impact their level of knowledge of HIV/AIDS, and their sexual attitudes and behaviour.

1.13 ANTICIPATED VALUE

Information on how knowledge of HIV/AIDS is acquired, and on the sexual attitudes and behaviour of adolescents with learning problems can help:

- to make educational authorities aware of the needs of adolescents with learning difficulties which would assist them in their planning and implementation of HIV/AIDS educational programmes
- the Department of Education to design appropriate sexual health education programmes for adolescents with learning difficulties
- the profession of social work to structure intervention programmes to meet the needs of adolescents with learning disabilities
- community organizations and other concerned authorities to plan prevention programmes which would take into account the education and diversity of adolescents with learning difficulties
- stimulate more research into the needs of all adolescents with special needs

1.14 THEORETICAL FRAMEWORK

The research is based on the ecological systems approach which sees the individual as part of a larger system, and interacting with numerous other systems on various levels. This view of the individual as a system constantly interacting with other systems in the environment is referred to as the ecosystems perspective.

According to Clements and Buchanan (1982), as cited in Dhabicharan (2002), thinking systemically refers to a way of “organizing theory according to holistic perspective”. Taking into account how different systems interact together, and how these interactions affect each other, is referred to as *Systemic Thinking*.

Ecosystems perspective has been influenced by ecology; which sees the whole environment as consisting of systems. Systems theory includes the whole environment. Ecosystems are seen as a system of systems: the individual systems, the family systems, the socio-cultural environment etc. This view enables the ecosystem theorists to speculate about

interrelatedness of multifarious systems (UNISA Psychology. 103/96, 1996), as cited in Dhabicharan (2002).

In this study the knowledge of HIV/AIDS of adolescents with learning disabilities and their sexual attitudes and behaviour are seen as products of both wider social systems and the organisational system. It perceives them as developing within the complex system of relationships that is affected by multiple levels surrounding the environment e.g. the school, the family, the community and policy. The adolescent with learning disabilities within the ecosystem framework can be seen as a challenge to the school educational system. To be effective, the education system needs to adopt a conceptual framework that views the adolescent with learning disabilities in totality. Dhabicharan (2002), cites Berk (1988), who states that human service professionals are concerned with "what happens at the interface of the individual and the environment"

The knowledge of adolescents' with learning disabilities in respect of HIV/AIDS, and their sexual attitudes and sexual behaviour does not occur in a vacuum. All systems in the environment of adolescents with learning disabilities have a direct influence on what he/she learns, and what impacts him/her. The adolescent's behaviour in turn, affects all systems that he/she interacts with.

At individual level, adolescence brings with it issues of physical and emotional changes. For adolescents with learning disabilities these issues are amplified because, in addition to the typical adolescent concerns, adolescents with learning disabilities are often despair over their learning problems. At the beginning of adolescence, young people with learning disabilities become aware of their disabilities, and struggle to come to terms with their 'differences'. They see their friends in mainstream schools and their siblings doing things that they are unable to do (SchwabLearning.org,

2006). The learning disability also affects their processing of knowledge of HIV/AIDS/sex, and the resulting sexual attitude and behaviour.

On a family level, poverty, unemployment, abuse of drugs, lack of attention and stimulation from parents can affect the sexual attitudes and sexual behaviour of adolescents with learning disabilities. At the community level poverty, unemployment, abuse of drugs, lack of resources (sport and other) can affect the sexual attitudes and sexual behaviour of adolescents with learning disabilities. At the societal level, unemployment, poverty and the mixed information they receive from observed behaviour and printed information coming their way, leads the adolescent to believe that the behaviour that they are exposed to is acceptable. At the national level the country's approach to, and the dissemination of information on HIV/AIDS may impact positively on all adolescents in the country. Adolescents with learning difficulties are further directly affected by the sexual attitude and behaviour role - modelled by the leaders of the country (Australian Disability Association, 2006).

At a religious and/cultural level, adolescents with learning disabilities adopt to a large extent the values and standards set by the religion and culture that they are exposed to, and to the extent that they are exposed to these. Research shows that religious adolescents have first sex at a later age than those who are less religious (Meier, n.d.). Adolescents with learning disabilities imitate the behaviour observed as they are able to function according to what is observed i.e. at a more concrete level and not to what is imaginary (SchwabLearning.org, 2006). Environmental factors may make the adolescent with learning disabilities more vulnerable to influences outside the family and the school.

Adolescents with learning disabilities do not exist in the vacuum. The family, the community, the environment, and organizational stresses, impact on their knowledge of HIV/AIDS, and on their sexual attitudes and behaviour.

What is learnt at school can be supported and reinforced at home or negated and/or underplayed.

The ecosystem approach guided the researcher to focus holistically, taking into account all the factors that influence the adolescents with learning difficulties, including the different subsystems, and how these systems impact on them. The influence of the school, the family, the community, and society in general on the sexual attitudes and sexual behaviour of the adolescent with learning disabilities is of utmost importance.

1.15 LIMITATIONS OF THE STUDY

According to Yegidis and Weinbach (2002), the very presence of the researcher affects the findings of the research to some degree. They go on to say that critics question whether there can be an objective study. The researcher must be aware of potential limitations and the effects it may have on the quality and validity of the results. Determinants such as time, resources and availability of subjects are constraints often experienced by researchers.

The limitations of the study include the following:

- The sample size was small. This prevented generalizations being made to all youth with learning difficulties.
- The research was limited to one school. This also prevented generalizations being made to other schools serving learners with learning disabilities.

1.16 ETHICAL CONSIDERATIONS

Consent was obtained from the Department of Education, the school principal and the school governing body, the parent or legal guardian, and the adolescents concerned. All the necessary information concerning the

study and the purpose of the research was supplied to them. The findings of the research are to be presented to both the Department of Education and to the school.

The gathering of information on sensitive topics can be upsetting. To protect the participants from harm, the use of information-gathering methods was kept to the strict minimum requirement to gain access to appropriate information on sensitive issues, in accordance with the basic ethical principles.

Where traumatic personal issues came up, the researcher, as a social worker, conducted a debriefing session and referred respondents to the in-house school psychologist.

1.17 ABBREVIATIONS AND DEFINITION OF THE CONCEPTS USED

| | |
|--------|--|
| UNAIDS | Joint United Nations Programmes on HIV/AIDS |
| WHO | World Health Organisation |
| ICPD | International Conference on Population Development |
| NGO's; | Non Governmental Organisations |
| UNFPA | United Nations Population Fund |
| GPA | Global Programmes for Action |
| SGB | school governing body |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children Fund |
| YRBSS | Youth Risk Behaviour Surveillance System |

HIV

HIV means Human Immunodeficiency Virus. HIV is known to destroy the human immune system. It lives in certain white cells present in body fluids and cannot survive outside the human body (The HIV/AIDS Emergency Guidelines for Educators, 2000).

AIDS

AIDS means Acquired Immunodeficiency Syndrome. AIDS is referred to as a syndrome because it is a combination of various signs, symptoms and infections. It is the final phase of HIV infection (The HIV/AIDS Emergency Guidelines for Educators, 2000).

HIV/AIDS EDUCATION PROGRAMMES

For the purposes of this study, the concept HIV/AIDS Education Programmes is used as an umbrella term for the different types of HIV/AIDS programmes implemented by the Department of Education.

LEARNING DIFFICULTIES//DISABILITIES

The American federal law defines “specific learning disability” as a disorder in one or more of the basic psychological processes involved in understanding or using spoken or written language. Skills of listening, speaking, reading, writing, and/or mathematics may be negatively affected (SchwabLearning.org).

For the purpose of this study, “learning difficulties/disabilities” will refer to mild to moderate mental retardation, where understanding, acquisition, organization, and retention of information are affected (Australian Learning Disability Association, 2006). Adolescent with “learning difficulties” are able to physically care for themselves. Their mental capabilities are limited but not to the extent that they are not able to secure outside employment.

WHO sets the boundary for mild mental retardation disability at IQ 50-70. In this research adolescents with learning difficulties refer to adolescents who are mild to moderately mentally retarded.

ADOLESCENT

For the purpose of this study the concept ‘adolescent’ refers to those between the ages 13 and 19 years.

1.18 STRUCTURE OF THE REPORT

This report comprises six chapters and is divided as follows:

Chapter One: Introduction and Background

This chapter presents a background to the study. It includes the rationale, the context, the theoretical framework, ethical considerations, the value and limitation of the study, and a definition of the concepts used.

Chapter Two: The knowledge of HIV/AIDS, and the sexual attitudes and behaviour of adolescents.

This chapter presents a discussion on adolescents with learning disabilities/difficulties, the current trends on adolescents' knowledge of HIV/AIDS, and the sexual attitudes and behaviour of adolescents, and programmes offered in different countries.

Chapter Three: Policy and Framework for Adolescents and HIV/AIDS Education.

This chapter presents a discussion on the Policy and Framework for Adolescents and HIV/AIDS Education.

Chapter Four: Research Methodology

This chapter describes the research methodology used in this study. It includes the design of the research, the selection of the sample, the data collection, ethical issues and the demographical information.

Chapter Five: Findings of the Present Study

This chapter examines and sets out the results of the study. The data from the empirical study was analysed through a process of content analysis and statistical comparisons.

Chapter Six: Conclusions and Recommendations

This chapter contains conclusions drawn from the study and makes recommendations based on the findings.

CHAPTER TWO

ADOLESCENTS WITH LEARNING DIFFICULTIES, AND THE SEXUAL ATTITUDES AND BEHAVIOUR OF ADOLESCENTS, AND THEIR KNOWLEDGE OF HIV/AIDS

2.1 INTRODUCTION

Nearly half of the world's six billion people are under the age of 25 (The United Nations Population Fund's State of World Population, 2003). These includes 1.2 billion adolescents aged 10 to 19. According to the South African Central Statistical Services (2007), South Africa has 10 million adolescents aged 10 to 19.

It has been estimated that there are about four million South African children who experience different forms of learning disabilities.

The discussion in this chapter addresses the following:

- Adolescents with Learning Disabilities/Difficulties
- Adolescents' Knowledge of HIV/AIDS
- Adolescents' Attitudes towards Sex
- Adolescents' Sexual Behaviour
- Vulnerability of Adolescents to HIV/AIDS Infection

2.2 ADOLESCENTS WITH LEARNING DIFFICULTIES

There is confusion regarding the use of the terminology of '*learning disability*'. It varies from country to country, and as to whether the perspective is medical, social or educational.

Learning disability and *learning difficulties* are used in the United States and sometimes elsewhere in the world to denote educational problems of a specific nature, such as dyslexia. In Great Britain, the Department of Health adopted *learning disability* as the preferred alternative to *mental handicap*. The World Health Organization (WHO) as well as Australia uses the term *intellectual disability*. In the United Kingdom, however, *moderate/severe learning difficulties* are used as a legal term in the field of education. (Mc Conkey, as cited in child-link.org, 2003)

In South Africa, the term *Intellectually Challenged* is being adopted. The term *Intellectually Challenged* is a broad concept and can incorporate the whole range of mental limitations.

Learning disability, formerly known as mental handicap or mental retardation, refers to a variety of disorders that affect the acquisition, retention, understanding, organization or use of verbal and/or non-verbal information. *Learning disabilities* range in severity and invariably interfere with the acquisition and use of one or more of the following important skills: oral language (e.g., listening, speaking, understanding), reading (e.g., decoding, comprehension), written language (e.g., spelling, written expression), and mathematics (e.g., computation, problem solving).

There is no clear and widely accepted definition of "learning disabilities." Because of the multidisciplinary nature of the field, there is ongoing debate on the issue of definition, and there are currently at least 12 definitions that appear in the professional literature. The various definitions do, however, have common elements viz. difficulties with academic achievement and progress; an uneven pattern of development (language development, physical development, academic development and/or perceptual development); learning problems are not due to environmental disadvantage; and learning problems are not due to mental retardation or emotional disturbance (Australian Learning Disability Association, 2006).

"Learning disability" is not a diagnosis but rather a description of a collection of symptoms which includes hyperactivity, reading problems, language problems, mathematical problems, writing problems, behaviour problems, and a host of other symptoms. These are all typical of brain-injured children. There are more than 300 different labels that are commonly used to describe brain-injured children; which are just descriptions of symptoms of brain injury ranging from a coma to mild learning problems and every kind and degree of brain injury in between.

A learning disability can affect the way in which an adolescent takes in, remembers, understands and expresses information. Adolescents with learning disability may be intelligent and have abilities to learn despite the difficulties experienced in processing information. Living with a learning disability can have an ongoing impact on friendships, schoolwork, self-esteem and daily life. Adolescents with learning disabilities can succeed when individualised self-management skills and strategies are developed and **relevant accommodation** is provided (Australian Learning Disability Association, 2006).

According to Broatch, as cited in Charles & Helen Foundation (2006), adolescents with learning disabilities often have problems that go far beyond those experienced in reading, writing, mathematics, memory, or organization. Strong feelings of frustration, anger, sadness, or shame can lead to adolescents experiencing psychological difficulties such as anxiety, depression, or low self-esteem, as well as behavioural problems such as substance abuse or juvenile delinquency. This could lead to sexual promiscuity/exploits for adolescents.

Several experts in the field of learning disabilities have researched the psychological difficulties often experienced by adolescents with learning disabilities (Raskind, as cited in Schwablearning.org, 2006). They conclude that the psychological problems experienced by them are more devastating than the academic challenges, and may follow them into adulthood. Some

presumed underlying reasons for the psychological, social, emotional and behavioural challenges one may face are the repeated failure adolescents with learning disabilities experience in the educational system which may misunderstand or ignore their needs, little positive feedback received, and their academic struggles and failures often being met with disapproval by teachers, peers, and parents. Disapproval can take the form of negative labeling of an adolescent.

Instead of developing a sense of pride in their accomplishments, adolescents with learning disabilities may end up frustrated and ashamed. These feelings only serve to damage the self-concept and result in a negative self-image. Low self-esteem and a lack of confidence only serve to further interfere with learning and academic success and reinforce a cycle of failure and negativity.

Research conducted by Kavale and Forness (1996), indicate that as many as 70% of children with learning disabilities suffer from poor self-esteem and eventually give up trying.

Another reason as to why adolescents with learning difficulties may develop psychological problems is the social difficulties they often experience. Research by Kavale and Forness (1996), indicate that as many as 75% of children with learning difficulties have social difficulties such as making and keeping friends. According to Raskind (as cited in Schwablearning.org, 2006), social and psychological problems are interconnected making it difficult to determine which one may have caused the other especially since psychological problems can have a negative effect on social interaction. Research has shown that adolescents with learning disabilities are less accepted, and often rejected by their peers. Educators and other adults also may tend to have negative views of adolescents with learning disabilities (SchwabLearning.org, 2006). Such social rejection can result in loss of self-esteem and negative views of oneself. In addition, social rejection can result

in feelings of loneliness, which, in turn, may lead to psychological difficulties such as anxiety and depression.

Research has shown that adolescents with learning disabilities may experience increased levels of anxiety, may be at greater risk for depression, experience higher levels of loneliness, may have a lower self-concept (self-esteem), are at greater risk for substance abuse, and may be at greater risk for juvenile delinquency (Charles & Helen Foundation, 2006).

According to Brooks (2001, as cited in Charles & Helen Foundation, 2006), self-esteem is a common issue for adolescents with learning difficulties although at times signs of low self-esteem may be masked by a variety of self-defeating coping strategies, such as quitting when tasks become difficult or frustrating; avoiding a task or activity for fear of failing; clowning to hide lack of confidence or to relieve pressure; controlling to counteract a sense of helplessness; being aggressive and bullying to fend off feelings of vulnerability; denying in order to manage the pain they would feel if insecurities were acknowledged; being impulsive and finishing tasks as quickly as possible just to get it over with.

For success, adolescents with learning disabilities require specialized interventions in the **home**, the **school**, and the **community**; interventions that are appropriate to their individual strengths and needs, including specific skill instruction, the development of compensatory strategies, and the development of self-advocacy skills.

2.2.1 PREVALENCE OF LEARNING DISABILITIES/DIFFICULTIES

There is no accurate data regarding prevalence rates of learning disabilities among youngsters. The United Nations Development Programmes estimates that in 1990, over five percent of the world's population was experiencing moderate to severe learning disability. This ranged from over seven percent in developed countries to over four percent in less developed

countries. In its 1995 survey, the **South African** Central Statistical Services reported a national learning disability prevalence rate of approximately five percent and it has been estimated that there are about four million South African children who experience different forms of learning disabilities. It is estimated that six to ten percent of the school-aged population in the United States have learning disabilities. Nearly 40 percent of the children enrolled in special education classes suffer from a learning disability. The Foundation for Children with Learning Disabilities estimates that there are six million adults with learning disabilities as well. The incidence of learning disabilities in Australia, as in other western countries, is suggested to be ten to twelve percent of the population, with four percent being severely affected (Australian Learning Disability Association, 2006).

2.2.2 CAUSES OF LEARNING DISABILITIES

The causes of disability (in general) listed in the White Paper on an Integrated National Disability Strategy (1997), include violence and war, poverty, lack of information, failure of medical services, unhealthy life styles, environmental factors, accidents and inherited and genetic factors.

Although currently little is known about the causes of learning disabilities, some general observations are made by the Child Development Institute (2006), viz. that some children develop and mature at a slower rate than others in the same age group. Subsequently they may not be able to do the expected school work. This kind of learning disability is called "maturational lag." Due to some unexplained disorder of the nervous system some children with normal vision and hearing may misinterpret everyday sights and sounds. Injuries before birth or in early childhood account for some later learning problems. Children born prematurely and children who had medical problems immediately after birth may also have learning disabilities.

Learning disabilities tend to run in families. It is therefore believed that some learning disabilities may be inherited. Learning disabilities are more common in boys than girls, possibly because boys tend to mature more slowly.

Some learning disabilities appear to be linked to the irregular spelling, pronunciation, and structure of the English language. The incidence of learning disabilities was found to be lower in Spanish or Italian speaking countries.

Irrespective of the cause of the learning disability the effects are always evident (The Child Development Institute, 2006).

2.2.3 EARLY WARNING SIGNS AND ASSUMPTIONS OF LEARNING DISABILITIES

A wide range of symptoms is evident in children with learning disabilities. These include comprehension and reasoning abilities. Hyperactivity, inattention and perceptual coordination may also be associated with learning disabilities but are not in themselves, learning disabilities. The primary characteristic of a learning disability is a significant difference between a child's achievement in some areas and the child's overall intelligence.

Learning disabilities typically affect five general areas viz. spoken language where there are delays, disorders, and deviations in listening and speaking; written language where difficulty is experienced with reading, writing and spelling; arithmetic where difficulty is experienced in performing arithmetic operations or in understanding basic concepts; reasoning where difficulty is experienced in organizing and integrating thoughts; and memory where difficulty is experienced in remembering information and instructions (Donald et al, as cited by The Child Development Institute, 2006).

Those with learning disabilities may not be able to read information presented to them, to remember information explained to them, or to make conclusions from information presented to them. These symptoms may not be very noticeable when the child is young.

Some of the common assumptions of adolescents with learning disabilities are that they tend to be easily confused by instructions; have difficulty with abstract reasoning and/or problem solving; have disorganized thinking; have poor short-term or long-term memory; have a lack of reflective thought prior to action; display impulsive behaviour; display inappropriate, unselective, and often excessive, affection; fail to see consequences for his actions; be overly gullible; easily led by peers; experience difficulty making decisions (Eloff and Ebersohn, 2003, as cited by The Child Development Institute, 2006).

While some symptoms are more common than others, none will have all these symptoms. All will, however, have at least two or three of these symptoms to some degree. The number of symptoms does not give an indication as to the severity of the learning disability/difficulty.

2.2.4 WORKING WITH ADOLESCENTS WITH LEARNING DISABILITIES

When working with adolescents with learning disabilities it is necessary to take the time to listen as much as possible in order to get the "message"; to look for and encourage their strengths, interests, and abilities, and to help them to use these as compensations for any limitations or disabilities; to accept them for what they are, and for their human potential for growth and development; to reward them with praise, good words, smiles, and a pat on the back as often as possible; and to be realistic in one's expectation of, and demands on them (The Child Development Institute, 2006).

Adolescents with learning difficulties need to be involved in establishing rules and regulations, planning schedules and activities, and need to be allocated responsibilities whenever possible. They need to be informed of any inappropriate behaviour and explained as to how others are affected or feel about their behaviour; then have them propose other more acceptable ways of behaving. Their errors and mistakes need to be corrected by showing or demonstrating to them what they should do. More importantly, they need role models for the behaviour they need to learn.

By reducing distracting aspects of their environment as much as possible and encourage the asking of questions, their ability to concentrate could be enhanced. Reading and discussing stories and articles, telling the story, and rereading the story or article, providing attractive, stimulating books and reading material, enhance their ability to learn.

For those with learning difficulties, traditional school grades are not important. What is important is that they progress at their own rates and are rewarded for doing so. They need to be provided with games, activities and opportunities that will stimulate their development. They need to be helped to develop their self-esteem and to compete with self rather than with others. Getting them involved in sport and/or social groups at school and in the community where they can interact by playing, helping, and serving others, helps develop the self concept.

Adolescents with learning difficulties need role models in all activities, and lots of physical contact like touching and hugging. Parents and specialists need to be involved in order to better understand what might be done to become more effective in the lives of adolescents with learning difficulties (The Child Development Institute, 2006).

An important component in working with adolescents with learning difficulties is to understand the complexities of interacting with other

adolescents, families, and communities. It is necessary to explore the sexual attitudes and behaviour of adolescents with learning difficulties, and their knowledge of HIV/AIDS given the high incidence of HIV/AIDS infection in South Africa.

2.3 KNOWLEDGE OF HIV/AIDS

According to the Oxford Dictionary, 'knowledge' can be defined as "specific information about something" e.g. of HIV/AIDS, "the state or fact of knowing", or "familiarity, awareness, or understanding gained through experience or study".

2.3.1 The essence of HIV/AIDS

HIV is the acronym for Human Immunodeficiency Virus. There are in fact two HI types or strains of viruses, named HIV-1, which has nine sub-types, and HIV-2, which is less infectious and predominantly found in West Africa (UNAIDS, 2001b). Both viruses originated from viruses found in African apes and monkeys that somehow infected humans within the last 100 years. Both HIV-1 and HIV-2 virus's cause HIV/AIDS.

HIV/AIDS were first identified in the United States (Yeats, 2001), which led to the incorrect understanding that the virus originated from that part of the world. According to the available evidence, HIV/AIDS has its origin in Africa, as it belongs to the family called retroviruses. These viruses have the ability to become a permanent part of the cell by building their genetic material into the cell's genetic material.

On entering the body the virus fuses with the host-cell membrane before entering the host cell. It then attaches itself to the DNA of the host cell and transcribes its RNA into the DNA of the host cell. Here it very rapidly duplicates itself. The cell, very pregnant with the virus explodes, releasing

the virus into the bloodstream. The new RNA will contain mutations. (After several generations build-up of mutations becomes lethal.) Even at this stage the virus cannot be detected. The virus then begins attacking the immune system, which develops anti-bodies to fight the virus. It is these anti-bodies which the body develops to fight the virus that indicates the presence of the virus; the individual is HIV positive. From the time of contracting the virus to the time that the blood tests can confirm the presence of the anti-bodies is called the 'window period'. With the latest medical testing available the 'window period' has been brought down from 6 months to 3 months, and presently to 3 weeks.

When the white blood cells are broken down, the immune system is weakened and eventually destroyed causing the person to become "immunodeficient". HIV is therefore a cause of immunodeficiency. The virus continually attacks the immune system gradually, almost completely destroying the once very strong immune system. When the immune system is too weak to fight off any germs, opportunistic infections e.g. tuberculosis (TB), several types of cancers (Kaposi's sarcoma, lymphomas), pneumocystis carini pneumonia (a parasitic infection of the lungs), certain types of yeast and fungal infections, and unusual intestinal infections, make the body very ill, eventually killing the person.

According to Yeats (2001), it takes several years for HIV to cause immunodeficiency, and, when it happens, the person develops AIDS (Acquired Immunodeficiency Syndrome). A person with AIDS has poor defense against other viruses, bacteria and infections. According to Swart-Kruger & Richter (1994), AIDS is a known killer, because those infected with HIV eventually become chronically ill and die.

One does not die from AIDS; the infected individual eventually dies from one of the opportunistic illnesses.

According to Sanders (2001), a person may develop flu-like *symptoms* within 10 to 21 days after infection with the virus. These symptoms may disappear for anything up to 5 - 20 years; the average time it takes an HIV infected person to develop full-blown AIDS, is nine years.

The early symptoms of HIV/AIDS include:

- prolonged fever
- persistent swollen glands especially in the neck, armpit, groin
- persistent diarrhea
- weight loss of more than ten percent of normal body mass
- night sweats
- changes in mental behaviour, such as confusion or forgetfulness.

These symptoms are, according to Van Rooyen & Louw (1994), known as "Aids Related Complex" (ARC). Only when the patient develops illnesses such as pneumonia, cancers, and illnesses of the central nervous system and other organs, is full-blown AIDS diagnosed. The patient is then unable to recover because of a poor immune system, and dies soon afterwards.

Some infected individuals may not have any of the symptoms for years. During this time the individual will be able to live a healthy lifestyle. However, he/she is still capable of spreading the virus. Approximately ten years after contracting the virus, the infected individual will have full blown AIDS. Some people progress very rapidly from stage one to stage four and can die within two years.

Two major factors influence the risk of infection:

- the prevalence of HIV/AIDS infection, and
- The individual's behaviour (The World Health Organisation, 1988).

2.3.2 Clinical stages of HIV/AIDS infection

The World Health Organisation (WHO) developed a staging system, which provides a clear picture of how HIV/AIDS progresses (Sanders, 2001).

Stage 1

Within a few weeks to a few months after infection, the individual develops a flu-like illness, with fever, swollen glands, headache, tiredness, sore muscles and diarrhea. These symptoms disappear and the patient feels normal. The virus however, remains active and continues to destroy the white blood cells. A blood test at this stage will render a HIV negative result. This stage can last for up to six months.

Stage 2

This stage is characterised by repeated infections of the upper airways, mouth ulcers and unintentional weight loss, shingles, rashes and other skin diseases, fungal infections and severe cracks in the corners of the mouth.

Stage 3

Clinical features at this stage include continued weight loss, persistent fever and diarrhea, thrush in the mouth, back of the throat and sometimes the female genitals, white patches in the mouth, leukoplakia, tuberculosis of the lungs (pneumonia) and severe infections.

Stage 4

Weight loss progresses, chronic diarrhea persists, the brain is affected and the patient may become confused, "opportunistic infections" (thrush in the oesophagus, pneumonia, herpes, fungal and parasitic infections throughout the body, infections in the brain and certain types of cancer) make the individual very ill which results in death.

In African countries, where it is very hot, HIV/AIDS causes diarrhea, rapid weight loss and dehydration that lead to death within six weeks after infection. This is called “Slim’s disease” (Van Rooyen & Louw, 1994).

2.3.3 The transmission of HIV/AIDS

Transmission of HIV/AIDS occurs when blood, or sexual fluids of an infected person passes into the body of another person (Swart-Kruger & Richter, 1994), or breast milk from an infected mother is fed to a baby. The virus can also be found in other body fluids such as saliva and urine, but the concentration in these fluids is very low and therefore they carry little risk of transferring the infection (Yeats, 2001). HIV/AIDS can also be transmitted to another person through direct injection under the skin, for example by a needle, or through thin, moist surfaces such as the mucous of the eye and nose (Yeats, 2001).

a) The most common ways of HIV/AIDS transmission

The most common ways of HIV/AIDS transmission are:

- heterosexual and homosexual intercourse - oral, anal or vaginal (Van Rooyen & Louw, 1994). According to Van Rooyen & Louw (1994), and Yeats (2001), this is the most common way that HIV/AIDS is transmitted.
- the transfusion of infected blood to non-infected persons, or contact with objects that had been contaminated with HIV/AIDS infected blood (Van Rooyen & Louw, 1994). In most countries blood donations are tested thoroughly for HIV infection (Yeats, 2001). It is now rare that HIV/AIDS is transmitted by blood transfusion.
- from an HIV infected mother to her child, either before or shortly after birth. This is described as “vertical transmission”. Mother-to-child transmission accounts for four to ten percent of all HIV/AIDS infections in Africa. The reason for this is probably that both pregnancy and HIV/AIDS

infection occur most commonly in young, adult women when they are most sexually active (Yeats, 2001).

- from an HIV/AIDS infected mother to her child during breast feeding.

b) The less common ways of HIV/AIDS transmission

Less common ways of HIV/AIDS transmission are:

- those in the medical occupations. Van Rooyen & Louw (1994), state that the risk of infection is only 0,3%.

c) Ways in which HIV/AIDS is not transmitted

HIV/AIDS is not transmitted by insects, sharing of food and drinks, shaking of hands, toilet seats, being in the same room and breathing the same air, the swimming pool, kissing, donating blood, touching an HIV/AIDS patient, or the sharing of clothing or cutlery.

2.3.4 Myths about HIV/AIDS

Among the myths about HIV/AIDS, the most recently prevalent is that having sexual intercourse with a virgin can cure HIV/AIDS (Sanders, 2001). A consequence of this is that many young girls have been raped in the mistaken belief that the rapist would be cured from his disease. The young raped girl contracts HIV/AIDS from the rapist and could pass it to her baby if she falls pregnant. Research indicates that one in three HIV-positive mothers passes the virus to her baby.

The fact that HIV/AIDS are inextricably linked (Sanders, 2001), is also being ignored. There is a belief that other factors than HIV, such as poverty, malnutrition, TB and drug abuse cause AIDS. Science has, however, proven that there is no way that a person can develop AIDS without first being infected by HIV. It has been suggested that widespread malnutrition, TB and

malaria increase the rate of HIV/AIDS infection by weakening people's immune systems and thus lowering their resistance to HIV/AIDS infection (Swart-Kruger & Richter, 1994).

A study undertaken in Alexandra, South Africa, found that adolescents believed that it is impossible for them to contract HIV/AIDS, and that it is a disease of the older person (Swart-Kruger & Richter, 1994). This belief is contradictory to the fact that worldwide adolescents have been identified as a high-risk group for HIV/AIDS infection (DiClemente, 1990). Sexually active girls withhold information about their sexual behaviour from their mothers in the belief that, by doing so, they will not fall pregnant or even contract HIV/AIDS.

A further myth is that it is possible to identify infected people by their physical appearance. According to Swart-Kruger & Richter (1994), it is a general tendency among adolescents to use physical appearance as a basis regarding safety in sexual encounters.

Another myth, according to Serote (1993), a perception among black people is that HIV/AIDS is something that the government introduced to reduce the number of black people and to scare black people so that they will have fewer children.

2.3.5 Prevention of HIV/AIDS infection

The saying "prevention is better than cure" is especially true with regard to HIV/AIDS infection, as to date no cure has been discovered. The best possible solution to the spread of HIV/AIDS appears to be its prevention (Sanne, 2001). A person who does not engage in sexual intercourse and does not inject drugs (or who uses clean, sterile needles and syringes for injections) has almost no chance of contracting HIV/AIDS (World Health

Organisation, 1994). Those who are HIV negative and who are mutually faithful to each other are at minimum risk of HIV/AIDS infection.

People who use high quality condoms correctly every time they have sexual intercourse can reduce their chances of HIV/AIDS infection. According to Yeats (2001), a condom is the simplest and most effective way of reducing the chances of HIV/AIDS infection in that a condom creates a barrier against germs and body fluids exchanging between partners during sexual intercourse.

In the absence of a cure the best prevention is *education*. Education is important (Van Rooyen & Louw, 1994), so that people can have knowledge of HIV/AIDS and realize their responsibility to live virtuously in order not to be infected with HIV/AIDS. The main aim in education, according to Van Rooyen & Louw (1994), has become to guide the child toward abstinence, and toward practicing sexual relationships only within a monogamous marriage.

To this Le Roux (1994), adds the promotion of responsible sexual behaviour, improvement of children's socio-economic status and reduction of their vulnerability to sexual and other forms of exploitation.

The HIV/AIDS epidemic is a serious threat to the health of all regardless of age, sex, social status, or race. HIV/AIDS affects the physical, emotional, moral, social, and economic well-being of the individual, the family, the community, the nation, and the world. The loss of human life and productivity due to this disease is a deterrent to socio-economic development (Mahidol, 1998).

According to the Mahidol (1998), specialists predict that by the year 2010 there will be 40 million AIDS orphans in Africa, most of who will have grown up with little or no social structure. More than 5.5 million children in eastern

and southern Africa have lost their mothers or both parents to AIDS. This has placed new stress on extended family and grandparents as they attempt to raise the orphaned children. People with HIV positive family members may need to drop out of school to care for a dying parent or to care and provide for younger siblings.

The prevalence of HIV/AIDS has given way to myths surrounding the virus. In sub Sahara Africa one of the most devastating myths is that by having sex with a virgin a man can cure himself of the HIV virus. This has led to the rape of young girls and intergenerational sex (Cho, 2003).

Besides the tragic human suffering caused by HIV/AIDS, the disease causes tremendous economic disruption because it strikes young people in their most productive years. The cost of health care, lost productivity, and care of orphans can weigh heavily on already fragile economies (Asian Development Bank, 2006). In South Africa, HIV/AIDS is expected to shrink the national economy by as much as \$22 billion by 2010 (News and Views on Sexuality: Education, Health and Rights, 2001/2002).

When HIV/AIDS claims the lives of people in their most productive years, grieving orphans and the elderly must contend with the sudden loss of financial support, communities must bear the burden of caring for those left behind, and countries must draw on a diminishing pool of trained and talented workers. As the epidemic worsens so will estimations of its effect on African economies, even without taking considering the broader human welfare issues. In South Africa 420,000 children were orphaned due to HIV/AIDS since the epidemic began, and the teacher death due to HIV/AIDS has increased to more than 40 percent in 2000 (HSRC, 2004).

According to Cho (2003), the effect of HIV/AIDS is the reduction of the working population, which could worsen the dependency ratio. More

children and elderly people will have to be supported by a smaller active labour force.

This has serious implications for children with learning difficulties. Losing parents have implications for who will care for adolescents with learning difficulties. This poses challenges for secondary care-givers viz. grandparents who are not equipped with skills to deal with adolescents with learning difficulties, and with their sexual attitudes and behaviour.

2.3.6 ADOLESCENTS KNOWLEDGE OF HIV/AIDS

If adolescents are to act safely, they must have accurate information about HIV/AIDS, and they must be able to apply it. Adolescents need to know general facts about HIV/AIDS, its transmission, prevention, HIV/AIDS testing, and so on. According to Anderson et al (1990), adolescents lacking such knowledge are more likely to engage in sexual risk behaviours, such as having two or more sexual partners and not consistently using condoms. Earlier studies of adolescents' general knowledge about HIV/AIDS found that adolescents were uninformed (DiClemente et al., 1992). DiClemente et al (1992), found that only 60% of their adolescent sample in San Francisco was aware that using condoms may help reduce the likelihood of contracting HIV/AIDS. According to Koopman et al., (1990); and Strunin & Hingson, (1987), adolescents are gaining moderately high levels of HIV/AIDS knowledge.

The lack of knowledge of HIV/AIDS infection and the lack of support from community, welfare and the education sectors, place these adolescents in a non-negotiable position. Young women frequently forced into the sex industry are at risk of becoming infected with HIV/AIDS. Fletcher (2000), found that in Cambodia many young people sell sex in order to survive on the street or support their

families. Poverty, violence, sexual abuse and other social problems places young women in a vulnerable situation to HIV/AIDS infection.

This often leaves the adolescent with learning difficulties even more at risk in that they are often unable to differentiate right from wrong, may be unaware of their rights, or feel that no one will listen if they say 'No' or later complain.

Folkman, et al (1979), make a useful distinction in describing general knowledge as that of hot and cold. They described hot information as highly meaningful and emotionally laden, having implications for a person's well-being, whereas cold information does not. The knowledge that needs to be taught to adolescents about HIV/AIDS is hot. It is about highly emotionally-laden issues e.g. disease, death, sex, and drugs. It is likely that emotions about these issues can block or disrupt learning about HIV/AIDS, just as they can also motivate learning. For example, an adolescent who is highly anxious about the illness and death associated with HIV/AIDS may not be easily convinced that HIV/AIDS cannot be transmitted through casual contact. On the other hand, if adolescents begin to feel positively about their own ability to cope with emotional issues, they will be more likely to change their behaviour.

Thus, whilst there is little data on the prevalence of HIV/AIDS infection amongst young people with learning difficulties it has been suggested that rates may be as high as in more general populations (Jacobs et al, 1989). There is therefore a need to include HIV/AIDS awareness training into educational programmes for adolescents with learning disabilities.

Craft (1987), delineated six rights which she viewed as basic for adolescents with learning disabilities which impinge on their value as sexual beings viz.

- The right to grow up i.e. to be treated with respect and dignity.

- The right to know i.e. have access to as much information about themselves and their bodies and those of other people, their emotions, appropriate social behaviour, etc, as they can assimilate.
- The right to be sexual and to make and break relationships.
- The right not to be at the mercy of the individual sexual attitudes of different caregivers.
- The right not to be sexually abused.
- The right to humane and dignified environments.

In accepting these basic rights it may be argued that the principles of sex education for adolescents with learning difficulties are no different than for other adolescents.

An evaluation of sex education programmes is essential. With regard to HIV/AIDS related illness, there are no immediate prospects for a cure. Education and health promotion remains the only weapon available to combat the spread of the disease.

Research indicates that adolescents do seem to have adequate knowledge of HIV/AIDS, and that most adolescents are concerned about HIV/AIDS, and that they have had helpful conversations with their parents about sex (The Kaiser Family Foundation, 2000; The National Campaign to Prevent Teen Pregnancy, 2002).

Unfortunately research in respect of the knowledge of adolescents with learning difficulties in respect of HIV/AIDS is lacking. It can be assumed that in view of their particular learning disabilities their knowledge in this respect would be lower than adolescents in general.

2.3.7 LEARNING DIFFICULTY AND THE ACQUISITION OF KNOWLEDGE

Adolescents with learning disabilities experience difficulty in reading, and in retaining information imparted to them. According to Young (as cited in Australian Learning Disability Association, 2006), adolescents with learning difficulties experience problems in the acquiring of new knowledge in that:

- They lack the basic skills necessary to acquire new knowledge.
- They are unable to systematically apply the basic skills they acquire to problem-solving situations.
- They are not able to use efficient or effective learning strategies.
- They do not have sufficient semantic knowledge to readily learn new content.
- Many are unable to retain knowledge.
- Many fail to take advantage of learning enhancers in the environment e.g. visuals.
- They tend not to actively participate in class i.e. ask questions or give feedback (Ellis, 1989).
- Many do not maintain eye contact and thus do not appear to be interested in the subject matter (Hazel et al., 1981, as cited in SchwabLearning.org, 2006).
- Many do not display effective or efficient social skills (Deshler et al., 1981).
- Many tend not to participate in recreational activities (Schumaker et al., 1980, as cited in Australian Learning Disability Association, 2006).

This has direct implications for the adolescent with learning disability in that he/she is not able to read and/or understand HIV/AIDS information, and to retain information imparted to him/her.

Professionals working with persons who are mentally retard are realising that the HIV/AIDS epidemic is a deadly threat to this population (Jacobs, et al 1989). Several reasons have been outlined as to why persons with

mental retardation can be identified as a high-risk group for contracting HIV/AIDS. The Virginia Department of Education's Family Life Curriculum (1991), and the National Institute for People with Disabilities in New York (YAI) (1995), has identified some of the factors which increase their vulnerability not only for HIV/AIDS infection but also for other STIs, sexual abuse and teenage pregnancy. The factors that place adolescents with learning difficulties at risk are as follows:

- *Knowledge:* Adolescents with learning difficulties are generally less knowledgeable than other learners about their bodies and their sexuality. This leads to poor decision making related to their sexuality and an inability to protect themselves. Many may not know when and who to ask for help, and may lack the cognitive or communicative skills necessary for asking questions. Many are often unable to get information from written materials.
- *Misinformation:* Adolescents with learning difficulties may have been misinformed about sex through peers, television, and "the street". Some adolescents with learning disabilities are more likely than others to believe myths and misinformation. They may also become confused and frightened by misinformation.
- *Social Skills:* Adolescents with learning difficulties may have limited opportunity for social development. Their chances to observe, develop, and practice social skills are limited or nonexistent. Many do not have basic social skills e.g. knowing how to greet others and how to show affection appropriately. In addition, deficiencies in social skills lead to difficulty in forming appropriate sexual relationships.
- *Power and Control:* Adolescents with learning difficulties are often easily influenced by others. They may do whatever others suggest without question, due to their dependency and desire to please. As a

result, they may be convinced or manipulated into engaging in high-risk behaviours.

- *Self-Esteem:* Adolescents with learning difficulties often have low self-esteem. In an effort to be accepted by others or to gain attention (either positive or negative), they are more likely than others to participate in risky behaviours.
- *Judgement:* Adolescents with learning difficulties often have poor judgement, poor decision-making skills and poor impulse control. Without direct instruction they are often unable to recognise the consequences of their actions. Poor impulse control indicates a lack of defensive mechanisms to "say no" or it could lead to curiosity about sex, thus placing them at risk for engaging in unsafe sex.
- *Choice of Sexual Partners:* Lack of social skills force adolescents with learning difficulties into a smaller choice of sexual partners in the community in which they reside and, may be forced into sexual behaviour with familiar people.
- *Lack of Interest in Recreation:* The general lack of interest in recreational activities among adolescents with learning difficulties expose them to situations of potential risk for inappropriate behaviour (e.g. sex, drugs and gangs).

This indicates the vulnerability of adolescents with learning difficulties to HIV/AIDS. These special characteristics of adolescents with learning difficulties suggest that the rate of HIV/AIDS infection could be at least as high as the general population prevalence rate.

As Broatch (as cited in SchwabLearning .org, 2006), mentioned, children with learning disabilities have problems that extend beyond problems in reading, writing, mathematics, memory, or organization. Strong feelings of

frustration, anger, sadness, or shame can lead to psychological difficulties such as anxiety, depression, or low self-esteem, which can lead to behavioural problems such as substance abuse or juvenile delinquency which in turn could lead to sexual promiscuity/exploits

Repeated failure in the educational system, unmet needs both at home and school often leave them feeling different from the others. This frequently leads them into behaviours that would seemingly keep them as “part of the group.” With a poor or damaged self-concept and resulting negative self-image, many tend to seek acceptance and acknowledgement from other adolescents around.

A lack of confidence makes them prey to the sexual advances of both adults and other adolescents. They are frequently taken advantage of in that they may not presumably remember details, and adults seldom take them seriously. Once abused or sexually exploited, sexual acting out is the invariable result.

According to Raskind (as cited in Schwablearning.org, 2006).), the learning disabled adolescent can enter a state of learned helplessness where they see little connection between their efforts and the ultimate outcomes. Many cannot foresee the consequences of their behaviour, and how their behaviour could lead to their detriment i.e. have physical, emotional or psychological consequences. Social difficulties such as making and keeping friends, and avoiding being rejected can lead to their giving in to sexual demands to maintain friendships.

At times, however, according to Brooks (as cited in Schwablearning.org, 2006), signs of low self-esteem may be masked by a variety of self-defeating coping strategies, such as clowning to hide lack of confidence or to relieve pressure; controlling to counteract a sense of helplessness; being aggressive and bullying to fend off feelings of vulnerability; denying in order

to manage the pain they would feel if insecurities were acknowledged; and being impulsive.

Adolescents with learning problems, in view of their specific problems, would experience greater difficulties in absorbing/imbibing and remembering information about HIV/AIDS and in making decisions since learning disabilities affect the acquisition, retention, understanding, organization or use of verbal and/or non-verbal information.

This is why this study is necessary: one needs to understand the 'what', 'why', and 'how' of the behaviour of adolescents with learning disabilities.

2.3.8 THE ROLE OF THE SCHOOL IN INCREASING THE KNOWLEDGE OF HIV/AIDS

The school provides a site that has the potential to reach large numbers of adolescents with HIV/AIDS education. The overwhelming majority of South African adolescents attend school; 97% of those aged 10 to 14 years and 83% of those aged 15 to 19 years attend school. The school has the potential to reach large groups of adolescents in an efficient manner, and students attending a school are to a large extent constant from day to day.

In almost any community the school is a setting where many people learn and work, care and respect each other and where the child spends a great deal of time. Schools are institutions that adolescents regularly attend, that are geared towards increasing adolescents' knowledge and improving their skills, and are especially well suited to educate adolescents about subjects such as sexuality. It is therefore reasonable to assume that the school is a setting where health programmes can have their greatest impact since they influence adolescents at an important stage in their development. Moreover, virtually all adolescents attend school before they initiate sexual risk-taking behaviours, and a majority is enrolled in school at the time of initiating sexual intercourse. Thus the school as a public institution

provides a strategic platform with a broad opportunity and mandate for addressing and reducing sexual risk-taking behaviours.

According to UNFPA (2002), future generations of adolescents are continually joining the world population. Efforts to educate adolescents about HIV/AIDS infection are never complete and require constant renewal. Peer education focusing on decision-making and negotiation skills can help adolescents ward off undesirable sexual relationships, exploitation and violence. Effective education about HIV/AIDS depends however, on the existence or development of an enabling environment. In Indonesia several obstacles e.g. cultural taboos have impeded efforts to educate adolescents about HIV/AIDS (UNFPA, 2002).

2.4 ATTITUDES OF ADOLESCENTS TOWARD SEX

Thurstone (as cited by Stiff and Mongeau, 2003), defines *attitude* as referring to the sum total of a person's inclinations, prejudices, ideas, fears and convictions on a specific topic. An attitude results in different people having different reactions toward similar objects or situations. Attitudes guide one's behaviour. An attitude is the first determinant of behavioural intention. It is the degree to which the person has a favourable or unfavourable evaluation of the behaviour in question. Hence it is important to understand the attitude of adolescents to sexual behaviour.

Sexual Attitudes arise from what one believes about sex: whether something is good or bad, whether teens should indulge in sex or not, the value of the opposite sex (not just to meet one's sexual needs). Sexual attitudes can arise from prescriptive and/or evaluative beliefs. Sexual attitudes elicit specific sexual behaviours.

The exposure to music, television, movies, and pornography where sexuality is expressed in different ways, often as aggressive or degrading

acts, negatively impacts the attitudes of adolescents. Sex is often used to advertise and sell products, from items of food to clothes and concepts etc. (Rotheram-Borus et al, 1987). The mixed messages on sex, constantly confronting the adolescent, often creates confusion on issues of sexual relationships. Adolescents are often unable to visualise the long term emotional and physical consequences of sexual relationships (Bradley et al, 1996). Adolescents with learning difficulties would experience even more difficulty in doing so.

Enlightened attitudes towards sexual activity amongst those with learning difficulties expose them to the additional threats faced by all sexually active young people of the late 20th and the 21st century viz. sexually transmitted diseases including HIV/AIDS related illnesses.

The sexual issues faced by those with learning difficulties are the result of society's acceptance of their sexuality. According to McCabe (1993), the individual's acceptance of the self as a sexual being will reflect the attitude of significant others. For one with learning disabilities and a lifetime of mixed messages about sexuality, and the prevailing attitudes of sexuality and sexual taboo, to assert a positive and wanted relationship is perhaps the most difficult challenge of all (McCabe, 1993).

The NICHD-funded Add Health Survey found that religion reduces the likelihood of adolescents engaging in early sex by shaping their attitudes and beliefs about sexual activity. Hence adolescents with strong religious views are less likely to have sex than are less religious respondents, largely because their religious views predispose them to the negative consequences of premarital sex.

Schwablearning (2006), found a tendency for those with learning disabilities to be conservative in their sexual attitudes. This is perhaps

due to both parents and caretakers having to respond to their "sexual vulnerability" with attempts to protect them.

Blunn et al (1984), suggest that two myths need to be disposed of in any discussion of sexuality and mental handicap, viz. that adolescents with learning difficulties are promiscuous with large sexual appetites that are likely to be expressed in unacceptable ways, and that they are childlike, innocent, and have no sexual appetite. The need for sex education to be built into health education programmes has been described as 'just as important as learning to boil a kettle' (Blunn et al, 1984).

There is no available research on the sexual attitudes of adolescents with learning disabilities. Hence there is a need for this particular research to gain some insight on the sexual attitudes of adolescents with learning difficulties.

2.5 ADOLESCENTS' BEHAVIOUR

Behaviour is the transmission of *intention* or *perceived behavioural control into action*. The intention is an indication of how hard people are willing to try and of how much an effort they are planning to exert, in order to perform the behaviour. Behaviour is influenced by three components: person's *attitude* toward performing the behaviour, the perceived social pressure, called *subjective norm* and *perceived behavioural control* (De Vries, 1997).

According to De Vries (1997), *behaviour* is a consequence of a complex process that can be examined from two perspectives. It can be considered to be the result of individual determinants such as attitudes, social influences and perceived abilities, or the result of factors beyond the individual such as social, political, economic, cultural, and legislative factors. At the onset of puberty, adolescents attempt to manage this anxiety by refraining from personal disclosure and form same-sex pairings. The decision to initiate sexual behaviour will depend upon the attitudes communicated by

the adolescent's parents, religion, the community norms and pressure from peers.

Human sexual behaviour is the behaviours that human beings use when seeking sexual or relational partners, gaining approval of possible partners, forming relationships showing affection, and mating. Sexual behaviour could include sexual intercourse and all other forms of sexual activity. This could be kissing, touching the body, holding hands, fondling, or touching the genitals.

There is no clear borderline between the sexual and nonsexual enjoyment of touching, or grabbing someone else's body. For example, holding hands may or may not have a sexual connotation, depending on culture, situation and other factors. Although the most common form of heterosexual sexual intercourse is universally regarded as sexual contact, there is a wide range of other sexual behaviours that may or may not be socially, legally, or ethically considered as *sexual relations*. The distinction between the sexual and the nonsexual becomes relevant in judging appropriate behaviour, in either a social setting or in the eyes of the law.

Information about adolescents' sexual behaviour (the attitudes they have, the decisions they make, and the actions they take) can help parents communicate with their adolescents, educators and concerned community groups design appropriate education programmes, and policymakers support sound health policies.

According to the WHO (2002), in many countries unmarried girls and boys are sexually active before the age of 15. With regard to South African adolescents and sexuality, research presents the following (Kaiser Family Foundation, 2001):

- 25% of the South African adolescents do not know that sexual intercourse with a virgin cannot cure HIV/AIDS

- 33% of adolescents between the ages of 12-17 years have already had sexual intercourse
- Four percent of adolescent females have already been pregnant
- Nine percent indicated that they had never heard of HIV/AIDS.
- 16% of the sexually active girls acknowledged that they exchange sexual intercourse for money, food, drinks or other gifts.
- 25% of the girls and seven percent of the boys have been forced to have sexual intercourse. In a study of girls living on the streets of Cape Town, Le Roux (1994), found that all the girls stated that rape and sexual assault were dangers that they encountered and feared. Gangs often regard the girls in the area as their property and available to them for sexual intercourse.
- The use of a condom is often viewed as an insult and proof of distrust. It is regarded as an indication that the person using it or requesting its use already has a sexually transmitted disease (Le Roux, 1994).

The tendency for adolescents to engage in high-risk behaviours, and the developmental changes that characterize the adolescent years have implications for the success of intervention programmes. Adolescence, by its nature, is a period of rebellion. According to Bradley et al (1996), adolescents often choose to go against the norms in order to establish their own unique self-identity. It is also a stage during which sexual activity begins and is often associated with risk taking behaviours. The rebellion, combined with sexual awareness and risk-taking behaviour, can lead the adolescent to become sexually active.

Research has found that adolescents are sexually active (The U.S. Centers for Disease Control and Prevention, 1999; Youth Risk Behaviour Surveillance System, 2001; A National Longitudinal Study on Adolescent Health, 2001; The Kaiser Family Foundation, 2002; In Their Own Right, 2002).

UNFPA (2003), found that despite the clear evidence of sexual activity among young people, traditional biases commonly preclude them from discussing sex with their parents, relatives, friends, teachers, or counselors. This leads to the misconceptions about HIV/AIDS, how the virus is transmitted, and how to protect themselves against the infection.

The age at which adolescents are becoming sexually active seems to be decreasing. Approximately one in five adolescents has engaged in sexual intercourse before his or her fifteenth birthday. Males (14 years or younger) are slightly more likely to have had intercourse than females of the same age (The National Campaign to Prevent Teen Pregnancy, 2002; The Kaiser Family Foundation, 2002).

Non-voluntary sex among adolescents is not uncommon. According to The National Campaign to Prevent Teen Pregnancy (2002), more than one in 10 girls who first had intercourse before age 15 describe it as non-voluntary and many more describe it as relatively unwanted.

Although adolescents were found to have more than one sexual partner, they did not maintain the relationships simultaneously. According to a study by The Kaiser Family Foundation (2002), 42 % reported one partner, 39 % reported two to five partners, seven percent reported six to nine partners, and four percent reported ten or more partners.

Not all adolescents who engaged in sexual activity continue to do so (The National Campaign to Prevent Teen Pregnancy, 2002; In Their Own Right, 2002)

Beside sexual intercourse, adolescents do engage in other forms of sexual activity. According to In Their Own Right (2002), many adolescent males aged 15 to 19 who had never had vaginal intercourse, engage in other

forms of sexual activity e.g. touching a woman's breasts, being stimulated to the point of orgasm by a partner, receiving oral sex, and giving oral sex.

Where adolescents are left without supervision, there tends to be a greater possibility of them becoming sexually active. In a study of school students in an urban district The Kaiser Family Foundation (2002), found a link between lack of adult supervision and increased adolescent sexual activity.

Adolescents list various reasons for engaging in sexual activity viz. met the right person, the other person wanted to, just curious, hoped it would make the relationship closer, many of their friends already had, adolescent relationships, the closeness of the relationship, the amount of trust that could be placed in a partner, go with what the partner wanted, alcohol and drugs, opinion of friends (Seventeen Magazine and The Kaiser Family Foundation, 2002).

There are various reasons why adolescents do not engage in sexual activity viz. the opinions of their parents, their partners, their friends, and their religious community, and their morals and values (The Kaiser Family Foundation, 2002; The National Campaign to Prevent Teen Pregnancy, 2002; Seventeen Magazine and The Kaiser Family Foundation, 2002).

Other influences on adolescents' decisions not to engage in sexual activity include their relationships, fear of pregnancy and STIs, having not met the right person, being far too young and choose to wait until they are older (The National Campaign to Prevent Teen Pregnancy, 2002; Seventeen Magazine and The Kaiser Family Foundation, 2002).

When mothers reported satisfaction with their relationships with their daughters, their daughters were more likely to report that they had not had sexual intercourse. High levels of mother-child connectedness are independently related to delays in sexual intercourse. Adolescents who feel

that their mothers disapprove of their having sexual intercourse are more likely to delay intercourse. This, however, seems to diminish for older girls (The Center for Adolescent Health and Development at the University of Minnesota, 1999).

Adolescents live in a world where there is constant worry about unintended pregnancy and STIs, including HIV/AIDS. During the past decade, condom use among adolescents has steadily increased with a majority of sexually active adolescents now reporting using condoms the last time they had intercourse. More adolescents say that it is important to use birth control each and every time they have sex (The National Campaign to Prevent Teen Pregnancy, 2002; The Kaiser Family Foundation, 2002).

However many adolescents do not use contraceptive methods consistently and continue to choose less reliable methods such as the "rhythm method" or withdrawal sometimes because of pressure from the partner (The Kaiser Family Foundation, 2004; The YRBSS, 2005).

Adolescents use various methods of contraception viz. birth control pills, withdrawal or "pulling out," the rhythm or calendar method, injectable contraceptive, periodic abstinence, use of a diaphragm, and other methods, including the morning-after pill, foam, cervical cap, suppository jelly or spermicidal cream without diaphragm (The Kaiser Family Foundation, 2004; The U.S. Department of Health and Human Services' National Center for Health Statistics, 2005).

There are many reasons why adolescents may choose to use a specific type of contraception: among other things, how well the method protects against unintended pregnancy and STIs as well as convenience, cost, and confidentiality (The YRBSS, 2005).

Condom use in 2004 among sexually active students in the USA increased to over 50% (The Kaiser Family Foundation, 2004; The U.S. Department of Health and Human Services' National Center for Health Statistics, 2005; The YRBSS, 2005).

In dating and casual relationships kissing and touching is often an integral part for the majority of adolescents. Many adolescents feel that it was more important to use a condom in a casual sexual relationship than with a boyfriend or girlfriend. Most adolescents say that the longer the relationship the more likely they are to discuss their sexual history and STI testing, and are more likely to use condoms (Seventeen Magazine and the Henry Kaiser Family Foundation, 2000).

Adolescent peer norms have a strong impact on their behaviour in sexual situations e.g. females are expected to be responsible for protection against unwanted pregnancy and STIs. However the female is dependent on the male's cooperation in his use of a condom (Rotheram-Borus et al, 1987). The male may refuse this cooperation because he may not see protection during sex as his responsibility.

However, males' willingness to use condoms may be underestimated. According to Kegeles et al. (1988), found that more males reported consistent condom use than females did and that females had misperceptions about their male partners' willingness to use condoms. Thus, HIV/AIDS education programmes must address these perceptions.

It is important to note those close to the adolescent have a very strong influence on the behaviour. This needs to be taken into consideration in the planning of appropriate educational programmes. The adolescent needs to be seen in the social context.

According to Foster (1993), poverty promotes the risks of HIV/AIDS infection among adolescents. Orphaned girls from impoverished homes are vulnerable to HIV infection because of 'sugar daddies' or sexual exploitation by relatives. Older siblings are often forced into prostitution to earn money to feed younger brothers and sisters. Orphaned adolescents end up living on the street thus increasing the risk of sexual abuse, drug addiction and exploitation.

Adolescents with learning disabilities/difficulties undergo the same physical changes and development as that of any adolescent. This is in keeping with human physiological growth and development. As the scientific literature indicates, individuals with mild mental retardation are sexually competent in terms of biological competency, desires and the psychological significance they attribute to sexual relations (Child Development Institute, 2006). Adolescents with learning disabilities/difficulties are also sexual beings.

There is, however, very little research on the sexual behaviour of adolescents with mild to moderate mental retardation. Sexual development broadly follows the normal pattern and that intimacy and sexual expression are a large part of the respondents' lives, despite significant others largely ignoring and/or denying their sexual needs. While the sex drive of adolescents with learning difficulties is likely to function normally, the reduced intellectual functioning and its implications may result in inappropriate sexual expression. The behaviour of individuals with learning disabilities is learned, shaped, and reinforced by environmental factors (The Child Development Institute, 2006).

Adolescents with physical, cognitive, or emotional disabilities have a right to sexuality education, sexual health care, and opportunities for socializing and sexual expression. Those around them should receive training in understanding and supporting their sexual development and behaviour. Individuals with learning disabilities and their caregivers should have

information and education about how to minimize the risk of sexual abuse and exploitation (SIECUS, 2001). They should be guided into the appropriate expression of sexuality. The areas of sexuality and intimate relationships are the most difficult of all human interactions to pursue. These, for those with learning disabilities, are insurmountable barriers (Brown, 1994).

Sex education is a central issue for community integration of persons with learning disabilities. Despite this, those with learning disabilities are greatly disadvantaged in the process: they are likely to experience difficulties when dealing with subtle and complex issues regarding their sexuality and sexual expression. Those from restricted family environments must learn appropriate forms of sex-related behaviours late in life in order to avoid negative social judgements.

Schwablearning (2006), found adolescents with learning disabilities to be more conservative in their attitudes, with significantly more gaps in their knowledge of contraception, venereal disease and abortion as compared to their non retard peers. They seemed to be in an extended childhood which casts their caretakers into protective roles. Parents of children with learning difficulties have generally been found to have confused and ambivalent attitudes towards the sexuality of their offspring. Many parents do not realize or come to accept that their children with learning disabilities undergo the usual pattern of sexual development (Schwablearning, 2006).

According to Brantlinger (1984), females generally receive more sexuality education from their parents than males do. Non-parent sources of information about sex, and models of rational and responsible decision making may be even less adequate for individuals who are mentally retarded. Peers are probably less knowledgeable than average and may not be good models of responsible behaviour. In addition, persons with learning difficulties, because of their limited literacy skills, and often limited

mobility in the community, may have little access to accurate and informative resource materials about sexual topics. They may be less capable of sorting out messages about sex from the popular media. School can be considered a source of sexuality education for students with mild mental retardation. There is little documentation that much sexuality education is actually being provided in the special education classroom (Brantlinger, 1984).

Teachers described their learners as frequently sexually active, predominantly misinformed or uninformed about sex, experiencing problems in sexual and social interactions, and anxious to learn more about sexuality in school. It is not clear as to how intellectual limitations will act as barriers to equipping adolescents with learning disabilities to deal with complex sexual issues. While skilled teaching may enable specific abilities to be achieved in such areas as contraceptive use or awareness of sexually transmitted diseases, it is not clear as to whether such teaching can raise these learners' levels of reasoning. Consequently, these young people may find it impossible to achieve the kinds of moral development that are required for more complex social judgements (e.g. abortion). Although opinions vary as to whether formal sex education makes a significant difference, there does seem to be a common view among professionals that sex education programmes are necessary (Ellis, 1989).

According to McCabe and Cummins (1996), adolescents with mild intellectual disabilities lack knowledge about sex and intimacy, and this in turn makes it difficult for them to form close interpersonal relationships.

2.6 VULNERABILITY OF ADOLESCENTS TO HIV/AIDS INFECTION

The onset of puberty often implies a change in the way girls and boys are treated by their parents, peers, extended family and community. The changes often mean marked differences in the opportunities and constraints girls and boys face, based on their gender. The imposition of strict gender norms can be especially dramatic for girls who may find their freedom of movement, educational and personal development, security, and life choices compromised. Boys will face pressures in terms of having to prove their masculinity and virility. Sexual activity among adolescence is increasing with many having sex even before the age of 13 (WHO, 2001).

Adolescence is a time of significant cognitive, emotional and physical development and is often characterised by exploration and experimentation.

2.6.1 Developmental changes during adolescence

There are four major domains affected by adolescent development:

behavioural, cognitive (awareness), affective (feelings), and social, which evolve as adolescents face age-specific tasks for becoming adults, the most important of which is identity development. According to Elbaum & Vaughn (2003), in a complex society, identity development is also complex: it evolves through changes in behaviour, cognition, and affect, and in the context of changing norms and social roles.

2.6.2 Behavioural Changes during Adolescence.

According to Haynes (1987), at the onset of puberty, adolescents refrain from personal disclosure in regard to their sexual fantasies and form same-sex pairings. The decision to initiate sexual behaviour will depend upon the attitudes communicated by parents, as well as community norms and pressure from peers. A *sexual milestone* is a specific kind of sexual

behaviour (e.g., first kiss, first time genital petting, and first sexual intercourse), for which a single first experience is considered to permanently change the person's sense of self and relationship to others e.g. when sexual intercourse is experienced for the first time, the sexual identity changes one from being a virgin to non-virgin. Once the person has attained a particular sexual milestone, he or she is likely to continue to engage in that kind of sexual activity. Research has shown a gradually escalating series of sexual milestones, in which holding hands and kissing precedes behaviours such as petting, which, in turn, precedes the onset of sexual intercourse. For adolescents proceeding through this graduated series, there is some time to learn from earlier psychosexual milestones before tackling the more complicated issues involved in having sexual intercourse (e.g., planning and using contraception; reducing risk of HIV/AIDS transmission). Hence, an important goal for reducing adolescents' risky behaviour is to delay the onset of sexual milestones to later ages.

There may be a greater need for early intervention with adolescents who typically do not proceed through the graduated series of sexual milestones.

Different cultures do not necessarily go through this progression; some cultures many engage in sex before reaching puberty (Nganwa, A., Batesaki, B., and Balaba, A. , nd).

2.6.3 Cognitive Changes during Adolescence

One of the most significant changes that occur during adolescence is a shift in the quality of cognition. Piaget proposed that as youth enter adolescence, they begin to develop what he termed *formal operational thought*. This period is generally marked by an adolescent's ability to engage in formal thought, characterised by abstract thinking, hence it is a transition period between Piaget's (1954) stages of concrete operational and formal operational thought. Formal thought is abstract reasoning, the capacity to

imagine hypothetical situations and to anticipate the consequences of different courses of action. It is the capacity to play out different possibilities in one's head before choosing the most suitable response. The development of formal operational thinking is important to reducing adolescents' risk of becoming HIV/AIDS infected. Formal operational thinking is involved when adolescents apply abstract principles about the transmission and prevention of HIV/AIDS infection to actual high-risk situations (Chilman, 1983).

The capacity for formal operational thinking takes time to mature; many persons do not fully develop it even by adulthood. Researchers have found that fewer than half of all adolescents have made the transition to formal operational thinking by age 18. Although young adolescents are more advanced in cognitive development than are children (Piaget, 1972 as cited in Chilman, 1983), they generally reason with less awareness of cost-benefit ratios than do adults. They underestimate the potential costs associated with certain actions; for example, they tend to believe that they are immune to risks such as unwanted pregnancies (Chilman, 1983). Even among young adults, there is a tendency to evaluate one's personal risk of health problems optimistically, as lower than for others of the same age and sex. The lower the perceived risk, the less interest there is in receiving information about preventing health problems (The Child Development Institute, 2006).

Adolescents vary considerably in how much their sexual behaviour is guided by rational thinking and conscious decision making. For adolescents to engage in strictly low risk behaviour, they need to know what this behaviour is and how they can define it in their own lives. They need to be able to construct several hypothetical courses of actions to take, some of which may be safer than others, and to be able to simultaneously evaluate these alternatives on the basis of considering several possible outcomes of each course of action. This systematic search for alternative solutions to a problem is part of formal operational thinking. Adolescents need to develop realistic appraisals of the costs and benefits of alternative courses of action

involving sex and drugs. They need help with thinking about how they will handle situations that are likely to elicit high-risk acts.

The adolescent who thinks in concrete terms concentrates on individuals and finds it difficult to take into account society as a whole (Snoman & Biehler, 1990). She suggested that adolescents with learning disabilities do not attain the stage of formal operations and the stage of concrete operations until much later. The adolescent with learning disabilities will develop over time and traverse the same developmental stages but the ultimate level of functioning attained will be lower.

The most obvious characteristic that distinguishes adolescents with learning problems from others is their limited cognitive ability, a limitation that inevitably shows up in their academic work. Many adolescents with learning disabilities have problems with the organisation of information, lack good judgment, display poor impulse control, have limitations in foresight and have difficulty generalising from one situation to another (Kaplan & Sadock, 1998). They have a general language deficit and specific problems using interpretive language. An additional disability often experienced is difficulty with memory, especially short-term memory. Some researchers suggest that the long term memory is about the same as that of their normal peers, that is, they are no more likely to forget what they have learned. However, this is only true when what is learned is consistent with their mental abilities (Schwablearning.org, 2006).

2.6.4 Emotional Changes during Adolescence

Adolescence is a time of increasing emotional energy. Adolescents tend to experience their emotions more intensely, and often undergo rapid fluctuations in mood. They are further confused about the origin of their feelings (as to whether the emotions are internally generated or are the consequence of an external situation), whether the feeling is likely to pass quickly or extend over time. Not only are adolescents often unable to identify

the source of their feelings, they are also unlikely to be able to differentiate and label them accurately. This emotional liability can lead to erratic and impulsive behaviour, as adolescents respond to a flood of emotions that they can neither identify, nor express, nor adequately cope with.

In view of their limited understanding adolescents with learning difficulties experience even more difficulty in understanding their own moods and feelings which in turn causes intense emotional hang ups during this time (Ellis, 1989).

CHAPTER THREE

POLICY AND FRAMEWORK FOR ADOLESCENTS, and HIV/AIDS AND EDUCATION

The discussion in this chapter addresses the following:

- The National HIV/AIDS Policy.
- International Efforts To Improve Adolescent Sexual Health
- HIV/AIDS Education

3.1 THE NATIONAL HIV/AIDS POLICY

The Education Department has published the National Policy on HIV/AIDS for Learners and Educators in Public Schools in terms of section 3 (4) of the National Education Policy Act 27 of 1996 in the government gazette on 10 August 1999 (hereinafter referred to as the National Policy on HIV/AIDS).

The National Policy on HIV/AIDS addresses the effects of the HIV/AIDS epidemic and the rapid increase in the rate of the infection in South Africa. The policy includes prevention and care within the framework of the educational system. The sections of the National Policy on HIV/AIDS of relevance to the implementation of HIV/AIDS education programmes in public schools are:

- **Section 2.10** states that learners must be educated about HIV/AIDS and abstinence. Life skills and HIV/AIDS education should be integrated into the whole curriculum, presented in a scientific but understandable way, and conducted on an ongoing basis. Provision should be made for qualified educators who were trained in HIV/AIDS to educate learners about the epidemic.

- **Section 2.10.1** states that the purpose of HIV/AIDS education is to prevent the spread of HIV/AIDS infection, to reduce fears of the epidemic and the stigma attached to it, and to promote non-discriminatory attitudes towards persons with HIV/AIDS. Education should ensure that learners acquire age and context appropriate knowledge and skills in order that they adopt and maintain behaviour that will protect them from HIV/AIDS infection.
- **Section 2.10.2** states that in the primary grades, the regular educator should provide education about HIV/AIDS, while at the secondary level; the school counsellor would ideally be the appropriate educator. Because of the sensitive nature of the subject, the educators selected to offer this education should be specifically trained and supported by the support staff responsible for life skills and HIV/AIDS education in the school and province. The educators should feel at ease with the content and should be role models with whom learners and students can easily identify. Educators should also be informed by the principal and educator unions of courses for educators to improve their knowledge of, and skills to deal with, HIV/AIDS.
- **Section 2.10.3** states that all educators should be trained to give guidance on HIV/AIDS. Educators should respect their position of trust and the constitutional rights of all learners and students in the context of HIV/AIDS.

This policy serves as a guideline for educators and learners in public schools in respect of:

- Teaching HIV/AIDS in the Classroom & mandatory requirements of the National Curriculum

- Learning Support Material
- Teacher Training
- School HIV/Aids Policy
- Health-Promoting Schools and Whole School Development
- Sexual Abuse and Educators

There is a clear indication that the National Educational Policy on HIV/AIDS recognises the need for each secondary school to have a qualified counsellor, and, for the empowering of educators through training, resources and support services, in order to have a positive impact on learners and students in relation to HIV/AIDS.

Section 2 (10.2 and 10.3) of the National Policy on HIV/AIDS placed enormous responsibilities on educators as role models and guides in respect of HIV/AIDS. It is therefore crucial that the educators themselves are empowered through training and capacity building in the implementation of HIV/AIDS education in school. Shah (2001), observed that not all educators have received the necessary training to implement the HIV/AIDS education programme in school. Those that have been 'trained' have only attended either a sexuality course, or a workshop on HIV/AIDS, or attended a week's course on HIV/AIDS which was run by the Department of Education.

Together with the National Policy on HIV/AIDS the Education Department has published a booklet: *The HIV/AIDS Emergency Guidelines for Educators*. It is available in all the spoken languages of South Africa. It offers the educator assistance with the dissemination of facts about HIV/AIDS, sexuality education, including prevention and transmission of HIV/AIDS and building a caring environment free from discrimination. The booklet draws attention to the problem of sexual activities in school, which are seen as contributing factors in the transmission of HIV/AIDS among young females.

The importance of training educators in the implementation of HIV/AIDS programmes extends beyond factual knowledge of the disease. Educators must receive comprehensive information on the legal implications of sexual relations with students and their obligations as role-models towards learners in the prevention and transmission of HIV/AIDS.

3.2 INTERNATIONAL EFFORTS TO IMPROVE ADOLESCENT SEXUAL HEALTH

The international community has repeatedly agreed to meet young people's developmental needs, including those relating to sexual and reproductive health. Despite this, young people often have little or no access to the information and services they need to make healthy, informed decisions about their sexual and reproductive lives (Population Action International, 2002).

The Population Action International action group (2002), explains why good sexual and reproductive health is critical to the well-being of youth. It states that the social and developmental consequences of sexual and reproductive decisions are far-reaching. An unintended pregnancy can irrevocably disrupt a young girl's life, precluding further schooling and training. Contracting HIV/AIDS can bring a young person's prospects for a healthy and productive future to an end.

According to The Population Action International (2002), adolescents have a right to the information and services they need to make healthy decisions about their lives. Since the International Conference on Population and Development in 1994, the international community has consistently reaffirmed the right of adolescents to age-appropriate reproductive health information and services that safeguard their rights to privacy, confidentiality, respect and informed consent. The international community

also has reaffirmed that the rights and responsibilities of parents to provide guidance in such matters should not prevent adolescents from having access to the information and services they need to enjoy good reproductive health as good sexual and reproductive health is crucial to national development.

Countries that fail to provide adolescents with the means to remain healthy and in school will lose on the other investments they make in adolescents. The decisions adolescents make about sex and pregnancy will have long-lasting consequences for their own health and welfare beside the consequences for their country's population growth.

The 1994 International Conference on Population and Development (ICPD) articulated a broad, rights-based commitment to sexual and reproductive health for adolescents. The ICPD Programmes of Action refers to the need for parents, and other adults to provide guidance and to respect the rights of adolescents to information and services. It calls on governments to overcome barriers to reproductive health care for adolescents and encourages health care providers to be open to adolescents. The objectives are to encourage responsible, healthy reproductive and sexual behaviour, which includes voluntary abstinence, among adolescents and to reduce HIV/AIDS and adolescent pregnancy.

At the International Conference of Population Development (1994), the governments of the various countries agreed on the following issues: the prevention of, and services for, sexually transmitted diseases and HIV/AIDS to become an integral component of reproductive and sexual health programmes at the primary health-care level; adolescents issues, and prevention of HIV/AIDS are to be addressed in prevention and education programmes and services; the responsibility to set the necessary policies into place falls on the government of the country.

Much emphasis is placed on education with the goal to ensure that by 2010 at least 95 per cent, of adolescents aged 15 to 24 have access to the information, education and the full range of services to protect them and to improve their health. Adolescents are to be actively involved in the planning, implementation and evaluation of development activities that have a direct impact on their daily lives. Multi-level youth programmes are to be developed taking into account all the needs of adolescents. Special attention is to be devoted to vulnerable and disadvantaged adolescents.

The governments have agreed on a strategy to combat the HIV/AIDS pandemic. Their discussions and subsequent plans, however, have not taken into consideration the adolescent with learning difficulties. The implementation therefore, has not affected those with learning disabilities.

The sexual and reproductive health of adolescents was once again a key issue in 2004 as governments reconvened for the 10-year review of ICPD. Representatives of 179 countries agreed to the objectives set forth in the original ICPD Programmes of Action, but since 1994, many of those countries have inconsistently addressed adolescents' reproductive health. Countries that have effectively addressed the issue have treated it as an urgent matter of public health rather than an issue of morality.

Sexuality education and services in schools are to reach millions of adolescents. Since a large number of adolescents attend school in most parts of the world, integrating sexuality education into school curricula is an important strategy. Studies have shown that fears of sex education contributing to earlier and less thoughtful sexual activity are misplaced. In the Netherlands, for example, sex education is universal, public messages about sexuality are widespread, and access to services is viewed as a basic human right. It was found that adolescents begin sexual activity later, have fewer partners and are far better prepared for sex as shown by low rates of unintended pregnancy, abortion and transmission of STIs (Meier, 2005).

The International Conference on Population and Development held in Cairo, Egypt in 1994 addressed several issues and tabled the following: the reproductive health needs of adolescents as a group is to be given priority. Societies are to directly respond to the felt needs of their adolescents to empower them to make wise decisions.

Parents and guardians are to assume a more assertive role in assisting and guiding their children/wards, and the country is to ensure that adolescents are provided with the necessary health services. Countries, with the support of the international community, are to protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number. Governments are to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs.

Adolescents must be fully involved in the planning, implementation and evaluation of such information and services with proper regard for parental guidance and responsibilities. Programmes should involve and train all stakeholders to ensure that adolescents receive the best services possible

It has been 13 years since that Conference. Much still needs to be done in many countries and their governments.

In June, 2000, representatives from 180 countries met at the Beijing Platform for Action to discuss issues pertaining to women. The document produced recognizes the specific needs of adolescents and the need to implement specific appropriate programmes for them. Programmes that were considered covered education and information on sexual and reproductive health issues and on sexually transmitted infections, including HIV/AIDS, taking into account the rights of adolescents and the responsibilities, rights and duties of parents.

Adolescent females were considered especially in relation to HIV/AIDS. Focus was on supporting and strengthening national capacity to work on all levels for the improvement of quality of life for adolescents, and for the education for the prevention of HIV/AIDS. Community strategies that will protect adolescent females, provide care and support to infected adolescent females and their families, and to mobilize all parts of the community in response to the HIV/AIDS pandemic were strategised.

Section 27 of the Bill of Rights (South African Constitution, 1996), recognizes everyone's right to access health care services. The National Adolescent Sexual Rights Document aims to focus attention on the rights of adolescents. The objective is to create awareness and provide services which will bring meaningful changes to the lives of adolescents in relation to sexually transmitted infections. This document was developed by adolescents for adolescents as part of the National Adolescent Friendly Clinic Initiative (LoveLife, 2002). The responsibility of HIV/AIDS education programmes in schools is to enlighten adolescents about their rights to sexual health. HIV/AIDS programmes must include life skill components to exercise these rights in a responsible manner.

According to LoveLife (2002), the rights of South African adolescents in relation to health care are often overlooked.

3.3 HIV/AIDS EDUCATION

HIV/AIDS has affected every country in the world. Some countries have acted with urgency in controlling the epidemic while others have approached the subject with caution and mixed feelings. HIV/AIDS educational programmes are often the outcome of the kind of response received from people in a position of authority and control.

The content of HIV/AIDS education needs to be multifaceted taking many issues into consideration while being implemented in schools.

Special consideration needs to be given in planning and implementing education programmes for adolescents with learning disabilities.

3.3.1 HIV/AIDS EDUCATION IN OTHER COUNTRIES

In **Britain** many programmes were planned and implemented on the awareness and prevention of HIV/AIDS. These attempts ranged from information-giving exercises to providing facts on HIV/AIDS through posters, and leaflets, to radio and television advertising (Aggleton et al, 1989).

The Policy of the Department of Education and Science (1987), emphasised the school as a place where adolescents could be educated about HIV/AIDS, and that schools should be prepared to respond to questions about HIV/AIDS from adolescents. According to Farquhar (1991), however, the circular had given no clear guidelines about HIV/AIDS education in the school. In the UK, Farquhar (1991), explained, sex education in schools was determined by school governors. Thus there are different approaches to, and views on, the inclusion of sex education in schools.

Dean (1994), explains the two stage plan, by the Department of Health in the UK viz. to increase health care services for adolescents, followed by a focus on sex education programmes in schools. The Education Department adopted a moralist view of sex education in schools as a form of encouragement rather than a form of deterrent to engage in early sexual intercourse. The consequence of such a view contributed to the gradual removal of conception, abortion and HIV/AIDS education from the science curriculum of secondary schools. Parents also had the right to remove their child from sex education programmes (Dean, 1994). According to Dean (1994), a national survey revealed that adolescents who received proper sex education at

school delayed sexual intercourse to a much later stage than those who acquired knowledge on sex from friends. Dean (1994), believes that a well planned sex education programmes in school can reduce the number of adolescent pregnancies, sexually transmitted infections and HIV/AIDS.

The Health Education authority was responsible for the HIV/AIDS awareness and prevention programmes. Local health and social services initiated interventions in schools, colleges and at community level using the information-giving model (Aggleton et al, 1992). The resource material was produced by staff of the Family Planning Association to be used within the broader framework of personal, social and health education. Videos, board and card games, have since been produced both commercially and by charitable trusts to provide a variety of resources and to create awareness and understanding of HIV/AIDS among adolescents. The resources are directed mainly towards prevention and transmission of the virus. Others responded to the need for behavioural changes, assertiveness and negotiating skills to avoid becoming infected with the virus (Aggleton et al., 1992).

The **New South Wales** Education Department placed a lot of emphasis on evaluations. The Department appointed special groups to monitor the implementation and effectiveness of programmes. Other professionals from the health and education sector were also involved in the evaluation process. These evaluations were used in the planning of future programmes and for the improving of HIV/AIDS education (AVERT, 2002).

The **United States** government had neglected the issue of education in the prevention of HIV/AIDS (AVERT, 2002). Some believed that nothing would deter adolescents who wished to engage in sex. Others felt that sex education, including the knowledge of HIV/AIDS infection

and prevention should be brought to the attention of adolescents at school and condoms should be freely available. Another group believed that sex was not for adolescents and that educating them on condom use only increased the risk of early sexual experiences. According to Draimin (1995), the mixed feelings and attitudes towards the awareness and prevention of HIV/AIDS have resulted in the differing policies in the various states towards the HIV/AIDS epidemic.

Research on health programmes which were part of and integrated into the curricula, and instituted by teachers who received special training in implementing HIV/AIDS education programmes can influence the way adolescents think and it can bring about changes in their attitudes, behaviour and knowledge (Rosenberg et al, 1992).

Rosenberg et al. (1992), recommend a well planned HIV/AIDS education programme integrated into the curriculum, rather than one-off exposure to HIV/AIDS awareness, to have a positive impact and beneficial outcome to health behaviour. The programme should enable the learner to develop the appropriate skills e.g. decision making and communication skills, resistance to peer pressure, and the building of self confidence and self-esteem, a suitable curriculum must be drawn up. This is a long-term programme (Rosenberg et al, 1992).

Such a programme was approved by the Centre of Disease Control, and by the Presidential Commission on the HIV/AIDS Epidemic, and supported by the National Association of School Boards and the National Association of State Boards of Education. According to Rosenberg et al (1992), the HIV/ AIDS education in schools was greatly improved by the national programmes, where schools were enabled to plan, implement and evaluate HIV/AIDS programmes with periodic surveys being conducted to assess students' knowledge, attitudes and behaviours that influence the spread of HIV/AIDS.

Walter (1993), found that school based HIV/AIDS prevention curriculum might play a role in curtailing the transmission of HIV/AIDS among multi-ethnic groups of adolescents, together with a broader social involvement.

Beside the school, both national and community based organizations also played an important role in reaching out to adolescents. They addressed drug abusers, adolescent pregnancy and sexually transmitted infections. The HIV/AIDS programmes included training adolescents as peer educators, peer/professional counsellor models and group educational sessions that reach those adolescents out of school.

Adolescents are being trained to provide outreach, education and support to other adolescents in a wide range of adolescent health issues, including HIV/AIDS, STIs and adolescent pregnancy (HIVInSite, 2001). Peer educators need to be adequately supported and receive intensive training for at least six months. The training would need to include individual mentoring and working closely with experienced educators and other peer educators (HIVInSite, 2001). Peer educator programmes are now firmly rooted as an added intervention in the prevention of HIV/AIDS and other health issues in United States.

In **West and Central Africa** HIV/AIDS education was being implemented within the context of family life and population education in schools. This framework includes biology, home economics and health, civic and moral education Fouilloux (1999). Fouilloux (1999), cites **Senegal** as an outstanding example which was set within the field of family education. According to him, the organization *Group for Research and Development on Population and Education* established one hundred and forty family education clubs which cater for 52% of adolescents. The

clubs offer adolescents training in leadership and training as peer educators. The aim is to create an awareness and prevention of HIV/AIDS by using peer educators to reach out to adolescents in and out of school. Every opportunity is used to reach out to the community e.g. on special days, or during special events. The HIV/AIDS infection rates have dropped significantly for the year 2000.

According to Wheeler (1999), the government and the community in **Uganda** waged a religious war against HIV/AIDS. Religious Institutions were involved. The Ugandan Ministry of Health, together with the United Nations Children Fund (UNICEF), drew up a thirty-six lesson curriculum which was administered at religious schools. The programmes were designed to promote an awareness of HIV/AIDS, its transmission, prevention, control. The lessons included life skills to enhance self confidence and the ability to cope with the pressures of growing up-resistance to peer pressure, communication skills and being assertive. Any difficulties experienced have been sorted out through negotiation and dialogue with parents and community leaders. Parents often found it difficult to talk to their adolescents about sexuality education and have welcomed the HIV/AIDS programmes.

Shuey et al. (1999), report that the Soroti district of Uganda improved access to information, peer interaction, and the performance quality of the existing school health education system, and that sexual activity among adolescents aged 14 years reduced from 43 percent to 11 percent after two years of programming.

Tanzanian efforts in the prevention of HIV/AIDS have been directed towards the primary school level as early intervention was regarded as essential towards developing positive behavioural patterns and reducing the risk of HIV/AIDS infection. According to Ndeki et al (1995), the *Ngao Shield Programmes* was planned at a time when traditional social

systems no longer were in place. The goal was to assist adolescents at school to make informed decisions. All role players were involved in the drawing up of the programmes which took into account the cultural and ethnic differences, the urban-rural factors in the region, and flexibility to adapt the educational materials. (Ndeki et al, 1995).

In **Cameroon** *peer education* was adopted as a strategy to increase contraceptive prevalence and reduce the rate of sexually transmitted infections and AIDS among adolescents in Cameroon. The Institute for Behavioural Studies and Research (IRESCO), tested interventions to improve adolescents' knowledge and practices regarding sexual and reproductive health, and to reduce the prevalence of sexually transmitted infections among adolescents. The project trained peer educators and developed and distributed professional-quality comic books, brochures, and a magazine to educate adolescents and promote discussion of reproductive health, sexually transmitted infections, and HIV/AIDS. Adolescents reported postponing sexual activity. Fidelity and abstinence increased, and fewer adolescents reported having multiple sexual partners. Abstinence was seen as the most effective protection against HIV/AIDS (Project publications, 1996).

3.3.2 HIV/AIDS EDUCATION IN SOUTH AFRICA

The control of the HIV/AIDS epidemic lies not only in the educating of the masses but also in the development of life skills to change irresponsible sexual behaviour.

The Department of Health has been responsible for preparing and distributing literature on HIV/AIDS. The media has been highlighting the effects of HIV/AIDS on the people of South Africa. The National and Provincial governments have implemented a number of prevention efforts in South Africa. These efforts include information, education,

and communication, peer education and behavioural risk reduction (Harrison, Smit, and Meyer, 2000).

The Department of Education has included in its school curriculum Life Orientation which covers HIV/AIDS in detail. The aim of the programmes is provide knowledge, develop skills, promote positive and responsible attitudes, and to motivate learners to engage in safe sexual behaviour to reduce the risk of possible HIV/AIDS infection (Harrison, Smit, and Meyer, 2000). The Department of Education's "Beyond Awareness Programmes" focuses on prevention utilizing the popular media and sponsoring HIV/AIDS awareness activities.

Adolescents with learning difficulties have however, not been given any special attention. Interventions are poorly designed in terms of objectives and content in relation to the development of cognitive skills (Kim et al, 1997). It has been left on the schools and educators concerned to adapt the information to suit the special need of these adolescents.

3.3.2.1 HIV/AIDS EDUCATION IN KWAZULU-NATAL SCHOOLS

The Education Department of KwaZulu Natal has adopted the National Education Policy Act No.27 of 1996 as a point of departure in the planning and implementation of HIV/AIDS awareness and prevention programmes in schools. A set of procedures has been adopted from the National Policy on HIV/AIDS by the Department of Education and Culture, KwaZulu Natal.

The procedures relate to:

- A safe school environment
- Prevention of HIV transmission during play and sport
- Education on HIV/AIDS
- Universal Precautions (National Policy on HIV/AIDS, 1999)

Since 2001 the Department of Education has been training educators to implement HIV/AIDS educational programmes in schools, and has phased in Life Orientation into the school curriculum. Life Orientation is presently compulsory for all learners. The content of Life Orientation covers all aspects of life skills such as relationships, HIV/AIDS, substance abuse, etc.

In South Africa, the National Policy on HIV/AIDS (1999), has prioritized the inclusion of HIV/AIDS and development of life skills within the school setting. In developed countries, literature indicates that there was a slow response to the inclusion of school-based HIV/AIDS educational programmes. Developing countries, given the high rate of HIV/AIDS, have initiated HIV/AIDS educational programmes at schools. The components of HIV/AIDS education programmes are directed towards behavioural changes, through the development of skills, awareness of HIV/AIDS and its transmission and developing a caring attitude towards people with HIV/AIDS.

The HIV/AIDS outreach programmes also cater for adolescents out of school. The success of HIV/AIDS programmes in the prevention and transmission of the virus depends on a host of factors. Clearly classroom education on its own will not solve the problem. The overall success of HIV/AIDS programmes in which sustainable behaviour change has taken place requires further research.

In most countries, as in South Africa, the high prevalence of HIV/AIDS demands urgent and immediate action to include all sectors of the population. The Global Programmes of Action (1992-1993), found that sex education is more effective if given prior to becoming sexually active. Programmes promoting, both abstinence and protected sex were successful. Education is considered as one of the key instruments in the control of the HIV/AIDS epidemic in all countries.

Whereas HIV/AIDS education has been the concern at both national and community level in all countries, with programmes being developed to meet the individual country's unique needs, the developing, pre-testing, implementing and assessing the effectiveness of HIV/AIDS education programmes where there are heterogeneous populations the challenge is even greater (Hunter et al, 1992). The only consideration given to adolescents with learning difficulties at both national and international levels is the use of poster and colourful pamphlets, and the creation of card and board games that are available in the commercial world. There is no documentation on sex education in the special education classroom.

Adolescents with learning difficulties, amongst others, must be taken into consideration when the school education programme for HIV/AIDS education is being revised. HIV/AIDS educators have to build a knowledge base while they implement and evaluate HIV/AIDS education programmes (Hunter et al, 1992).

Internationally there has been minimal or no special programmes planned. In South Africa adolescents with learning difficulties are placed in Special Schools which have educators who have been trained in teaching adolescents with special needs. The programme that was designed for the schools in general is being adapted for the adolescents with learning difficulties.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 INTRODUCTION

According to Yegidis and Weinbach (2002), a scientific method of acquiring knowledge is a particular way of acquiring knowledge: it is a way of thinking about and investigating assumptions about the world. The particular scientific method chosen will depend on the study being undertaken. Whereas the natural sciences allow the researcher to investigate or find explanations for natural phenomena in a carefully controlled environment the social sciences deal mainly with finding explanations for social phenomena and human actions. Social research permits the acquiring of in-depth knowledge of social phenomena despite possible constraints (Bless and Higson-Smith, 2000). According to Babbie (1995), social science research is organised around two activities viz. measurement and interpretation of data. Measurements are either qualitative or quantitative.

This chapter is structured under the following headings:

- Research Design
- Research Method
- Sampling Strategy
- Data Collection Techniques
- Methods of Data Analysis

4.2 RESEARCH DESIGN

Descriptive design examines characteristics of a single sample where it explores aspects of the phenomena of interest. A descriptive study design is one in which the primary goal is to assess a sample at one specific point in

time without trying to make inferences or causal statements. It can identify areas for further research, help in the planning of resource allocation (needs assessment), to provide information about a specific issue, condition or disease and is helpful in revealing patterns and connections that might otherwise go unnoticed (Neuman, 2000).

Descriptive research involves collecting data in order to test hypotheses or answer questions concerning the current status of the subjects of the study. It determines and reports the way things are.

According to De Vos (1998), a research design is a logical strategy for gathering evidence about knowledge desired. It must be efficient in order to yield the sought after knowledge. A descriptive design can be qualitative or quantitative in nature. The researcher chose the descriptive design for the study. According to Kumar (1999), a study classified as descriptive research attempts to describe systematically a situation, a problem, or a phenomenon.

Descriptive research was used in this study as it provided the researcher with information on the knowledge of HIV/AIDS, and the sexual attitudes and behaviour of adolescents with learning disabilities. It does not limit one to any one method of research: almost all methods of data collection can be used e.g. questionnaires, interviews, and/or direct observation.

4.3 RESEARCH METHODS

The purpose of quantitative studies is that the researcher would be able to make generalizations, predictions, causal explanations.

The researcher chose a quantitative method for this study in that she sought to make generalizations to the population of adolescents with disabilities. According to Yegidis and Weinbach (2002), quantitative research is

designed to produce data that tell us how many people do or think something, and to be statistically reliable. It is a type of research that emphasizes the numerical measurement of variables – the issue of measurement is of primary importance. Quantitative research incorporates the statistical (*how many?*) element, designed to quantify the extent to which a target group are aware of, think this, believe that or are inclined to behave in a certain way.

In quantitative research personal experiences are quantified, measured on some scale before they can be scientifically studied. It excludes qualitative research which is focused on the individual meanings of experiences to the people who lived them. This study did not focus on the meaning of experiences. Rather, it focused on the extent to which adolescents with learning disabilities are aware of HIV/AIDS, their attitudes towards sexual behaviour, and their inclination to behave in specific sexual ways.

According to Yegidis and Weinbach (2002), quantitative methods are also employed in descriptive research. This was a descriptive study. A questionnaire was the instrument of data collection.

4.4 THE PILOT STUDY

According to Cooper and Schindler (2002), a pilot study is conducted to detect weaknesses in design and instrumentation and provide proxy data for selection of a probability sample. Cohen, et al (2007), defines a pilot study as a trial run of the study, using the chosen instrument and randomly selected participants, similar to those in the final study. The pilot study was conducted to test the use of a questionnaire as an appropriate tool for data collection

Six adolescents with learning difficulties were randomly selected for the pilot study. A non-probability availability sample was used. The planned pilot study was discussed with each class during the guidance period and the need for volunteers to participate in a small trial research was made known. Three males and three females volunteers were needed (ten percent of the proposed sample). From the volunteers in each grade, three males and three females from each grade were randomly selected. Name lists according to gender were compiled for each grade.

During the pilot study it was evident that the adolescents with learning disabilities had a short attention span and did not readily engage in any discussion or express themselves freely. The use of the questionnaire instead of an interview schedule was therefore most appropriate.

For the pilot study, the researcher filled in six questionnaires: one from each grade with two being selected from grade ten to provide the sample of six. Their demographic characteristics are reflected in the table below.

| Table 4.1: Demographic characteristics of the respondents In the pilot study | | |
|---|---------------|------------|
| Category | Results | Percentage |
| Gender | Male (3) | 50% |
| | Female (3) | 50% |
| Age | 14 yrs (1) | 17% |
| | 15 yrs (1) | 17% |
| | 16 yrs (2) | 33% |
| | 17 yrs (2) | 33% |
| Race | Black (3) | 50% |
| | Indian (3) | 50% |
| Religion | Christian (4) | 67% |
| | Hindu (2) | 33% |

| | | | |
|-------|----|-----|-----|
| Grade | 6 | (1) | 17% |
| | 7 | (1) | 17% |
| | 8 | (1) | 17% |
| | 9 | (1) | 17% |
| | 10 | (2) | 33% |

The usefulness of the pilot study was that it provided the researcher with feedback on the type of information the questions in the questionnaire elicited from the respondents. The questionnaire seemed too long especially since the learners experienced difficulty in maintaining focus. The questionnaire was then shortened with some of the repeated questions removed. Some questions needed explanation. These questions were then rephrased so as to make it easier for the participants to understand.

4.5 SAMPLING

By sampling, some of the elements of the population to be studied are selected, so that inferences can be drawn about the entire population to be studied. Populations tend to be very large and for this reason, researchers rarely study every element in the population. Rather, they select a portion of the population for study – that is defined as the sample. The population element or the unit of analysis is the subject on which the measurement is being taken. In this study the unit of analysis is the adolescent with learning difficulty.

According to Bless and Higson-Smith (2000), “a random sample is selected on some planned basis to ensure that every element has the same opportunity of being selected. It is thus possible to estimate the extent to which the findings based on the sample are likely to differ from what would have been found by studying the whole population.”

There are two main types of sampling designs viz. probability sampling and non probability sampling

In probability sampling, sampling is based on random selection of subjects and each element has an equal chance of selection in the sample (Kumar, 1999). According to Cooper and Schindler (2000), it is a controlled procedure where each element in the population is given a known non-zero chance of selection. There are five probability sampling designs viz. simple random sampling, systematic random sampling, stratified sampling, cluster sampling and stage sampling.

In non probability sampling random selection of subjects does not apply. Non-probability sampling is nonrandom and subjective. There are five non-probability sampling designs, namely, quota sampling, accidental sampling, judgmental or purposive sampling, dimensional sampling, and snowball sampling commonly used in qualitative research (Cohen et al, 2007). Some research projects under study require cases to be purposefully selected to fit a small series of categories. Purposive sampling guarantees that certain elements relevant to the research design will be included.

Damorosa Secondary School was chosen as the population to be studied since it is the only school that caters for adolescents with learning problems coming from Chatsworth and the surrounding areas.

The researcher used stratified random sampling which is probability sampling. A stratified sample is one obtained by separating the population into non-overlapping groups, called strata and then selecting a simple random sample from each stratum. It is used either to increase precision or to boost sample numbers within some sectors of the population. According to Mark (1996), the population is divided into strata or subgroups by population characteristics. A simple random sample is then drawn for each stratum or subgroup. The research facilitator controls the relative size of

each stratum, rather than letting random processes control it, without compromising the representivity within a sample (Neuman, 2000).

For this study the researcher divided the population into five strata or subgroups according to the five grades at the school. Each stratum (grade) was then divided according to gender and ethnic group.

The researcher compiled a name list for each grade. Each grade list was divided according to gender and ethnic group. Names from each grade were placed into boxes according to gender and ethnic group. Each grade had six boxes. Two names from each of the boxes were randomly drawn yielding a sample of 12 respondents from each grade. Together the five strata yielded the 60 respondents for the study.

There are 300 learners at Damorosa Secondary School representing three (3) all population groups. Table 2 indicates the distribution of respondents that comprised the sample.

Table 4. 2: distribution of respondents that comprised the sample

| | |
|---|----------------|
| Total population at Damorosa Secondary School | 300 |
| Males | 240 |
| Females | 60 |
| Grade 6 | 50 |
| Grade 7 | 75 |
| Grade 8 | 55 |
| Grade 9 | 60 |
| Grade 10 | 60 |
| Range of Ages | 13 to 19 years |

4.6 ETHICAL CONSIDERATIONS

According to Cooper and Schindler (2002), ethics are norms and standards of behaviour that guide moral choices about our behaviour and our relationship with others. The goal of ethics in research is to ensure that no one is harmed or suffers adverse effects of the research activities. The researcher provided the following information to the respondents prior to administering the questionnaires:

- A brief explanation of the benefits expected from the research
- The time expected to be spent on completing the questionnaire
- That confidentiality of their responses and the anonymity of the respondents will be maintained at all times
- That participation in the study was voluntary and that they had the right to withdraw from the research at any stage if they so desired.

Informed Consent was obtained from parents and legal guardians. Consent was also obtained from the respondents who participated in the research. They needed to know what the study was about, and how it would benefit or impact on their circumstances.

Consent was also obtained from the Department of Education, and the school principal, well in advance. All the necessary information concerning the study was supplied to them. The purpose of the research was made known to each level. A copy of the findings of the study is to be made available to all key role players.

Information gathering on sensitive topics can be upsetting. To protect learners from harm, the use of information-gathering methods was kept to a minimum required to gain appropriate information on sensitive issues, in accordance with the basic ethical principles.

Debriefing sessions were held with some of the respondents regarding some sensitive issues e.g. rape.

4.7 METHOD OF DATA COLLECTION

In an attempt to compile first-hand information on the knowledge of HIV/AIDS and the sexual behaviour and attitudes of adolescents with learning difficulties, the researcher utilised the questionnaire as a method of data collection.

The carefully planned questionnaire, tested during a pilot study, was drawn up to elicit reliable and valid responses from the chosen sample. The data was quantitative in nature. The purpose of the questionnaire was to provide biographical, factual, behavioural and attitudinal data on HIV/AIDS. This provided the basis for an in-depth statistical analysis of the responses to the questionnaire.

The questionnaire was divided into *six* (6) categories as follows:

- **Section One: Demographic Data of the Respondent**

This section obtained data such as the name, age, sex, ethnic group, grade, religion, etc.

- **Section Two: Support Systems**

This section sought to ascertain what support systems are available to the learner with learning difficulties both during and after school hours.

- **Section Three: Knowledge of HIV/AIDS**

This section sought to ascertain the level of the learner's knowledge about HIV/AIDS, and the source of their information.

- **Section Four: Attitudes towards Sex**

This section sought to ascertain the learners' attitudes towards sex and the possible influences on the shaping of their attitudes.

- **Section Five: Sexual Behaviour**

This section sought to ascertain the learners' sexual behaviour and the possible influences on their sexual behaviour.

- **Section Six: Recommendations**

This section sought to ascertain any possible recommendations learners may have in respect of programmes at Damorosa and social work services.

The questionnaire contained both closed and open-ended questions. The close-ended questions were used to collect factual information about the learners. The open-ended questions allowed the respondents to elaborate answers and to make recommendations. The administration of each questionnaire took approximately 40 minutes.

Sixty questionnaires were personally administered by the researcher at a school in Chatsworth for adolescents with learning difficulties. On receiving the parent/guardian/learner consent-form duly completed an appointment was set up to suit the particular respondent. In instances where the respondent lived in Chatsworth an appointment was set for after school hours. Where the learner lived outside Chatsworth and needed to board

public transport, an appointment was made for school intervals, during the course of the normal school day. Both school intervals on a particular day were used for the completion of a questionnaire.

The questionnaire was filled in the researcher's classroom which is both private and very quiet; away from the playfield and the school traffic. Furthermore, the classroom door was kept closed to ensure privacy throughout the session. Respondents relaxed with their sandwiches in the classroom and hence were both comfortable and at ease.

The classroom permitted total privacy. Due to the sensitive nature of issues discussed no video or audio recording was done. Before commencing with the questionnaire the respondent was once again made aware of the right to withdraw from the research. The purpose of the research and the issue of confidentiality were once again explained to the respondent. With the agreement of the respondent the questionnaire was administered. None of the respondents who brought in a duly completed consent form withdrew from the research.

The questions were asked in the specified sequence and the answers presented by the respondents were noted.

Debriefing sessions were arranged for two of the respondents who were raped. These respondents were referred to seek assistance from the in-house psychologist.

4.8 METHOD OF DATA ANALYSIS

Analysis is the process of bringing order to the data, organising what is there into patterns, categories and basic descriptive units (Babbie, 1995).

Collins (1998), outlines the following stages to be followed by researchers:

- Classifying data into categories where the researcher records all data.
- Visual representation of data.
- Representing and visualizing.

The information from each questionnaire was organised into relevant sections and converted into a percentage. The sections covered a description of the study unit, the knowledge of HIV/AIDS, sexual attitudes, sexual behaviour, support systems and recommendations. The data was captured on an Excel spreadsheet, and was processed using the statistical package SPSS. Statistics are presented with the use of tables and graphs.

The processed data was then analysed and compared to findings of similar studies with adolescents. Conclusions and recommendations were then drawn from the processed data.

4.9 LIMITATIONS OF THE STUDY

Many factors can contribute to the limitation of a study. Every research project is confronted with problems which may relate to the method used to collect data, selection of respondents or the way in which data is presented (Rubin and Babbie, 1997). The researcher must be aware of potential limitations and the effects it may have on the quality and validity of the results. Determinants such as time, resources and availability of subjects are constraints often experienced by researchers.

The limitations with this study were:

- The sample was too small. This prevented generalizations from being made.
- The research was limited to one school. This prevents generalizations being made about other schools serving learners with learning problems.
- Researcher bias could have presented itself in that some of the questions had to be explained to respondents.

4.10 SUMMARY

The study was designed to ascertain the knowledge of HIV/AIDS and the sexual attitudes and behaviour of adolescents with learning difficulties in the Chatsworth and surrounding areas.

A descriptive research was used in this study as it provided the researcher with in-depth information on the knowledge of HIV/AIDS, and the sexual attitudes and behaviour of adolescents with learning disabilities.

A quantitative research approach was adopted where a questionnaire was used to gather the data. A pilot study was undertaken with volunteer learners at the same school.

Stratified, probability sampling was used in this research. Damorosa Secondary School was chosen as the population to be studied since it is the only school that caters for adolescents with learning problems from the Chatsworth and surrounding areas.

Because of the very sensitive nature of the study, ethics were a matter of concern and were given high priority. Consent was also obtained from the Department of Education, the school principal, the parents and guardians, and from the respondents themselves. A copy of the findings of the study is to be made available to the Department of Education and to the school principal.

The information from each questionnaire was organised into relevant sections that covered a description of the unit of analysis, the knowledge of HIV/AIDS, sexual attitudes, sexual behaviour, support systems and recommendations. The data was processed and analysed and compared to findings of other studies with adolescents in respect of the relevant sections.

Conclusions and recommendations were then drawn from the processed data.

The possible limitations with this study were that the sample was too small; the research was limited to one school and researcher bias could have presented itself in that some questions had to be explained to the respondent.

Chapter five highlights the findings of the study.

CHAPTER FIVE

RESULTS, ANALYSIS AND DISCUSSION

5.1 INTRODUCTION

This study explored the knowledge of HIV/AIDS, and the sexual attitudes and behaviour of adolescents with learning difficulties in the Chatsworth and surrounding areas. Out of a total of 300 learners, 60 learners completed the questionnaire. The purpose of this research was to obtain information in answer to the following questions:

- What is the level of knowledge of HIV among adolescents with learning difficulties?
- What are the attitudes of adolescents with learning difficulties towards sex?
- How do adolescents with learning difficulties behave, sexually?
- Where do adolescents with learning difficulties obtain their knowledge of sex and HIV/AIDS?
- How adolescents with learning difficulties view the school's programmes on sex/HIV education?

This chapter deals with the results pertaining to the above questions.

The abbreviation "No." refers to "number"

Percentages have been rounded to the nearest whole numbers.

5.2 DEMOGRAPHIC PROFILE OF RESPONDENTS

5.2.1. Age of the Respondents

The ages of the respondents are reflected in Table 5.1.

Table 5.1

Age of respondents

| Age in years | Male No. | Male % | Female No. | Female % | Total No. (row) | Total % (row %) |
|---------------------|-----------------|---------------|-------------------|-----------------|------------------------|------------------------|
| 13 - 14 | 8 | 13 | 8 | 13 | 16 | 26 |
| 15 - 16 | 12 | 20 | 12 | 20 | 24 | 40 |
| 17 - 18 | 10 | 17 | 10 | 17 | 20 | 34 |

5.2.2 Gender of Respondents

The gender of the respondents is reflected in Table 5.2.

Table 5.2

Gender of respondents

| Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|--------------------|---------------|----------------------|-----------------|---------------------------|------------------------|
| 30 | 50 | 30 | 50 | 60 | 100 |

An equal proportion of males (30) and females (30) were included in the sample. This ensured a balance in terms of gathering information about the attitudes of both males and females with learning disabilities towards sex and HIV/AIDS, and provided data to allow the comparison of both genders in terms of the issues being studied.

5.2.3 Religious Affiliation of Respondents

The religious groups to which respondents belonged are reflected in Table 5.3.

Table 5.3**Religious affiliation of respondents**

| Religion | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|------------------|------------------------|-------------------|--------------------------|---------------------|-----------------------------------|--------------------------------|
| Christian | 23 | 38 | 19 | 32 | 42 | 70 |
| Muslim | 3 | 5 | 4 | 7 | 7 | 12 |
| Hindu | 4 | 7 | 7 | 11 | 11 | 18 |

As is evident in Table 5.3 the majority of the respondents (70%) belonged to the Christian faith, whilst 18% belonged to the Hindu faith, and 12% to the Muslim faith.

5.2.4 Race Group of Respondents

Table 5.4 reflects the ethnic groups of the respondents.

Table 5.4**Ethnic group of respondents**

| Ethnic Group | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|-------------------------|------------------------|-------------------|--------------------------|---------------------|-----------------------------------|--------------------------------|
| African | 11 | 18 | 14 | 23 | 25 | 41 |
| Indian | 11 | 18 | 13 | 22 | 24 | 40 |
| Coloured | 8 | 14 | 3 | 5 | 11 | 19 |

The majority of the respondents were Africans and Indians. Although the school caters for all race groups, there are no Caucasian learners at the school. There is a similar school in the greater Durban area that caters

primarily for Caucasian learners with learning difficulties. Previously the other race groups had no such school to meet these needs. Damorosa, previously an Indian school now caters for all race groups.

5.2.5 School Grade of Respondents

Table 5.5 indicates the distribution of respondents according to school grades.

Table 5.5

School grades of respondents

| Grade | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|--------------|------------------------|-------------------|--------------------------|---------------------|-----------------------------------|--------------------------------|
| 6 | 6 | 10 | 6 | 10 | 12 | 20 |
| 7 | 6 | 10 | 6 | 10 | 12 | 20 |
| 8 | 6 | 10 | 6 | 10 | 12 | 20 |
| 9 | 6 | 10 | 6 | 10 | 12 | 20 |
| 10 | 6 | 10 | 6 | 10 | 12 | 20 |

As reflected in Table 5.5 each of the grades at the school was equally represented. This ensured an equal participation of respondents from all the school grades.

5.3 RESPONDENTS KNOWLEDGE OF HIV/AIDS

5.3.1 Respondents' Awareness of HIV/AIDS

Table 5.6 reflects the correct responses of the respondents' to the knowledge of HIV/AIDS.

Table 5.6

Distribution of respondents according to their correct responses to knowledge of HIV/AIDS

| | Male % | Female % | Total % (row %) |
|--|-------------------|---------------------|--------------------------------|
| AIDS is caused by HIV | 38 | 37 | 75 |
| HIV is transmitted through blood, semen, vaginal fluids, and breast milk | 40 | 43 | 83 |
| HIV is commonly spread by having sexual intercourse with someone who is infected with the virus | 47 | 40 | 87 |
| HIV is commonly spread by sharing needles or syringes with someone who has the virus. | 33 | 40 | 73 |
| HIV can spread from an infected pregnant woman to her unborn baby during pregnancy, birth, and breast feeding. | 43 | 40 | 83 |
| HIV is not spread through casual contact such as kissing, hugging, sharing of clothing, or eating utensils | 48 | 45 | 93 |
| Condoms used during sex can help prevent HIV spreading from one person to the next. | 33 | 40 | 73 |
| Young people do get HIV. | 47 | 38 | 85 |
| There is a no cure for HIV | 18 | 39 | 57 |
| Taking a shower/bath after sex does not reduce the risk of getting HIV | 43 | 40 | 83 |
| Condoms <u>do</u> protect one (100%) from getting infected with HIV. | 18 | 10 | 28 |
| There is a cure for HIV. | 32 | 11 | 43 |
| Those who look healthy could also have HIV. | 37 | 35 | 72 |

As reflected in Table 5.6 the majority of the responses were correct. The level of awareness of HIV/AIDS among respondents was high. Seventy two percent of the respondents agreed that those who looked healthy could also have HIV/AIDS. They were aware that one could look well while infected with the virus. One of the myths of HIV/AIDS is that it is possible to identify those who are infected by their physical appearance. The finding of this study is contrary to the findings of Swart-Kruger and Richter (1994), where they found a tendency among adolescents to use physical appearance as a basis to gauge their safety from contracting HIV/AIDS.

In this study 85% of the respondents were aware that adolescents too could contract HIV/AIDS. This finding too is contrary to the findings of a study undertaken in Alexandra, South Africa, where Swart-Kruger and Richter (1994), found that adolescents believed that it is impossible for them to contract HIV/AIDS as it is a disease of the older person.

According to the Population Council (2004), knowledge of reproductive health/STDs/HIV is generally good, but could be improved. While almost all respondents in their research were aware of sexual transmission and modes of prevention, many gaps in their knowledge were apparent. In particular, there was a lack of knowledge that HIV/AIDS could be transmitted by sharing needles and other unclean instruments, and could also be transmitted from mother to child during pregnancy, labour, and delivery. An analysis of the overall responses in this study however, shows that the knowledge of HIV/AIDS of both males and females was good although there were some disparities between male and female learners; the incidence of belief that there is a cure for HIV/AIDS, and that condoms are 100% protection against HIV/AIDS was higher for males than females.

5.3.2 Respondents' Knowledge of the Symptoms of HIV/AIDS

Table 5.7 reflects the respondents' correct responses to the knowledge of the symptoms of HIV/AIDS.

Table 5.7

Distribution of respondents according to their correct responses to the knowledge of the symptoms of HIV/AIDS

| Symptoms of HIV/AIDS | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|--|--------------------|---------------|----------------------|-----------------|---------------------------|------------------------|
| Rapid Loss of Weight | 20 | 33 | 24 | 40 | 44 | 73 |
| Diarrhea | 8 | 13 | 9 | 15 | 17 | 28 |
| Recurring Fever and/or night sweats | 11 | 18 | 23 | 39 | 34 | 57 |
| Recurring or unusual skin rashes | 15 | 25 | 18 | 30 | 33 | 55 |
| Loss of muscular strength | 20 | 33 | 24 | 40 | 44 | 73 |

It is evident from Table 5.7 that, on average, only 50% of the respondents knew all the symptoms of HIV/AIDS. The symptoms more commonly known (73%) were *rapid loss of weight*, and *loss of muscular strength*.

5.3.3 Knowledge of HIV/AIDS Preventive Measures

Figure 1 indicates the respondents' knowledge of the measures of preventing HIV/AIDS.

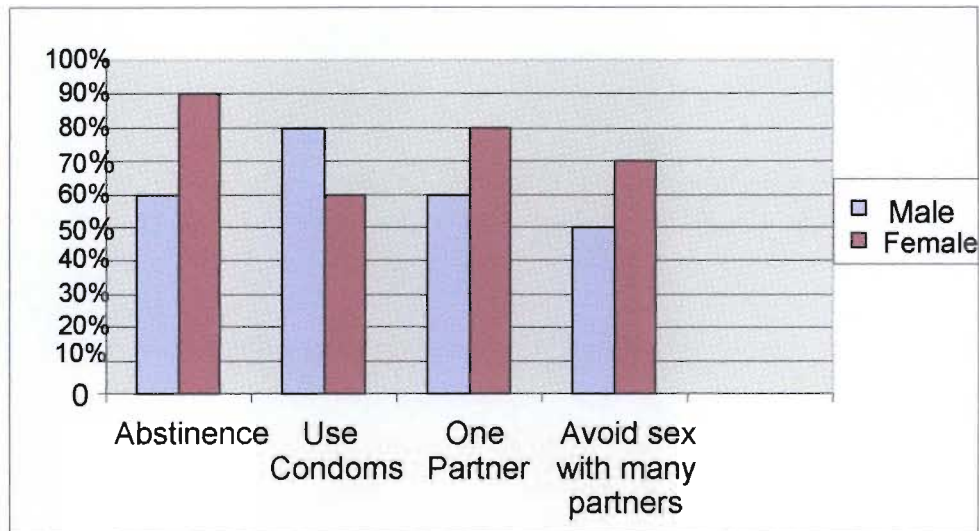


Figure 1

Distribution of respondents according to their knowledge of HIV/AIDS preventive measures

As is evident in Figure 1 the majority of the respondents, both male and female, are knowledgeable about ways to avoid getting infected with HIV/AIDS. The majority of respondents (90%) indicated that abstinence from sex is the most important measure in preventing HIV/AIDS. Condom use and the sticking to one partner were identified by 78% of respondents as ways of getting infected by HIV/AIDS.

The findings of the study contradict the findings of the Population Council Research (2001), where students were found to have misperceptions about HIV. Although the great majority of students knew something about HIV, they were unaware or mistaken about other important information concerning HIV prevention.

5.3.4 Respondents' Sources of Information about HIV/AIDS

Figure 5.2 indicates the sources of respondents' information on HIV/AIDS.

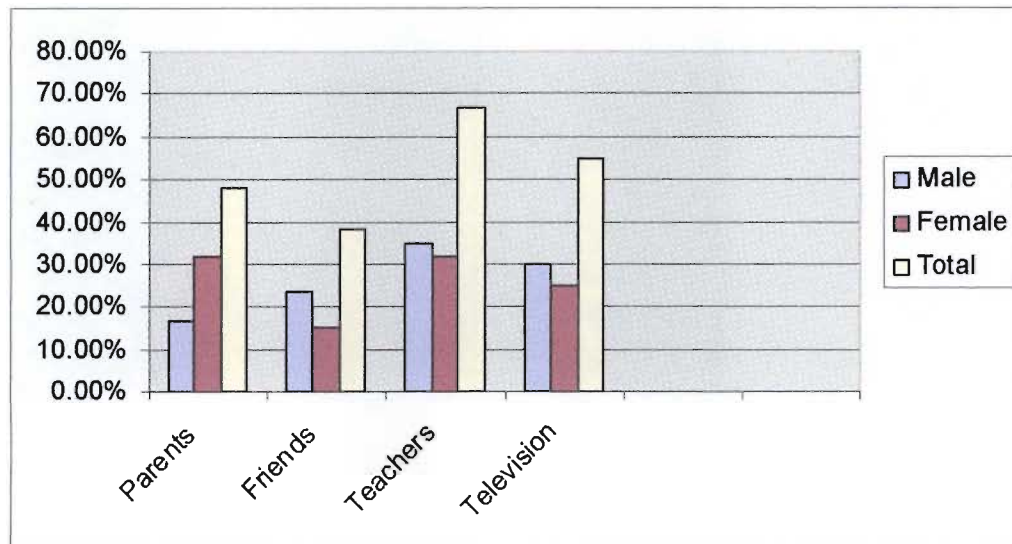


Figure 5.2

Distribution of respondents according to the sources of their information on HIV/AIDS

Respondents listed various sources from which they obtained their information about HIV/AIDS. As is evident in Figure 5.2 67% of the respondents regarded their educators as their source of information. This indicates the increasingly important role that the educators are beginning to play in the life of the adolescent. This is an important finding since the school is the primary source of HIV/AIDS education.

Only 48% of the respondents received information from their parents which may be due to either their parents' lack of knowledge of the subject or their parents feel that it is taboo to talk about such issues.

Slightly over 50% of the respondents indicated that the media (television) is an important source of information on HIV/AIDS.

5.4 SEXUAL BEHAVIOUR OF RESPONDENTS

5.4.1 Sexual Activity of Respondents

Table 5.8 reflects the distribution of respondents who had engaged in sexual activity.

Table 5.8

Distribution of respondents who had engaged in sexual activity

| Engage in Sex | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|----------------------|--------------------|---------------|----------------------|-----------------|---------------------------|------------------------|
| Yes | 12 | 20 | 1 | 2 | 13 | 22 |
| No | 18 | 30 | 27 | 45 | 45 | 75 |
| Other - Rape | 0 | 0 | 2 | 3 | 2 | 3 |

As is evident in Table 5.8 75% of the respondents did not engage in sexual activity. The researcher's assumption was that adolescents with learning disabilities have difficulty retaining information about HIV/AIDS and would therefore engage in sexual activity.

The findings of this research are contradictory to the findings of the study undertaken by Lovelife (2002), where approximately 67% of adolescents reported having had sexual intercourse. Studies by Lovelife (2002), found that sexual experience increased with age, with 48% of 15-19 year olds reporting having had sex compared to 89% of 20-24 year olds.

Whereas Lovelife studies (2002) also reported that there were no differences in the participation in sexual activity by both genders, the finding in this study shows that more males are sexually active.

5.4.2 Respondents Reasons for not having Sex

Figure 5.3 reflects the reasons why the respondents did not engage in sexual activity.

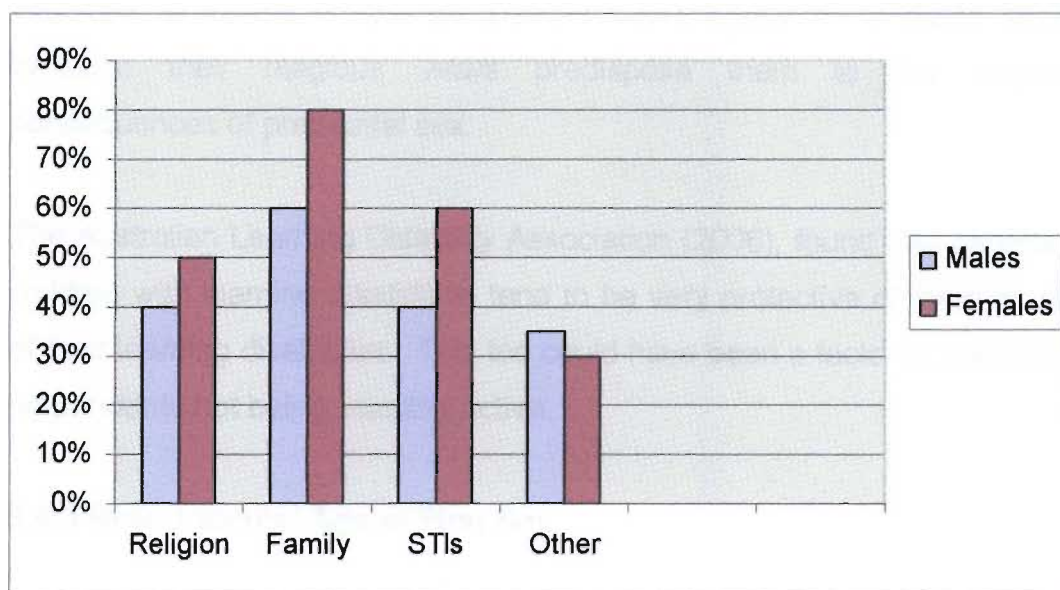


Figure 5.3
Distribution of respondents according to their reasons for not having sex

As indicated in Figure 5.3 the respondents who had not engaged in sex cited several reasons for not having had sex. 70% had made their decisions to abstain to conform to the expectations of their families.

The findings suggest that most respondents have delayed the onset of sexual experience through an active decision not to have sex because of family, religion, and STIs. As indicated in Figure 5.3 the family had the most impact on their decision.

Almost 59% of respondents listed religion as a reason for not engaging in sexual activity. This is in congruent with the findings of the NICHD-funded Add Health Survey (The National Institute of Child Health and Development,

2006). The NICHD-funded Add Health Survey found that religion reduces the likelihood of adolescents engaging in early sex by shaping their attitudes and beliefs about sexual activity. Hence adolescents with strong religious views are less likely to have sex than are less religious respondents, largely because their religious views predispose them to the negative consequences of premarital sex.

The Australian Learning Disability Association (2006), found that parents of children with learning disabilities tend to be very protective of them in view of their learning disabilities. This too could have been a factor in the 75% of respondents not being sexually active.

5.4.3 Respondents' Age at First Sex

Table 5.9 reflects the age at which male and female respondents first engaged in sex.

Table 5.9

Distribution of respondents according to their age at first sex

| Age at first sex | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|------------------|-------------|--------|---------------|----------|--------------------|-----------------|
| 11 | 0 | 0 | 1 | 2 | 1 | 2 |
| 12 | 0 | 0 | 0 | 0 | 0 | 0 |
| 13 | 1 | <2 | 1 | 2 | <2 | 3 |
| 14 | 3 | 5 | 0 | 0 | 3 | 5 |
| 15 | 5 | 8 | 1 | 2 | 6 | 10 |
| 16 | 2 | 3 | 0 | 0 | 2 | 3 |
| 17 | 1 | 2 | 0 | 0 | 1 | 2 |

Table 5.9 reflects the age of both male and female respondents at first intercourse. As reflected in Table 5.9 both sexes began engaging in sexual

activity from as early as 11 years. Since the age of sexual experimentation is reflected as 11 years it suggests that HIV/AIDS intervention measures should begin at primary school. In a study by Lovelife (2002), the mean age for first sex for males was 16.4 years and 17 years for females. The findings of this study indicate that the age of sex experimentation has become lower. Adolescents with learning disabilities are becoming sexually active at an earlier age.

As is indicated in Table 5.9 more male than female respondents were sexually active. This is congruent with the findings of The Horizons school-based studies by the Population Council (2001), where more males than females were having first sex at or before 15 years of age. It may be that males were more likely to report early sex than females.

5.4.4. Age of Respondents' Partners

Table 5.10 indicates the age of the respondents' partner at first sex.

Table 5.10

Distribution of respondents according to the age of their partner at first sex

| Age of partner at first sex | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|-----------------------------|-------------|--------|---------------|----------|--------------------|-----------------|
| 11 - 15 | 8 | 13 | 0 | 0 | 8 | 13 |
| 16 - 20 | 4 | 7 | 1 | 2 | 5 | 9 |
| 21 - 25 | 0 | 0 | 0 | 0 | 0 | 0 |
| 26 - 30 | 0 | 0 | 0 | 0 | 0 | 0 |
| > 30 | 0 | 0 | 2 | 3 | 2 | 3 |

The majority of male respondents' first experience of sexual intercourse occurred with females between the ages of 11 – 15 years. For the female respondents (67%) their first sexual experience was with older males.

According to Table 5.10 two of the female respondents were victim of intergenerational sex; they were sexually exploited by older males. Sex with older men is of great concern for females with learning disabilities especially in relation to HIV/AIDS prevention. There is a difference in power between partners, and the less powerful partner (the adolescent with learning disability) is liable to be manipulated or coerced.

There has been much written about the gender dynamics of such coercion, with women having been shown in many societies not to be in a position to assert themselves in sex contexts, or to make choices about sexual participation. A number of studies found that a large number of young females compared to males tend to be infected with HIV/AIDS, because of intergenerational sexual partnerships. For female learners, intergenerational sex sets in early, as 67% of those aged 10-18 years who have sex involuntarily, had had sexual partners aged +30 years

In a focus group discussion in Gaborone, adolescents indicated that females often resorted to prostitution in order to meet their financial needs. This is another reason why adolescent females are involved in sex with older males (Kaiser Family Foundation, 2003).

5.4.5 Respondents Use of Condoms

Table 5.11 reflects the distribution of respondents according to their use of a condom during their first sexual experience.

Table 5.11

Distribution of respondents according to use of condom during their first sexual experience

| Used condom at first sex | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|---------------------------------|--------------------|---------------|----------------------|-----------------|---------------------------|------------------------|
| Yes | 4 | 7 | 0 | 0 | 4 | 7 |
| No | 8 | 13 | 3 | 5 | 11 | 18 |

As indicated in Table 5.11 seven percent of male respondents used condoms during their first sexual experience. In this study only one of the three female respondents who engaged in sexual activity did so willingly. Safer sex usually depends more on the ability to convince partners that it is in their mutual best interests to use a condom, without changing the basis of the relationship. Proposing condom use by women introduces an assertiveness and confidence that sex partners may not welcome.

The findings of this study are congruent with that of The Population Council (2002), which found that many adolescents are not confident that they know how to use a condom, correctly. Although many adolescents said that they knew how to get a condom, a large proportion reported that they did not know how to use one. Even among adolescents who were confident that they knew how to use a condom, many did not report using one at their first sexual encounter.

The Population Council (2002), also found that consistent condom use is more frequent with regular partners than casual partners: 63 % reported condom use during their last sexual encounter with a primary partner, and 85 % reported condom use with a casual partner during last sexual encounter. Consistent condom use during the last month was higher among men with their regular partners (70 %). Adolescent males with casual partners were less likely (49 %) to report consistent condom use with every

casual partner over the last month. This is consistent with the findings in this study and that of Lovelife (2002), which found that 52% of sexually experienced adolescents reported using a condom during last sex encounter.

5.4.6 Respondents' ongoing Sexual Behaviour

The distribution of respondents' according to their ongoing sexual activity is indicated in Figure 5.4.

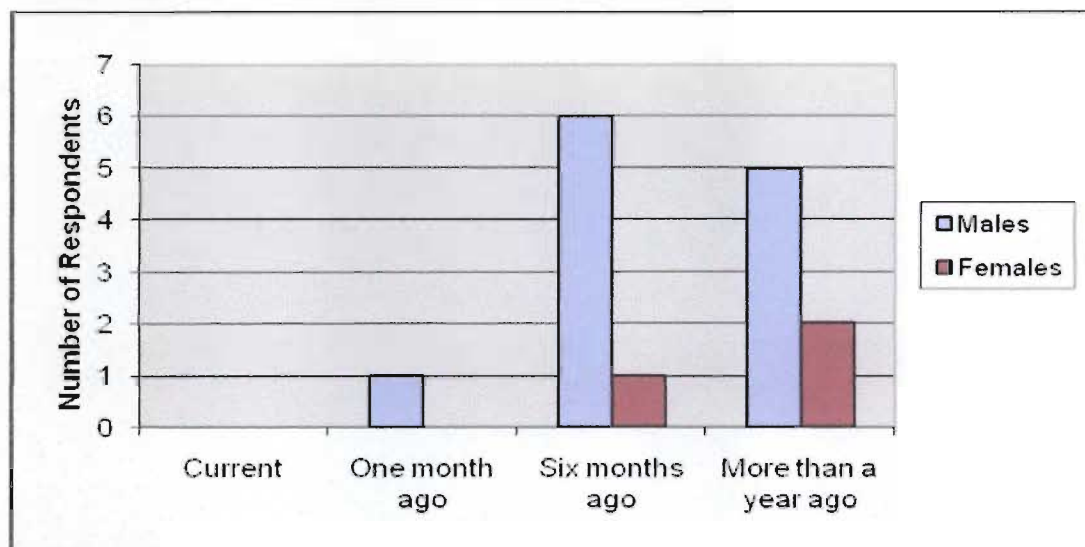


Figure 5.4
Distribution of respondents' according to their ongoing sexual activity

As reflected in Figure 5.4 respondents' ongoing sexual activity was relatively low as the respondents were not sexually active at the time the study was undertaken. This finding confirms the study undertaken by Lovelife (2002), who found that 17% indicated that they had not had sex in the past 12 months.

According to the Population Council (2004), adolescents have sex intermittently and that secondary abstinence among adolescents has increased. Adolescents view secondary abstinence as an important option and this behaviour should be supported through the life skills programmes.

5.4.7 The Nature of Respondents Relationships

Table 5.12 indicates the nature of the relationship between the respondents and the person with whom they had sex.

Table 5.12

Distribution of respondents according to the nature of the relationship with the person with whom they had sex

| relationship with sex partner | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|--|------------------------|-------------------|--------------------------|---------------------|-----------------------------------|--------------------------------|
| Boyfriend | 0 | 0 | 1 | 2 | 1 | 2 |
| Girlfriend | 5 | 8 | 0 | 0 | 5 | 8 |
| Other:Casual | 7 | 12 | 0 | 0 | 7 | 12 |
| :Raped | 0 | 0 | 2 | 3 | 2 | 3 |

According to the Schwablearning Foundation (2006), relationships among adolescents with learning disabilities are generally casual. Adolescents with learning difficulties experience difficulty in initiating and maintaining relationships. This does not lead to an opportunity for frank discussion between partners on HIV prevention strategies.

47% of the sexually active males in this study engaged in casual sex. This concurs with the finding of Lovelife (2002), where 31 % of sexually experienced youth had had more than one sexual partner during the 12 months preceding the survey.

5.4.8 Respondents Reasons for Having Sex

Table 5.13 indicates the reasons why respondents engaged in sex.

Table 5.13

Distribution of respondents according to their reasons for engaging in sex

| Reason for having sex | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|------------------------------|--------------------|---------------|----------------------|-----------------|---------------------------|------------------------|
| love partner | 5 | 8 | 1 | 2 | 6 | 10 |
| peer pressure | 3 | 5 | 0 | 0 | 3 | 5 |
| Experimentation | 4 | 7 | 0 | 0 | 4 | 7 |
| Rape | 0 | 0 | 2 | 3 | 2 | 3 |

As indicated in Table 5.13 ten percent of the respondents had sex because they loved their partners. Only five percent, which consisted of male respondents only, engaged in sex due to peer pressure.

As reflected in Table 5.13, three percent were forced to have sex. This applied to only the female respondents. Two of the female respondents were raped by non-family members. A study by Lovelife (2002), found that six percent reported having been forced to have sex: this included both males and females. The study by Lovelife (2002), also found that adolescent females were much more likely to report that their first sexual experience was unwanted compared to adolescent males (28% compared to one percent).

5.4.9 The Number of Sexual Partners of Respondents

Table 5.14 indicates the distribution of respondents according to the number of sexual partners they have had to date.

Table 5.14

The number of sexual partners of respondents

| Total Number of Sexual Partners | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|--|--------------------|---------------|----------------------|-----------------|---------------------------|------------------------|
| 1 | 8 | 13 | 3 | 5 | 11 | 18 |
| 2 | 3 | 5 | 0 | 0 | 3 | 5 |
| 3 | 1 | 2 | 0 | 0 | 1 | 2 |

As indicated in Table 5.14 18% of the respondents reported that they had had only one sexual partner. Of those who were sexually active 44% had had only one sexual partner. This is congruent with the study undertaken by Lovelife (2002), where, among sexually experienced adolescents, 35% reported only having had one sexual partner. The study by Lovelife (2002), also found that adolescent males were less likely to report having had only one lifetime partner compared to adolescent females.

The findings of this study concurs with the finding of The New Horizons Study (The Population Council, 2004), where 31 % of sexually experienced adolescents had had more than one sexual partner.

There is a strong difference between males and females with respect to the likelihood of having more than one partner. Males are more inclined to have more than one sexual partner and this inclination needs to be addressed in educational programmes about sex and HIV/AIDS (Ssempe, 2003, as cited by The Population Council, 2004).

5.4.10 Respondents Trust in Relationships

Table 5.15 indicates the number of respondents whose partners had other sexual partners whilst they were in a relationship.

Table 5.15

Respondents' partner's relationship with other sexual partners

| Partner has other partner/s | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|--|------------------------|-------------------|--------------------------|---------------------|-----------------------------------|--------------------------------|
| Yes | 0 | 0 | 1 | 2 | 1 | 2 |
| No | 4 | 7 | 0 | 0 | 4 | 7 |
| Don't know | 8 | 13 | 2 | 3 | 10 | 16 |

The differences in how a partner is classified are likely to affect issues of trust and the use of condoms. Therefore the issues of trust in a relationship, and casual partners have been explored.

Thirty six percent of the respondents who engaged in sexual activity did not know if their partners had other sexual partners whilst they were in a relationship. This suggests that although the majority of the respondents had one partner, they did not trust their partners and were unsure of whether or not their partners were not cheating on them.

In this study, more male respondents trusted their partners compared to female respondents. Seven percent of male respondents did not think that their partners had other partners compared to none of the female respondents (Table 5.15).

5.4.11 Supervision of Respondents

Supervision of adolescents with learning disabilities is especially important in that research has shown that adolescents with learning disabilities may experience increased levels of anxiety, may be at greater risk for depression, experience higher levels of loneliness, may have a lower self-concept (self-esteem), are at greater risk for substance abuse, and may be at greater risk for juvenile delinquency (Charles & Helen Foundation, 2003).

The persons responsible for after-care supervision of the respondents are reflected in Table 5.16.

Table 5.16

Distribution of respondents according to their after-school supervision

| After-School Care | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|------------------------------|------------------------|-------------------|--------------------------|---------------------|-----------------------------------|--------------------------------|
| Parents | 14 | 24 | 20 | 33 | 34 | 57 |
| Grandparents | 4 | 7 | 6 | 10 | 10 | 17 |
| Maid | 2 | 3 | 1 | 2 | 3 | 5 |
| Siblings | 2 | 3 | 2 | 3 | 4 | 6 |
| Relatives | 2 | 3 | 0 | 0 | 2 | 3 |
| None | 6 | 10 | 1 | 2 | 7 | 12 |

As reflected in Table 5.16, 12% of the respondents did not have anyone to supervise them after school. The majority of the respondents were supervised after school and this could be the reason for the 75% of respondents not engaging in sexual activity.

The Kaiser Family Foundation, (2002), in a study of school students in an urban district, found a link between lack of adult supervision and adolescent sexual activity. Ku et al (1993), assert that adolescents are more likely to

engage in sexual activity where there is a lack of adult supervision. They go on to say that sexual activity amongst adolescents usually takes place after school when adolescents are left alone.

5.4.12 After-School Activities of Respondents

As indicated in Table 5.17 respondents engaged in more than one activity in the afternoons.

Table 5.17

Distribution of respondents according to their after-school activities

| After - school Activities | Male No. | Male % | Female Number | Female % | Total No. (row) | Total % (row) |
|----------------------------------|-----------------|---------------|----------------------|-----------------|------------------------|----------------------|
| Household Chores | 15 | 25 | 20 | 33 | 35 | 58 |
| Watch Television | 22 | 37 | 20 | 35 | 42 | 72 |
| Homework | 5 | 8 | 14 | 23 | 19 | 31 |
| Friends come over | 4 | 7 | 2 | 3 | 6 | 10 |
| Go over to Friends | 4 | 7 | 4 | 7 | 8 | 14 |
| Play with siblings | 2 | 3 | 1 | 2 | 3 | 5 |
| Listen to Music | 4 | 7 | 1 | 2 | 5 | 9 |

As reflected in Table 5.17 58% of the respondents were given household tasks. Household tasks prepare adolescents for adult life, besides meaningfully occupying them. 72% watch television which is realistic considering that there are not many alternate activities for learners with learning disabilities in the community from which they come.

None of the respondents engaged in sports. This is in keeping with what Schumaker et al, (1980), as cited by The Australian Disability Association (2006), said, viz. that many adolescents with learning disabilities tend not to participate in recreational activities.

Ten percent of the respondents spend most afternoons in church or mosque. This emphasises the importance of religious institutions in the lives of adolescents with learning disabilities. Religious institutions need to design programmes to meet the needs of the young person.

The finding of the study indicates that most of the respondents were meaningfully occupied after school. This could have been the reason for the 75% of respondents not being sexually active. According to Kaufman (as cited by The Population Council, 2002), it is possible that when young people have more opportunities for education or work, they may be more likely to forgo sexual activity, or to engage in safer sex practices when they do have sex.

5.5 SEXUAL ATTITUDES

5.5.1 Respondents view on Adolescent Sexual Behaviour

Table 5.18 indicates the respondents view about adolescent's engaging in sexual behaviour.

Table 5.18

Distribution of respondents according to their view on sexual behaviour amongst adolescents

| Adolescents should engage in sexual behaviour | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|--|------------------------|-------------------|--------------------------|---------------------|-----------------------------------|--------------------------------|
| Yes | 15 | 25 | 3 | 5 | 18 | 30 |
| No | 15 | 25 | 27 | 45 | 42 | 70 |

As is evident in Table 5.18, the majority of the female respondents (90%) did not agree that adolescents should engage in sexual behaviour. This is in keeping with what actually happens amongst adolescents. A study by The Population Council October (2001, Horizons school-based studies), found that more males at school were sexually active.

5.5.2 Sex after the first meeting or date

Table 5.19 indicates respondents' view on engaging in sex after the first meeting/date.

Table 5.19

Distribution of respondents according to their view on the engaging in sex after the first meeting or date

| Sex after the first meeting/date | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|---|--------------------|---------------|----------------------|-----------------|---------------------------|------------------------|
| Yes | 3 | 5 | 0 | 0 | 3 | 5 |
| No | 27 | 45 | 30 | 50 | 57 | 95 |

As indicated in Table 5.19 95% of the respondents did not agree that adolescents should engage in sex after the first meeting or date.

5.5.3 Gender and Sexual Activity

Table 5.20a indicates respondents view as to whether females should have sex at any age.

Table 5.20a

Distribution of respondents according to their view on whether females should have sex at any age

| A female should have sex at any age as long as she is willing to | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|---|--------------------|---------------|----------------------|-----------------|---------------------------|------------------------|
| Yes | 2 | 3 | 0 | 0 | 2 | 3 |
| No | 28 | 47 | 30 | 50 | 58 | 97 |

As reflected in Table 5.20a, 97% of respondents did not agree that females should have sex at any age.

Table 5.20b indicates respondents view as to whether males should have sex at any age.

Table 5.20b

Distribution of respondents according to their view on

| A should have sex at any age as long as he is willing to | Male No. | Male % | Female Number | Female % | Total No. (row) | Total % (row %) |
|---|-----------------|---------------|----------------------|-----------------|------------------------|------------------------|
| Yes | 15 | 25 | 3 | 5 | 18 | 30 |
| No | 15 | 25 | 27 | 45 | 42 | 70 |

As reflected in Table 5.20b, 70% of respondents did not agree that males should have sex at any age.

As is evident in Tables 5.20a and 5.20b both male and female respondents have differing standards for male and female sexual activity. This is in keeping with the trend in the broader society where men are allowed more sexual freedom.

5.5.4 Precautions during sex.

Table 5.21 indicates respondents' view on who should be responsible for taking precautions during sex.

Table 5.21

Distribution of respondents according to their view on who should be responsible for taking precautions during sex

| Responsible for taking precautions during sex | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|--|--------------------|---------------|----------------------|-----------------|---------------------------|------------------------|
| responsibility of both partners | 15 | 25 | 30 | 50 | 45 | 75 |
| It is the males' responsibility | 15 | 25 | 0 | 0 | 15 | 25 |

On issues relating to taking precautions, 75% of the respondents agreed that it is the responsibility of both partners to take precautions during sex.

There was however, a gender difference in their opinion. Whereas all the females agreed with it being the responsibility of both partners, only 50% of the male respondents did so.

5.6 SEX EDUCATION and HIV/AIDS PROGRAMMES

5.6.1 The School Programmes

All the respondents indicated that the school has an HIV/AIDS/Sex Education Programmes which is built into the Life Orientation syllabus.

- Nature of Activities

According to all the respondents the school programmes consists of four or five periods of class discussion. Learners are involved in the discussions. A test is subsequently based on the discussion. A question on the section is usually included in the school exam.

- Content

According to all the respondents the basic aspects of HIV/AIDS are discussed. Besides the classroom discussions the school observes HIV/AIDS week towards the latter half of the year. During the HIV/AIDS week all classes focus on the topic of HIV/AIDS, and classes enter poster competitions. The posters are displayed for all to view.

During the week of the orientation of new learners who enter the school at the beginning of the year, community resources are brought in to address the new learners on HIV/AIDS and other issues.

Only in the final year at school does sex education during Life Orientation take place.

- Facilitators

According to all the respondents, the programme is presented by the relevant subject teachers on the level of the learners who have learning disabilities. The educators are not given any special training for the course.

- Duration and Regularity of the Programmes

According to all the respondents the school's programme on HIV/AIDS is a part of the five-year syllabus at the school. However, during a specific year, 3-4 classroom lessons are spent on the HIV/AIDS education programme, and a few lessons during HIV/AIDS awareness week focus on HIV/AIDS.

At the beginning of the year community organisations are utilized, to address new learners on HIV/AIDS. During the course of the year community organisations are occasionally invited to do presentations on HIV/AIDS.

5.6.1.1 The Impact of the School's Programmes on Respondents

Tables 5.22a and 5.22b indicate the impact of the school programme on respondents.

Table 5.22a

Distribution of male respondents according to their view of the school's HIV/AIDS/sex education programme

| The school programmes... | Yes Number | Yes % | No Number | No % | Total Number (row) | Total % row %) |
|--|-----------------------|------------------|----------------------|-----------------|-----------------------------------|-------------------------------|
| gave me knowledge about HIV/AIDS | 30 | 100 | 0 | 0 | 30 | 100 |
| Helped me to talk to family about HIV/AIDS issues | 10 | 34 | 20 | 66 | 30 | 100 |

| | | | | | | |
|--|----|----|----|----|----|-----|
| Made me more aware of the risks of unsafe behaviour | 15 | 50 | 15 | 50 | 30 | 100 |
| Made me talk more openly with my girl/boyfriend about HIV/AIDS, and sex | 5 | 16 | 25 | 84 | 30 | 100 |
| Caused me to make behavioural changes | 10 | 33 | 20 | 67 | 30 | 100 |
| Caused me to limit/reduce the number of sexual partners | 20 | 67 | 10 | 33 | 30 | 100 |
| Caused me to be more assertive in insisting on condom use. | 10 | 33 | 20 | 67 | 30 | 100 |
| Caused me to talk to my peers about HIV/AIDS | 20 | 67 | 10 | 33 | 30 | 100 |

Table 5.22b

Distribution of female respondents according to their view on the school's HIV/AIDS/sex education programme

| The school programmes..... | Yes No. | Yes % | No No. | No % | Total No. (row) | Total % (row %) |
|---|--------------------|------------------|-------------------|-----------------|--------------------------------|--------------------------------|
| gave me knowledge about HIV/AIDS | 30 | 100 | 0 | 0 | 30 | 100 |
| helped me to talk to family about HIV/AIDS issues | 12 | 40 | 18 | 60 | 30 | 100 |
| made me more aware of the risks of unsafe behaviour | 30 | 100 | 0 | 0 | 30 | 100 |
| made me talk more openly with my girl/boyfriend about sex and HIV/AIDS | 2 | 6 | 28 | 94 | 30 | 100 |
| caused me to make behavioural changes | 1 | 3 | 29 | 97 | 30 | 100 |
| caused me to limit/reduce the number of sexual partners | 1 | 3 | 29 | 97 | 30 | 100 |
| caused me to be more assertive in insisting on condom use. | 1 | 3 | 29 | 97 | 30 | 100 |
| caused me to talk to my peers about HIV/AIDS | 15 | 100 | 15 | 100 | 30 | 100 |

As indicated in Tables 22a and 22b both male and female respondents in this study have been positively impacted by the school's programme. This concurs with the finding of a study by Love life (2002), where, after a school programme most (77%) reported that condoms could be used to prevent HIV/AIDS; indicated that they had changed their own behaviour to avoid HIV/AIDS; 44% reported having talked to their parents about HIV/AIDS; and 20% reported having been tested for HIV/AIDS.

5.6.2 Professional Services

- **School Psychologist**

All the respondents indicated that the school has a psychologist. She attends to their problems at school in addition to attending to other school matters. This makes it difficult for the respondents to gain access to the psychologist whenever they may need her, or as often as they sometimes may need to.

- **Guidance Counsellor**

All the respondents indicated that there is no school guidance counselor at the school. Previously it was the school guidance counselor who guided the learners through their decisions of a choice of career, and who also attended to their personal problems both academically and socially. This task, too, is now attended to by the psychologist.

- **Social Worker**

All the respondents indicated that the school does not have a school social worker. In the cases of emergency the psychologist draws on the services of the community social worker, which is a difficult task. The social workers attached to community organizations have too many

demands on their limited resources. They are therefore not in a position to attend to the crisis of every school in the area they service.

5.6.2.1 The availability of the Services

All the respondents indicated that since the school psychologist has to fulfill many tasks she is not readily available to them. Only learners in crisis and 'problem' learners are attended to by the school psychologist.

5.7.3 Respondents' use of professional services in the community

Table 5.23 indicates respondents' use of the community's professional services.

Table 5.23

Distribution of respondents according to their use of professional services in the community

| use of professional services in the community | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|--|--------------------|---------------|----------------------|-----------------|---------------------------|------------------------|
| Yes | 18 | 30 | 20 | 33 | 38 | 63 |
| No | 12 | 20 | 10 | 17 | 22 | 37 |

As is evident in Table 5.23, the majority of respondents and/or their families have used the services of a social worker in respect of their family problems.

5.7.3 School Social Workers

Table 5.24 reflects respondents view on the need for school social workers.

Table 5.24

Distribution of respondents according to their view on the need for social workers

| Need for school social workers | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|---------------------------------------|--------------------|---------------|----------------------|-----------------|---------------------------|------------------------|
| Yes | 23 | 38 | 30 | 50 | 53 | 88 |
| No | 7 | 12 | 0 | 0 | 7 | 12 |

As is evident in Table 5.24 88% of the respondents wanted a school social worker to be attached to the school. School social workers are the link between the home, the school, and the community. As members of the educational team, school social workers promote and support students' academic and social success by providing specialized services to regular and special education students. (special-ed-careers.org)

Access to a school worker would assist adolescents with learning difficulties to clarify their attitudes, beliefs, and concerns about various issues, including HIV/AIDS, that may be troubling them.

Access to counselling on HIV/AIDS issues is vital, as it helps both troubled and infected learners to talk about their problems and to obtain information about their conditions, and how they could live positively with the disease and with those around them who are infected.

5.7.4 Type of Service that would be expected from a School Social Worker

Table 5.25 indicates respondents' expectation in respect of the type of service that is offered by a school social worker.

Table 5.25

Distribution of respondents according to their view on the type of service that is offered by a school social worker

| Types of social work service | Male Number | Male % | Female Number | Female % | Total Number (row) | Total % (row %) |
|-------------------------------------|--------------------|---------------|----------------------|-----------------|---------------------------|------------------------|
| Individual Counselling | 30 | 50 | 30 | 50 | 60 | 100 |
| Group Therapy | 25 | 42 | 23 | 38 | 48 | 80 |
| Community Work | 16 | 27 | 20 | 33 | 36 | 60 |

As is evident from Table 5.25 all respondents expect individual counselling from a school social worker. The majority of the respondents was in receipt of professional social work services from community social workers and hence was aware of such services. 80% of the respondents expected group therapy; the school had previously used the services of student social workers who had provided group therapy to a number of learners.

5.6.3 Respondents Suggestions on a School Programmes

The following suggestions were made by the respondents.

- **HIV/AIDS Programmes**

The majority of the respondents requested that the school have more programmes on HIV/AIDS e.g. films and shows (acts by guest groups) highlighting HIV/AIDS, display of books and posters on HIV/AIDS, and being able to talk more openly about HIV/AIDS.

- **Specialised Educators.**

The majority of the respondents stated that all schools, from primary school onwards, need to have specialised HIV/AIDS coordinators or educators. They found that some of the educators appeared to be uncomfortable about discussing and teaching certain topics related to sexuality and HIV/AIDS.

- **Resource Programmes**

The majority of the respondents requested the provision of televisions in the institutions so that learners could view the programmes “Buddies”, and other relevant HIV/AIDS educational programmes.

- **Other Methods**

It is the respondents’ view that the ideal educator should use humour and other techniques to help learners relax and participate in discussions. Respondents also suggested that educators use more interactive methods such as role playing, small group discussions and more presentations from guest speakers/groups.

- **HIV positive people as guest speakers**

The majority of the respondents suggested that since many adolescents with learning disabilities are unaware of the true extent of HIV/AIDS, persons who have been infected should be invited to come in and talk to the learners at school. Ten percent of the respondents stated that have been exposed to infected persons or knew of someone who had died of HIV/AIDS.

- **Peer education**

Although respondents did not know the concept of *peer education*, they mentioned that it would be good if the learners at school taught one another about what they had learnt about HIV/AIDS.

- **School Social Work Services**

The majority of the respondents stated that learners needed counselling whenever necessary. Presently, community social work services were only accessed when a crisis arose or when the counselor needed to access them. Respondents also noted the following:

- Professionals who are responsible for these services at school do not have sufficient time to help learners who are in need of counseling.
- There are no workshops where learners can freely interact to discuss issues. The HIV/AIDS/sex education programme is conducted during class lessons which is of limited duration.
- Counselling is not taken seriously: structured times are not set aside for counseling where learners could freely access the service.
- Respondents stated that educators do not openly discuss personal issues with them. There could be various reasons for this, amongst others, time constraints, the lack of parental involvement and hence

their not being able to obtain the necessary parental permission to do so.

- **Religion and Culture**

The majority of the respondents stated that religion is very important and must be taught at home and promoted at school; schools should encourage the inclusion of different religious groups in their programmes. In this way values in respect of different aspects of life could be promoted.

5.8 CONCLUSION

The findings of this study indicate that adolescents with learning disabilities have adequate knowledge about how HIV/AIDS is transmitted and how it can be prevented. Respondents in this study had good access to accurate HIV/AIDS information, and they are regularly being exposed to HIV/AIDS information from a range of different sources. Educators and parents are playing active roles in disseminating information on HIV/AIDS to educate adolescents with learning disabilities. Major sources of HIV/AIDS information were educators, parents, the television, and friends.

As a result of the input from these various sources 75% of the respondents abstain from sex. In a majority of cases the decision to abstain from sexual activity was willfully undertaken by the adolescent with a learning disability.

In respect of their sexual attitudes, 70% of the respondents did not agree that adolescents should become sexually active, and that sex should not form part of a relationship after a first meeting or date. This is in keeping with the 75% of the respondents who abstain from sex. There is still however a gender bias present in terms of whether male vs. female adolescents should be sexually active. The view of both sexes tended to slant on the side of the male being allowed to have sex during adolescence.

CHAPTER 6

CONCLUSIONS and RECOMMENDATIONS

6.1. INTRODUCTION

This chapter discusses the main findings of the study with reference to the key objectives, and provides some recommendations regarding HIV/AIDS/sex education for learners with learning difficulties.

The literature examined HIV/AIDS from a social, psychological, behavioural, economic and educational perspective. Relevant policies and procedures pertaining to the rights and responsibilities of adolescents were discussed. This study also has implications for further research.

6.2 THE RESEARCH

This study investigated the knowledge of HIV/AIDS, and the sexual attitudes and behaviour of adolescents with learning difficulties.

The following objectives were implemented to achieve the aims of the study:

- to ascertain the current knowledge of HIV/AIDS of learners with learning difficulties.
- to ascertain the sexual attitudes and behaviour of learners with learning difficulties.
- to identify the different sources and contexts from which learners with learning difficulties acquire their knowledge and understanding of sex and HIV/AIDS.
- to make recommendations to the Department of Education to work toward developing relevant models and/or the bridging of any gaps in the existing programmes of HIV/AIDS for learners with learning difficulties.

- To make recommendations to the SW profession on their planning of appropriate programmes for learners with learning difficulties.

6.3 THE CONCLUSIONS

The following conclusions can be drawn from the findings:

6.3.1 KNOWLEDGE OF HIV/AIDS AND HIV/AIDS PREVENTIVE MEASURES

The findings in this study indicate that adolescents with learning disabilities have a good knowledge of HIV/AIDS. This refutes the assumption of the researcher that adolescents with learning difficulties are not able to retain knowledge about HIV/AIDS.

Review of literature indicates that a learning disability can affect the way in which an adolescent takes in, remembers, understands and expresses information. However the respondents in this study were able to take in, remember, understand and express the information taught to them. The Australian Learning Disability Association (2006), did state that adolescents with learning disability may be intelligent and have abilities to learn despite the difficulties experienced in processing information, and that adolescents with learning disabilities can succeed when individualised self-management skills and strategies are developed and relevant accommodation is provided (Australian Learning Disability Association, 2006).

This finding in this study is in keeping with the findings of research among adolescents who do not have learning disabilities. The Kaiser Family Foundation (2000), found that adolescents do have adequate knowledge of HIV/AIDS, and that most adolescents are concerned about HIV/AIDS.

Research however has shown that sexual health knowledge varies as a function of gender. Males and females are exposed to a number of different

social influences and attitudes with the potential to mediate their sexual behaviour (Hillier & Harrison, 1999). Furthermore, adolescent females are more likely to gain information about pregnancy and STIs from magazines targeting females. Males have no real equivalent information source equal to that of women's magazines that are available (Hillier, Warr, & Haste, 1998). Research suggests that the availability of information through magazines results in gender differences in knowledge levels when tested (Carrera, Kaye, Philliber, & West, 2000; Langille, Andreou, Beazely, & Delaney, 1998). In particular, adolescent females have been shown to be more knowledgeable about contraception (Langana, 1999) and STIs (Hillier et al., 1998). In this study overall knowledge levels of both males and females was high.

Educators played a very important role in influencing the knowledge, and sexual attitudes and behaviour of adolescents with learning difficulties. The respondents accepted what they had been taught by educators, and moreover saw educators as important resources in times of need. Educators need to create more open channels of communication and to play a more central role in sexuality education for adolescents with learning difficulties.

Other important sources of the knowledge about HIV/AIDS amongst adolescents with learning disabilities were the family, television, and religious leaders. This finding confirms the assumption of the researcher that the knowledge of HIV/AIDS of adolescents with learning difficulties is obtained from various sources. The finding of this study contradicts that of Morrell et al (2001), who found that adolescents rarely communicate with their parents or other adults about sexual and reproductive health issues. He also found that adolescents receive too many conflicting messages about sex and sexuality from various sources and hence make their decisions about sex in the absence of accurate information, and access to support and services. They therefore lack confidence and the skill to

negotiate sexual issues, contraception and prevention of infection (Morrell et al, 2001).

6.3.2 SEXUAL BEHAVIOUR

The onset and rapid spread of HIV/AIDS has forced us to examine the conceptualization of HIV/AIDS among adolescents. How adolescents define having sex is important because it helps determine whether they consider themselves to be at risk, how they respond to HIV/AIDS prevention efforts, and how they report their sexual experiences.

The focus of this study on sexual activity was primarily on sexual intercourse rather than other kinds of sexual activities. The findings of the study show that respondents were positive in their attitudes towards sexuality issues, and that 78% of the respondents were not engaging in sexual behaviour. The level of knowledge of HIV/AIDS among the respondents was high and subsequently did seem to affect their behaviour. This contradicts the finding of Hutchinson et al (2001), who noted that even though adolescents may have high knowledge of HIV/AIDS, they are often unable to act on that knowledge.

6.3.2.1 Sexual Activity

In this study 23% of the respondents, some as young as twelve years, had engaged in sexual behaviour. Adolescents are becoming sexually active at an earlier age. It is therefore recommended that life skills education should focus on younger adolescents. The age at first sexual encounter is an important risk factor in HIV/AIDS infection and should therefore be considered an important factor in HIV/AIDS prevention practices (Population Action International, 2002).

According to Broatch, as cited in Charles & Helen Foundation (2006), adolescents with learning disabilities often have strong feelings of frustration, anger, sadness, or shame which can lead to their experiencing psychological difficulties such as anxiety, depression, or low self-esteem, as well as behavioural problems such as substance abuse, juvenile delinquency, sexual promiscuity or sexual exploits for adolescents.

Another reason as to why adolescents with learning difficulties may develop psychological problems which may in turn lead to sexual promiscuity or sexual exploits, is the social difficulties they often experience. Living with a learning disability can have an ongoing impact on friendships, schoolwork, self-esteem and daily life. As many as 75% of adolescents with learning difficulties have social difficulties such as making and keeping friends. Social and psychological problems are interconnected making it difficult to determine which one may have caused the other especially since psychological problems can have a negative effect on social interaction. Adolescents with learning disabilities are less accepted, and often rejected by their peers. Such social rejection can result in loss of self-esteem and negative views of oneself. In addition, social rejection can result in feelings of loneliness, which, in turn, may lead to psychological difficulties such as anxiety and depression, sexual promiscuity or sexual exploits (Kavale and Forness, 1996; Raskind as cited in Schwablearning.org, 2006). Despite their social and psychological problems 78% of the respondents in this study did not engage in sexual activity.

A further risk factor for female adolescents is that in some societies, initiation into sex often involves coercion, increasing the risk of trauma during intercourse and the potential for HIV/AIDS transmission. In this study two of the female respondents were raped by older men. This is also one of the reasons why female adolescents have their first sexual experience with older men (Population Action International, 2002). Sex with older men is an important issue for females with learning disabilities especially in relation to HIV/AIDS prevention. There is significant difference in power between

partners, and the less powerful partner (the adolescent with learning disability) is liable to be manipulated or coerced. This increases the need for the programmes to teach assertive behaviour, as well as respect of the opposite sex.

The majority of male respondents in this study had younger partners at first sex. Those who had not engaged in sex cited several reasons for not having had sex. The findings in this study suggest that most respondents have delayed onset of sexual experience through an active decision not to have sex. The family had the most impact on the decision not to have sex. This concurs with the finding of the Australian Learning Disability Association (2006), where parents of children with learning disabilities tend to be very protective of them.

Religion also played an important role in the decision not to engage in sexual activity. According to the NICHD-funded Add Health Survey (The National Institute of Child Health and Development, 2006), religion reduces the likelihood of adolescents engaging in early sex by shaping their attitudes and beliefs about sexual activity. Hence adolescents with strong religious views are less likely to have sex than are less religious respondents, largely because their religious views lead them to view the consequences of having sex negatively. This is in congruent with the findings of the study.

The majority of respondents stated that they had sex because they 'loved' their partners. The word "love" can be used in different ways, sometimes to mean affection or emotional commitment and sometimes to mean simply a desire for sexual relations with the person (Ssempe, 2003, as cited by The Population Council, 2004).

Only five percent of the sexually active respondents engaged in sex due to peer pressure. These were only the male respondents. Peer pressure needs to be addressed in the school HIV/AIDS/sex programmes.

Another factor affecting the decision of the respondents in this study was the fear of STIs. This emphasises the importance of the ongoing HIV/AIDS/sex educational programmes at school.

Research consistently demonstrates that even when adolescents are knowledgeable about safe sex practices, they are not deterred from unsafe sexual behaviour and many still fail to protect themselves from unwanted pregnancy and STIs (Marsiglio & Mott, 1986; Orr, 1992). There seems to be little or no direct relationship between sexual and contraceptive knowledge and actual behaviour and contraceptive use (Kelly, 1996; Levison, 1995), and many adolescents don't realize they're at risk (Magnani et al cited by The Population Council, 2004). In this study only seven percent of respondents who had engaged in sex had used the condom, and these were only the male respondents. Females generally experience difficulty in negotiating safe sex (Population Council, 2004).

It can be assumed that adolescents with learning disabilities would be likely to engage in sexual activities in contexts quite different to those of other adolescents. They are unlikely to have the same means and understanding to negotiate HIV/AIDS preventive practices and are therefore likely to approach the problem in different ways. Therefore there is a need to understand sexual activity at different cognitive levels in order to design appropriate intervention programmes (Schwablearning.org, 2006).

6.3.2.2 Relationships and Sexual Practices

According to the Schwab Learning Foundation (2006), relationships among adolescents with learning disabilities are generally casual. Adolescents with learning difficulties experience difficulty in initiating and maintaining social relationships. This prevents an opportunity for frank discussion between partners on HIV/AIDS prevention strategies. In this study 50% of those who were sexually active engaged in casual sex thus engaging in high risk

sexual activity. This concurs with the finding of Lovelife (2002), where 31% of sexually experienced adolescents had had more than one sexual partner during the twelve months preceding the survey.

The finding in this study indicates that more male respondents trust their partners not to be involved in other relationships while they are in a relationship with them. Many sexually experienced adolescents have more than one sexual partner and females are less likely to report having multiple partners (The New Horizons Study, 2004; Ssempe, 2003, as cited by The Population Council, 2004). This needs to be addressed in sex and HIV/AIDS education efforts. This study confirms this finding in that the majority of those who had more than one sexual partner were the males. The issue of trust and respect needs to be incorporated into the sex/HIV/AIDS programmes at school.

6.3.2.3 Support Structure

Only twelve percent of the respondents did not have anyone to supervise them after school. This could be the reason for the small percent of sexual activity. Parents of children with learning disabilities tend to be protective of them. Adolescents are more likely to engage in sexual activity where there is a lack of adult supervision as most sexual activity amongst adolescents takes place after school where adolescents are left alone (Ku et al, 1993; The Kaiser Family Foundation, 2002).

Many of the respondents spent their afternoons at church or mosque. This emphasises the importance of religious institutions in the lives of many of the learners. Religious institutions need to design programmes to meet the needs of the young person and hence provide support structure especially for those who do not receive support from family.

Employment after school hours can also offer the necessary support structure needed by many adolescents. It also provides a constructive

activity in the afternoons thereby avoiding possible sexual activity (Kaufman, 2002).

6.3.3 SEXUAL ATTITUDES

Religion is a determining factor in adolescents' decision to have sex. The finding in the study confirms this in that the majority cited religion as a determining factor in their decision. Religion has a negative correlation with socio-sexual attitudes such that the more religious students are more conservative in their socio-sexual attitudes. Researchers have found religiosity to be an important protecting factor against early initiation of sexual intercourse and drinking (Laksmana, 2003).

The majority of the female respondents in this study, as compared to the males, did not agree that adolescents should have sex as long as a condom is used. This finding concurs with the findings of Population Council October (2001, Horizons school-based studies) where more males than females at school are sexually active, and with the finding in this study where the majority made their decisions about sex in relation to the standards of the family. Gender differences in attitudes toward male/female sex do exist (Koch et al, 1999, as cited by Laksmana, 2003).

Family standards in this study had the greatest impact on the sexual decisions of the respondents.

Social adjustment, which otherwise has not had a significant relationship with any other factors of sexual behaviour, has a negative relationship with socio-sexual attitudes such that those who are more socially adjusted are more likely to have conservative socio-sexual attitudes. The reason for this might be that those who are more socially adjusted tend to support the more popular consensus and are more likely to conform to the opinion of the society which has been conservative towards these socio-sexual attitudes

(Laksmana,2003).

The majority of respondents (almost an equal number of male and female) did not agree on engaging in sex after the first meeting or date. However they had differing standards for male and female sexual activity. Almost all respondents (small difference between male and female) stated that a female should not become sexually active whilst still at school. 70% (45% male and 25% female) however stated that a male should not become sexually active whilst still at school.

The links between condom use and the knowledge and attitudes of adolescents have been extensively researched. The majority of sexually active Kenyan adolescents in Thailand say that they are not at risk. Condom use among sexually active adolescents in Thailand is very low (Koopman et al, 1990).

In this study only 17% of those who were sexually active used condoms. The majority of respondents however, agreed with the statement that safe sex is the equal responsibility of both partners. There was however, a gender difference in their opinion. More females than males agreed with the statement.

6.3.4 SEX EDUCATION and HIV/AIDS PROGRAMME

The School Programme

The school has a HIV/AIDS/Sex Education Programme which forms a part of the Life Orientation syllabus. The programme has had an impact on the respondents. The school programme consists of four/five periods of class discussion during which the basic aspects of HIV/AIDS are discussed. Sexuality education is only taught in the final year at school.

The programmes are presented by the relevant subject educators at the intellectual level of the learners. The educators are not given any special training for the course. The school's programme covers the five-year syllabus at school. However, during a specific year beside the HIV/AIDS awareness week, four/five lessons are spent on the topic.

In addition to the classroom discussions the school observes HIV/AIDS week towards the latter half of the year. Various community organisations serving the local community are brought in especially during the week of orientation of the new learners who enter the school at the beginning of each year.

Learners are then tested on the contents of the programme during class tests and again during the examinations.

In this study both male and female respondents reported that they have gained considerable knowledge about HIV/AIDS after being exposed to the HIV/AIDS programme conducted at school. A study by Love life (2002), also indicated that after a school programme, adolescents reported positively of the issues of HIV/AIDS.

6.3.5 PROFESSIONAL SERVICES

The school does have a psychologist who to attend to all the problems experienced by learners at the school.

The school does not have a school guidance counselor. This task is presently not being attended to as the psychologist does not have the time to do so.

The school does not have a school social worker.

Community social workers do not have the time to focus on specific schools in their areas of operation or to be of direct assistance to the schools. When attending to crises in the community, community social workers must prioritize amongst all the cases that are brought to their attention.

Majority of the respondents in this study and/or their families have used the services of a community social worker. The services utilized were not in respect of their learning disabilities but in respect of social problems in their families.

6.4 RECOMMENDATIONS

Arising from the findings of this study and the suggestions made by the respondents, the following recommendations are being made.

6.4.1 THE SCHOOL

In the absence of a cure of HIV/AIDS the best prevention is education. Education is important so that people can have knowledge of HIV/AIDS and realize their responsibility to live virtuously in order not to be infected with HIV/AIDS. The main aim in education has become to guide the child toward abstinence and toward practicing sexual relationships only within a monogamous marriage (Van Rooyen and Louw, 1994).

To this, Le Roux (1994), adds, the promotion of responsible sexual behaviour, improvement of children's socio-economic status and reduction of their vulnerability to sexual and other forms of exploitation.

The most obvious characteristic that distinguishes children who are mildly retarded from those of their non retard peers is their limited cognitive ability, a limitation that inevitably shows up in their academic work. Many mildly retarded adolescents have problems with the organisation of

information, lack good judgment, display poor impulse control, have limitations in foresight and have difficulty generalising from one situation to another (Kaplan & Sadock, 1998). Mildly retarded people have a general language deficit and specific problems using interpretive language. An additional disability often experienced by mildly mentally retarded persons is difficulties with memory, especially short-term memory. Some researchers suggest that the long term memory of retarded persons is about the same as that of their normal peers, that is, mentally retarded persons are no more likely to forget what they have learned than the non retard. However, this is only true when what is learned is consistent with their mental abilities (Schwablearning.org, 2006).

Adolescents with learning disabilities may also have difficulties with organizational skills, social perception and social interaction, but they can succeed when individualised self-management skills and strategies are developed and relevant accommodation is provided (Australian Learning Disability Association, 2006). For success, persons with learning disabilities require specialized interventions in home, school, and community settings; appropriate to their individual strengths and needs, including specific skill instruction, the development of compensatory strategies, and the development of self-advocacy skills (Mexico Childlink.org, 2003).

Twenty percent of the respondents in this study reported being sexually active with two or more partners. This study has shown that adolescents with learning difficulties do experiment with sex sometimes involving multiple sexual partners and highlights the importance of effective sex education programmes at an early age.

According to Jacob et. Al. (1989), the need for sex education programmes assumes a greater importance for these adolescents, not only because of

their lack of knowledge, but also because of their limited access to accurate information.

In the HIV/AIDS/sex education programmes for adolescents with learning difficulties, the format of teaching should be revised. Teaching values and self control, promoting recreational activities and promoting healthy living will stimulate attitudinal and behavioural changes such as delaying of sexual activity until physically and emotionally mature.

6.4.1.1 Objectives of Sex/HIV/AIDS Education Programmes for Adolescents with learning difficulties

A comprehensive sex/HIV/AIDS education programmes needs to be part of the whole school curriculum. The educational intervention for adolescents with learning difficulties must:

- **Promote**

- changing attitudes about sex and HIV/AIDS
- communication among learners and significant others such as parents and educators around sex and HIV/AIDS
- networking with community resources with regard to sex/HIV/AIDS education and services
- partnerships among family, religious, school, media, business and other community groups
- recreational activity (Schumaker et al, 1980, as cited by The Australian Learning Disability Association, 2006)

- **Teach**

- assertive behaviour: to express their needs assertively, to say "no" in risky situations, and communicate with confidence.
- values
- the use of self-talk to guide themselves successfully through sexually risky

situations

- self-control
- effective and efficient social skills (Deshler et al, 1981)

- **Enable**

- to identify relevant community resources and to access these resources as and when needed
- to identify and change dysfunctional thoughts
- to solve interpersonal problems through clarifying the problem, identifying risks, costs and opportunities, evaluating alternative strategies for fixing the situation, trying out an alternative, and analyzing success.

- **Build**

- skill that foster a positive self-concept
- skill that foster higher levels of self-efficacy.
- skill to handle peer pressure
- skill in initiating and maintaining relationships
- skill to label, assess and control the intensity of their feelings in high risk situations
- skill to identify when they are being taken advantage of

- **Encourage**

- to continue abstaining from sex or to delay the onset of their sexual debut
- communication with parents and other significant adults

- **Provide**

- a forum to discuss their sexuality
- an opportunity to be actively involved.
- correct information about the severity of the disease and the personal susceptibility of adolescents with learning disabilities to contracting HIV/AIDS

- role models which are exceptionally important to adolescents with learning disabilities
- opportunity to systematically use the basic skills that are required in problem-solving situations

In sex/HIV/AIDS education programmes for adolescents with learning difficulties, the format of teaching should be revised as they are generally not able to read and/or understand HIV/AIDS/sex information, and to retain information imparted to them (Young, 1991 as cited by the Australian Learning Disability Association, 2006).

6.4.2 THE DEPARTMENT OF EDUCATION

To enable schools that are catering for children with learning disabilities it is important that the Department of Education:

- provide counsellors for all LSEN schools
- provide school social workers for all LSEN schools
- provide for the networking of parents, and community members serving adolescents with learning difficulties
- enhance education about HIV/AIDS/sex through practices that foster caring, respect, self-efficacy, self-esteem and decision-making and conditions that allow for the healthy development of students, educators and other school staff
- provide ongoing training to educators especially those who are responsible for HIV/AIDS/sex education
- engage adolescents with learning difficulties in HIV/AIDS/sex education in the classroom and through peer education and a variety of other learning experiences such as theatre, song and poster design
- teach adolescent males and females to respect themselves, and to respect each other
- move from a top-down approach to a more bottom-up, participatory approach to curriculum development and the delivery of services, with

- particular emphasis on including adolescents with learning difficulties, other adolescents, educators, parents and the community
- provide ongoing HIV/AIDS/sex education training of educators
 - provide ongoing support services for educators
 - provide quality basic education
 - promote sport and recreational activity both in the school and the community especially for adolescents with learning difficulties
 - provide a structured resource network within the communities they service and within the Department of Education itself

6.4.3 THE GOVERNMENTAL POLICY MAKING

To make effective what the Department of Education and what the various schools catering for adolescents with learning disabilities attempt to implement to improve the status of adolescents with learning disabilities in the face of the HIV/AIDS epidemic, the Government should consider the following in their policy making and planning for education:

- the conflict between what adolescents learn in school and what they learn from other sources, especially the media
- the importance of involving the larger community, including parents, school administrators, the church, the mass media, and other concerned groups, in the development and promotion of population education programmes
- The majority of our adolescents watch television each day. Thus the television provides an important, available and effective medium to reach and make a positive impact on them. Beside introducing more educational and life-skills programmes, government needs to visit the type and quality of the programmes that our adolescents are exposed to everyday. Government needs to be proactive in this respect.

- Programmes must be designed with socio-cultural sensitivity, and keeping gatekeepers in mind. A mass promotion of condoms does nothing for the values of families or to effect behavioural change.
- To maximize impact, programmes should collaborate with related efforts (horizontal networking).
- Adolescents with learning difficulties must be involved in designing, implementing and evaluating programmes. There should be creativity and mix in programmes design. Where possible, NGOs and religious groups should be involved in programmes design, implementation, and evaluation. In this study, religious leaders played a notable role in disseminating information on HIV/AIDS, and sex. Education, information and communication strategies should be comprehensive and always combined with services.
- Adolescents with learning disabilities learn from the actions of adults: role models are extremely important to them. Adults in Government need to become *worthy role models*.

6.4.4 PROFESSIONAL SERVICES

There is a need for a school social worker to be attached to the school. A multi-disciplinary team comprising a social worker, psychologist, and an occupational therapist would best be suited to the needs of learners with learning disabilities. School social workers can be a link between the home, the school, and the community. As members of the school educational team, school social workers can promote and support learners' academic and social success by providing specialized services to special education learners (www.special-ed-careers.org/career_choices).

School social workers can offer individual counseling, group therapy, family counselling and community liaison services.

Services may include:

- assessment of learners' needs
- crisis prevention and intervention
- advocacy for learners, parents and the school district
- provision of ongoing emotional and behavioural support to learners
- collaboration and consultation with community agencies, organizations and professionals

School Social Workers could help learners:

- increase academic success
- improve interpersonal relationships
- cope with difficult and crisis situations
- develop self esteem and self discipline
- learn problem solving, conflict resolution and decision management skills

(www.special-ed-careers.org/career)

Schools catering for learners with learning disabilities would benefit from the services that can be offered by a school social worker. Stabilising and building relationships with families; building, strengthening, and encouraging families; and networking with the communities from which the learners come would provide greater insight into the realities of the learners as well as help establish links for the learners, their parents, and their community resources.

6.4.5 OTHER ROLE PLAYERS

• Families, other significant adults and friends

In planning programmes for children with learning disabilities it is of utmost importance that parents are involved in it. Respondents named parents as an important source of information on HIV/AIDS. The majority made their

decisions about sex according to their family standards. Parent involvement in HIV/AIDS education activities needs to therefore be acted upon with urgency. In conjunction with other health service providers and the schools, parents of learners may be addressed on issues of adolescents' sexuality and HIV/AIDS. Schools must take the initiative to actively involve parents in taking responsibility for providing their adolescents with support and information on sexuality. The sustainability of HIV/AIDS education programmes is thus taken a step further from the school to the home.

Parents of adolescents with learning difficulties have generally been found to have confused and ambivalent attitudes towards the sexuality of their offspring (Nganwa et al, n.d.). Parents and members of the extended family can be an important positive force in the lives of adolescents and youth: they can serve as positive behavioural role models, provide emotional and psychological support and encouragement, become promoters of autonomy and independence and brokers for needed services; and transmitters of values and information.

It should be borne in mind that in many South African cultures parents have played a relatively small role in the sexual socialization and education of their children. In the Zulu culture, for example, in the case of a female it was the responsibility of a senior female relative such as an aunt or older sister. This is illustrated by the results of a study conducted among urban black mothers: communication with their children about sexuality was poor, and none had spoken to their children about HIV/AIDS. Parents do want their children to know about sexuality, but they often do not want to be the ones providing the information. Their own background may not have given them the language and skills to talk openly and confidently about such matters with young people (Ssempe, 2003, as cited by The Population Council, 2004).

• **Community-based organisations**

Community-based organisations include, amongst others, welfare organisations, religious groups, youth groups, social groups, and sport groups. Involvement in community-based organizations is often primarily motivated by a desire to participate in sport, recreation or community service. However, such involvement can have other benefits and/or functions.

Many community-based organisations provide information and guidance about topics such as drugs. These organisations need to look into extending themselves further by providing our adolescents with meaningful, structured programmes in HIV/AIDS/sex education. Adolescents with learning disabilities need to be especially catered for and motivated to participate in programmes being offered. The organizations need to provide adolescents with learning difficulties with social support, skills training, constructive alternatives to risk behaviour, a sense of belonging, responsibility to others, and increased self esteem through achievement and the consequent personal satisfaction and public recognition.

Community based organisations such as non-governmental organisations, cultural societies, religious groups, sport groups, medical workers can also provide support, information and practical assistance to schools on HIV/AIDS/sex education programmes.

- **Religious and Cultural Organisations**

In this study religion and religious leaders too, played a very important in influencing the knowledge, and the sexual attitudes and behaviour of adolescents with learning difficulties. The respondents accepted what they had been taught by these people, and considered them as important resources in times of need. Religious leaders are important for the

development of a safe and supportive environment for all children. They need to create more open channels of communication and to play a more central role in sexuality education for adolescents with learning difficulties.

- Sport

In this study sport groups play an insignificant role in impacting the adolescent with learning difficulties. Sport groups are in an advantageous position in terms of impacting the adolescents. Membership to sport groups is voluntary and very attractive to the young person who enjoys the physical action. Sport groups can use this to impact the adolescent in respect of HIV/AIDS/sex education.

- Mass Media

In this study 55% of the respondents named the television as a source of their knowledge of HIV/AIDS. The mass media plays a key role particularly in creating and maintaining general awareness of the epidemic. Correct information needs to be disseminated at all times as it becomes a greater task to undo the damage done by incorrect teaching than having to teach those who do not have any information about any issue at hand. The media needs to provide ongoing programmes in respect of HIV/AIDS especially targeted at adolescents with learning disabilities.

Most importantly all institutions, organisations, and groups serving adolescents with learning disabilities need to speak with one voice which can be heard and remembered by our adolescents with learning difficulties: a voice which promotes quality life for all.

As discussed, programmes must be designed with socio-cultural sensitivity and keeping these gatekeepers in mind: a mass promotion of condoms

does nothing for the values of families or to effect behavioural change. Sexuality education must be specifically addressed in the context of the cultural and traditional norms and values of the communities in which the schools are situated. It is therefore imperative that all stakeholders be involved in HIV/AIDS/sex education. Collaborative efforts by the educators, school management teams, school governing bodies (SGB) and community organisations should give impetus to the programmes in schools. An interactive model, structured by educators, parents, religious and community groups and adolescents with learning disabilities to meet the special needs of adolescents with learning difficulties, is strongly recommended. This is in keeping with The National Policy on HIV/AIDS Education (1999), which states in Section 2.11, that an HIV/AIDS implementation plan should reflect the needs, ethos and values of a specific school or institution and its community. The choice and content of HIV/AIDS programmes rests with the school management, members of the school board and parents.

To maximize impact, programmes should collaborate with related efforts (horizontal networking). Vertical networking between policy makers, service providers and learners with learning difficulties is needed to create a supportive environment and create awareness. The well-being of adolescents with learning difficulties affects all equally. It is important that all stakeholders plan for adolescents with learning difficulties constructively: programmes that would promote sustainability and that would have real and lasting improvement in the well-being of adolescents with learning difficulties.

6.5 IMPLICATIONS FOR FURTHER RESEARCH

The links between condom use and the knowledge and attitudes of adolescents have been extensively researched (Hardeman, Pierro, & Manneti, 1997; Johnson, Rozmus, & Edmison, 1999). Research consistently

demonstrates that even when adolescents are knowledgeable about safe sex practices, they are not deterred from unsafe sexual behaviour and many still fail to protect themselves from unwanted pregnancy and STIs (Marsiglio & Mott, 1986; Orr, 1992; Zelnick & Kanter, 1980). There seems to be little or no direct relationship between sexual and contraceptive knowledge and actual behaviour and contraceptive use (Kelly, 1996; Levison, 1995). Hence, further research needs to focus on attempts to clarify adolescent sexual behaviour rather than simply recording knowledge and attitudes regarding pregnancy, STIs and condom use.

This study lends itself to the implementation of a more structured HIV/AIDS education programmes at the school. A longitudinal study could be undertaken, on the present sample of respondents from grade six, over a period of two to four years. The findings of this study can serve to form the basis of future evaluation of changes in the level of knowledge of HIV/AIDS, and the sexual attitudes and behaviour of these adolescents with learning difficulties.

Since this study was conducted in an English medium public school for learners with learning difficulties, it can be replicated in any other similar institution.

6.6 CONCLUSION

Increasing numbers of adolescents are becoming sexually active from as young as 13 years. HIV/AIDS has brought a new examination of what having sex means, especially among adolescents. How adolescents define having sex is important because it helps determine whether they consider themselves to be at risk, how they respond to HIV/AIDS prevention efforts, and how they report their sexual experiences.

Enlightened attitudes towards sexual activity amongst adolescents with learning difficulties expose them to the additional threats faced by all sexually active adolescents of the 21st century i.e. HIV/AIDS related illness and other sexually transmitted disease. Martin (1988), has suggested that there are two opposing myths that need to be disposed of in any discussion of sexuality and mental handicap viz. that people with learning difficulties are promiscuous with large sexual appetites that are likely to be expressed in unacceptable ways, and that they are childlike, innocent and have no sexual appetite. It is therefore necessary to build sex education into health education programmes as it is 'just as important as learning to boil a kettle' (Blunn et al, 1984).

Thus, whilst there is little data on the prevalence of HIV/AIDS infection amongst adolescents with learning difficulties there is a need to include HIV/AIDS awareness training into such programmes. It has been suggested that the rate may be as high as in more general populations (Jacobs et al, 1989). If adolescents with learning disabilities are to act safely, they must not only have accurate information about HIV/AIDS, they must be able to apply it.

Sex education can delay the onset of sexual activity or decrease the number of sexual encounters. Adolescents who were already sexually active adopted safer sexual practices after having received sex education. Sexuality education is most effective if begun before the onset of sexual activity. Adolescents exposed to HIV/AIDS education have been known to engage in less risky behaviour (Futerman, 2000; The World Health Organisation, 2002).

Sustained HIV/AIDS education programmes increase the possibility of bringing about change in risky behaviour. Development of life skills and changing of risky behaviour are factors which require interventions that are maintained until significant targets are achieved.

The mass media plays a key role particularly in creating and maintaining general awareness of the epidemic. Complementing the mass media, a wide variety of ways are used to disseminate information about HIV/AIDS, often with messages targeted at specific audiences.

All role players must be involved in the drawing up of the programmes which must take into account the cultural and ethnic differences, the urban-rural factors in the region, and flexibility to adapt the educational materials (Ndeki et al, 1995).

When closing the 13th International AIDS Conference in Durban in July 2000, our former president, Nelson Mandela, said that '*we have to rise above our differences and combine our efforts to save our people. History will judge us harshly if we fail to do so now, and right now.*' The time to act is now.

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UNIVERSITY OF
KWAZULU-NATAL

09/06/2006
Attention: Mr M.G. Gumede
Dept. of Education PMBurg.

Sir

Re:Consent to undertake research

This serves to confirm that Indira Gilbert is currently registered for the Master's Degree in Social Work. She plans to undertake a research on **The Knowledge of HIV/AIDS, and the sexual Attitudes and Behaviour of Adolescents with Learning Difficulties at Damorosa School in Chatsworth.**

In order to undertake the research she requires official consent from the department as she plans to interview students from grade 6 to grade 10. Your assistance will be appreciated.

Thank You

Dr.G.Suraj-Narayan

[Senior Lecturer: School of Social Work and Community Development]



PROVINCE OF KWAZULU-NATAL
ISIFUNDAZWE SAKWAZULU-
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Date:
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Datum: 13/01/2008

Pi-due:

88bustso Alwar

Mrs I Gilbert
70 Yranus Street
Woodhurst
Chatsworth 4092

RE: APPROVAL TO CONDUCT RESEARCH

Please be informed that your application to conduct research has been approved with the following terms and conditions:

That as a researcher, you must present a copy of the written permission from the Department to the Head of the institution concerned before any research may be undertaken at a departmental institution bearing in mind that the institution **is not obliged to participate if the** research is not a departmental project.

Research should not be conducted during official contact time, as **education programmes should** not be **interrupted**, except in exceptional cases with special approval of the KZNDoE.

The research is not to be conducted during the fourth school term, except in cases where the FCZNDoE deem it necessary to undertake research at schools during that period.

Should you wish to extend the period of research after approval has been granted, an application for extension must be directed to the Director. Research, Strategy Development and EMIS.

The research will be limited to the schools or institutions for which approval has been granted.

A copy of the completed report, dissertation or thesis must be provided to the RSPDE Directorate.

Lastly, you must sign the attached declaration that, you are aware of the procedures and will abide by the same.

for SUPERINTENDENT GENERAL
KwaZulu Natal Department of Education



PROVINCE OF KWAZULU-NATAL
ISIFUNDAZWE SAKWAZULU-NATALI
PROVINSIE KWAZULU-NATAL

DEPARTMENT OF EDUCATION

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Uauku:
Datum; 241051200

List of Schools where Research will be conducted: 1;

Damorosa Secondary School

For **SUPERINTENDENT**
(KwaZulu Natal Department of Education)
GENERAL



INtILbkdHH0VISI

Enquiries:
Imibuzo: Sibusiso Alwar
havrde:

PROVINCE OF KWAZULU-NATAL
ISIFUNDAZWE SAKWAZULU-NATALI
PROVINSE KWAZULU-NATALI

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*FAD OFFICE

Date:
Usuka:
Datum: 131Gb12D06

RE: PERMISSION TO CONDUCT RESEARCH

TO WHOM IT MAY CONCERN

This is to serve as a notice that Indira Gilbert has been granted permission to conduct research with the following terms and conditions:

- That as a researcher, he/she must present a copy of the written permission *from the* Department to the Head of the Institution concerned before any research may be undertaken at a departmental *institution*.
- Attached is the list of schools she/he has been granted permission to conduct research in. However, it must be noted that the schools are not obligated to participate in the research if it is not a KZNDaE project.
- I Gilbert has been granted special permission to conduct his/her research during official contact times, as it is believed that their presence would not interrupt education programmes. Should education programmes be interrupted, he/she must, therefore, conduct his/her research during nonofficial contact times.
- No school is expected to participate in the research during the fourth school term, as this is the critical period for schools to focus on their exams.

for SUPERINTENDENT GENERAL KwaZulu
Natal Department of Education

Dear Parent/Guardian

Consent

I, Mrs Gilbert, educator at Damorosa Secondary School, am undertaking a research for a Masters in Social Work. The research involves my interviewing 50 learners from the school.

Damorosa Secondary School has been chosen for the Research to be undertaken in that it caters for adolescents with learning difficulties. The necessary permission has been obtained from the Department of Education, the Principal and the School Governing Body.

It is also necessary to obtain consent from the learners concerned and their parents. Your child/ward _____ is therefore also required to sign consent at the bottom of this letter.

The interviews are to be carried out during the school breaks (learners living outside the Chatsworth area) and/or after school hours (for learners living in the Chatsworth area). Should the interviews be undertaken after school hours, I will transport the children involved to their homes on that day. You will be notified of the day in advance, and utmost care would be taken in doing transporting.

The Research involves that I interview each learner as chosen. I assure that the information would be confidential and used solely for Research purposes. The findings of the Research, and recommendations are to be made known to the school and the Department of Education to enable the structuring of its programmes for learners with learning difficulties.

Should you at any stage wish to withdraw consent, please feel free to do so by writing in. ²⁶⁰⁷⁵³¹
You may contact my supervisor **Dr G. Surajnarayan**, at 031•if there is anything you may wish to discuss about the research.

Thank you for your cooperation.

Yours Faithfully

Mrs I. Gilbert

QUESTIONNAIRE

SECTION A: Socio-Demographic Details:

Please tick the appropriate block.

1. Age

| 13 | 14 | 15 | 16 | 17 | 18 | other |
|----|----|----|----|----|----|-------|
| | | | | | | |

2. Gender

| Male | Female |
|------|--------|
| | |

3. Religious Affiliation

| Christian | Muslim | Hindu | Other |
|-----------|--------|-------|-------|
| | | | |

4. Ethnic Group

| Black | White | Indian | Coloured |
|-------|-------|--------|----------|
| | | | |

5. Grade at School

| 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|----|
| | | | | |

SECTION B: KNOWLEDGE OF HIV/AIDS

| WHICH OF THE FOLLOWING STATEMENTS DESCRIBE HIV/AIDS? | YES | NO |
|--|-----|----|
| AIDS is caused by HIV | | |
| HIV is transmitted blood, semen, vaginal fluids, and breast milk | | |
| HIV is commonly spread by having sexual intercourse with someone who is infected with the virus | | |
| HIV is commonly spread by sharing needles or syringes with someone who has the virus. | | |
| HIV can spread from an infected pregnant woman to her unborn baby during pregnancy, birth, and breast feeding. | | |
| HIV is not spread through casual contact such as kissing, hugging, sharing of clothing, or eating utensils. | | |
| Condoms used during sex can help prevent HIV spreading from one person to the next. | | |
| Young people do get HIV. | | |
| There is a no cure for HIV | | |
| Taking a shower/bath after sex does not reduce the risk of getting HIV | | |
| Condoms <u>will</u> (100%) protect one from getting infected with HIV. | | |
| Those who look healthy could also have HIV. | | |

| SYMPTOMS OF HIV/AIDS | YES | NO |
|-------------------------------------|------------|-----------|
| Rapid Loss of Weight | | |
| Diarrhoea | | |
| Recurring Fever and/or night sweats | | |
| Recurring or unusual skin rashes | | |
| Loss of muscular strength | | |
| Other | | |

| PREVENTION OF HIV/AIDS | YES | NO |
|-------------------------------|------------|-----------|
| Abstinence | | |
| Condoms | | |
| Only one partner | | |
| Avoid too many partners | | |
| Avoid prostitutes | | |
| Other | | |

SOURCE OF INFORMATION ABOUT HIV/AIDS

| | |
|-------------------|--|
| Parents | |
| Friends | |
| Teachers | |
| Television | |
| Movies | |
| Siblings | |
| Religious Leaders | |
| Other | |

SECTION C: SEXUAL ATTITUDES AND BEHAVIOUR

SEXUAL BEHAVIOUR

1. Whom do you go to after School?

| Parents | Grandparents | Neighbours | Other |
|---------|--------------|------------|-------|
| | | | |

2. How do you spend your time after school?

3.

| | Yes | No |
|--------------------------------------|-----|----|
| Have you engaged in sexual activity? | | |

4.

| What are your reasons for not having sex? | |
|---|--|
| Religious principles | |
| HIV/AIDS and health concerns | |
| Culture | |
| Family | |
| Other (specify) | |

5. At what age did you start having sex?

6. What was the age of your first sexual partner?

7. When you have sex, do you use a condom? _____

8.

| If Yes, how often? | Yes |
|--------------------|-----|
| Always | |
| Most of the time | |
| Some of the time | |
| Never | |

9. What is your relationship with the person with whom you last had sex?

10.

| What are your reasons for having sex? | |
|---------------------------------------|--|
| Enjoyment | |
| The experience | |
| Money | |
| Forced | |
| Fear of losing partner | |
| Love | |

11.

| How many sexual partners have you had? | |
|--|--|
| 1 - 2 | |
| 3 | |
| 4 | |
| + 4 | |
| Don't know | |

12. Do you think that your partner has other sexual partners?

| | Yes | No | Do not know |
|--|-----|----|-------------|
| Do you think your partner(s) has/ have other sexual partners? | | | |

SEXUAL ATTITUDES

1.

| | Yes | No |
|--|-----|----|
| Is it acceptable for adolescents to have sex as long as a condom is used? | | |

2.

| | Yes | No |
|---|-----|----|
| Is it acceptable to have sex after the first meeting/date? | | |

3.

| | Yes | No |
|---|-----|----|
| Is it acceptable for a girl to have sex at any age as long as she is willing to? | | |

4.

| | |
|---|------------|
| Who should be responsible for taking precautions during sex? | Yes |
| My partner only | |
| Myself | |
| Both of us | |

**SECTION E: THE IMPACT OF THE SCHOOL HIV/AIDS
PROGRAMME ON BEHAVIOUR, KNOWLEDGE,
AND ATTITUDES**

1. What type of HIV/AIDS Programme is available at your school?

2. How often is the programme conducted at your school?

3. How many lessons are used for the programme?

4.

| What are the benefits of the school programme? | Yes |
|--|------------|
| Educated me about HIV/AIDS issues | |
| Helped me to talk to friends, family, or others about HIV/AIDS, sexuality and about lifestyle issues in general | |
| Made me more aware of the risks of unsafe behaviour | |
| Made me think more about the openness and honesty of romantic relationships, and to talk more openly with my girl/boyfriend about HIV/AIDS, and sex | |
| Caused me to make behavioural changes, including the use of condoms, delaying or abstaining from sex | |
| Caused me to limit/reduce the number of sexual partners | |
| Caused me to be more assertive in insisting on condom use | |

Suggestions for future School Programmes

SECTION F: SOCIAL WORK SERVICES

1.

| Which of the following services are available at your school? | |
|---|--|
| Psychologist | |
| Guidance Counsellor | |
| Social Worker | |
| Other | |

2.

| | Yes | No |
|---|-----|----|
| Is the counseling service at school available whenever you need it? | | |

3.

| | Yes | No |
|---|-----|----|
| Has your or the family at any stage used the services of a community social worker? | | |

4.

| | Yes | No |
|--|-----|----|
| Do you think that there is a need for a social worker at school? | | |

5.

| What type of service do you expect from a Social Worker at School? | Yes | No |
|--|-----|----|
| Individual Counselling | | |
| Discussion in Groups | | |
| Other | | |

RECOMMENDATIONS

Informed Consent

I, _____, parent/guardian of _____, do hereby confirm that I understand the contents of this document and the nature of the research project, and consent to my child's/ ward's participation in the research (as explained in the letter).

Should I, at any stage wish to withdraw consent, I will notify Mrs Gilbert in writing.

Consent is also given for Mrs Gilbert to transport my child/ward home on the day of the interview, and will not hold her responsible should any mishap occur while she does so.

Signed: Parent

Learner

Date

Witness

Witness