SOPHIA HEMMET
HÖGSKOLA

HIV PREVENTION FOR ADOLESCENTS IN SOUTH AFRICA

HIV PREVENTION FÖR UNGDOMAR I SYDAFRIKA

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Authors: Anna Karlsson
Felicia Blomqvist Hassell
Mentor: Karin Casten Carlberg
Examinor: Margareta Westerbotn

ABSTRACT

Background
It is estimated that 6.1 million people have HIV in South Africa, which makes it the country with the highest number of people living with HIV in the world. Adolescents are a severely affected and exposed group, since they tend to have several risk factors and a risky sexual behaviour. However, sexual education is implemented in school and there are special prevention programmes for adolescents in the country.
Aim
The aim of this study was to examine the HIV prevention work for adolescents in South Africa.
Method
The study was accomplished with a qualitative method and a semistructured interview design. The respondents were reached through purposive sampling and snowballing. In total six interviews were accomplished with people active within school, healthcare and different organisations.
Results
South Africa is a diverse country with many different cultures, beliefs and languages. Due to all the differences in the country, the widespread poverty and the previous political situation the challenges are many when it comes to prevention work. The key findings of the thesis are the importance of education and gender empowerment for adolescents to prevent the further spread.
Conclusion
HIV prevention for adolescents is important to reduce the HIV epidemic in South Africa. However, further education and gender empowerment is needed. Stigmatization and poor adherence to ART is also issues that need to be addressed in order to make progress in the prevention work. A mutual goal has appeared in the field of HIV prevention; to have zero new infections.
Keywords
HIV, Prevention, Adolescents, South Africa, Education, Contraceptive use, Sexual behaviour.

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BACKGROUND

Human immunodeficiency virus

Human immunodeficiency virus [HIV] is a blood-borne infection transmitted through blood and body fluids. It can be transmitted through unprotected sexual contact; vaginal, anal or oral. The transmission can also occur by sharing needles or receiving a blood transfusion from an infected person. It can also be transmitted during pregnancy, childbirth and breastfeeding from an infected mother to her infant. HIV is not transmitted through ordinary day-to-day contact as hugging, kissing, sharing food or water (World Health Organization [WHO], 2013).

HIV is a retrovirus that infects different cells of the body, especially cells of the immune system (leukocytes), and destroys or impairs their function. When the leukocyte levels are significantly low the immune defence becomes weaker and the person is more susceptible for other severe infections, for example tuberculosis. Those infections are called opportunistic infections since they are taking the opportunity while the defence is low (Centers for Disease Control and Prevention, 2013).

Acquired immunodeficiency syndrome

When a person becomes affected by one or several opportunistic diseases the most severe stage of HIV is achieved, acquired immunodeficiency syndrome [AIDS]. How long it takes before a person develops AIDS is individual. Antiretroviral drugs [ARV] can however slow down the progress. Once HIV infects a human, one can never completely recover from it, although, one can today live a long and healthy life with ARV without developing AIDS (Centers for Disease Control and Prevention, 2013).

The HIV situation in South Africa

South Africa has the highest number of people living with HIV in the world, 6, 1 million of the total population of 52 million people in the country (WHO, 2009). However, the incidence of new HIV infections in the country has reduced with 41 percent from the year 2001 to 2011, due to increased political leaderships and HIV prevention and treatment programmes (UNAIDS World AIDS Day Report, 2012).

The South African government has historically shown a little interest in the fight against HIV and AIDS and barely admitted its existence (Posel, 2011). According to Ragnarsson, Onya and Aarø (2009) interventions that have been made have been inadequate and ineffective and too costly compared to the response. Further on the authors' states that the reason the interventions have not generated in good result is depending on that people have not been given a good foundation of knowledge about the disease. Therefore, Ragnarsson et al. (2009) argue that to educate people in the country would probably lead to more adequate and cost-effective results of the intervention programmes.

Smith et al. (2012), Namisi et al. (2013), Louw, Peltzer and Chirinda (2012) define adolescents as youths 15-24 years old. Swartz et al. (2012) indicates that adolescents are one of the major risk groups for HIV transmission. Especially the ones that exhibit a lot of risk behaviours like early sexual activity and substance abuse. In addition to this the ones who tend to drop out of high school are in a greater extent vulnerable for being exposed to HIV due to insufficient education and knowledge.

Healthcare in South Africa
All citizens and legal long-term residents in South Africa are entitled for health and free healthcare. This is stated in the Constitution of the Republic of South Africa (ACT 1996:108, section 27-28) and since the year of 2010 South Africa has a National Health Insurance [NHI]. It is also specifically stated that everyone has the right to reproductive health care.

Focus within South Africa's healthcare system is placed on "*prevention of diseases and promotion of health*". In comparison to the previous healthcare system, the present healthcare with the NHI is thought to be more cost-effective and above all; accessible for everyone. The Constitution of healthcare has four stated focusing areas, of which one comprises the combat against HIV, AIDS and tuberculosis. Within this area there are further special targets to work preventatively against HIV. Addressing the need of behavioural changes, medical male circumcision [MMC], early prevention of mother to child transmission and improved handling of sexual transmitted infections [STI's] is some of the targets (Department of Health Republic of South Africa, n.d.).

Education as prevention
According to Swartz et al. (2012), the longer education adolescents get the more knowledge about sexual behaviour and sexual transmitted diseases they achieve. For teachers in high school, sexual education and reproductive health could perceive as a difficult subject to bring up in teaching. It is a delicate topic and teaching a subject that to some individuals might be associated with a lot of taboo could lead to that teachers circumvents the topic and omit important details. This might result in students getting incorrect information about sexual- and reproductive health. Many students in the above mentioned study stated that they believed that HIV was harmless to them. According to Swartz et al. (2012) this shows how inaccurate sexual education they might have received.

Smith et al. (2012) examined secondary school teachers' attitudes towards sexual education, HIV, AIDS and adolescents' sexuality in rural South African schools. The attitudes found were investigated in ways of how they could affect the governmental school-based sexuality educational programme. The findings varied but generally the teachers' attitudes were more focused on the students' irresponsible behaviour and less good choices than the actual risk-reducing factors known to prevent HIV.

Reddy and Frantz (2011) claims that age is strongly associated with knowledge about HIV since a study made among South African university students showed that younger students were less aware of the fact that they could get infected by HIV or they did not know about the risks. Older students had more understanding and answered that there were a great risk of getting infected, however, women on both universities were reported to be more aware of the risks. Luseno and Wechsberg (2009) showed in their study a connection between testing for HIV and level of education for women, the higher level of education the more likely the woman was to test her herself.

<u>The Life Orientation programme</u>
Implementation of sexual education in South African schools has struggled with a lot of challenges over time. Schools segregated by race due to Apartheid and gender based discrimination; putting black people and young women in an indelicate situation, has been some of the main problems. This has complicated the introduction of a national curriculum for sexual education and reproductive health (Smith et al., 2012). However, a Life

Orientation programme has been included in the national curriculum. Life Orientation is a course, which is part of the national curriculum; from grade one up to grade 12 in the South African educational system. The programme contains guidelines for the schools with certain topics and how to work with these together with the students. The Department of Education supply schools with workbooks in different languages. There are four focus-areas within the course. The first one, the life skills area, focuses on health promotion, both on a personal- and on a society level. HIV and AIDS are addressed, together with the importance of prevention for STI's. The issues related to teenage-pregnancies are also included (Department of Education Republic of South Africa, 2003).

Full implementation of the Life Orientation programme in South African schools has increased the knowledge of HIV and AIDS, but also the claimed condom use, according to Smith et al. (2012). This curriculum is however not completely deep-laid, but gives plenty of opportunities to formulate the education with given topics (Department of Education Republic of South Africa, 2003). According to Smith et al. (2012) teachers' training in Life Orientation has shown to have an impact in the education delivered. In addition to this, the teachers' comfort in teaching the subject played an important role and the authors noted that this was strongly reflected on the teachers' knowledge of their own HIV status.

Sexual behaviour

According to Hoque and Ghuman (2012), young people is a risk group for contracting HIV, regarding the fact that younger people tend to have an experimental phase where they examine their own sexuality and often have more than one sexual partner. In addition to experimenting with their sexuality they also often introduce alcohol and drugs at the same period of life, which is a combination of a risk-behaviour for contracting HIV infection, the authors claim.

Louw et al. (2012) graded risky sexual behaviour after; sexual debut before 15 years old, ever had sex without consent, having had sex with someone significantly older, number of transactional sex partners, how often sex was practiced and if having more than one sexual relation at the same time. Further on Louw et al. (2012) consider self-efficacy as an important factor for changes in health-related behavior, defining high self-efficacy as having confidence to behave in a certain kind of way, for instance using condom during sexual intercourse. Self-efficacy is however not the same as the actual behaviour. The researchers also identified the directly most secure ways of reducing the risks for HIV transmission as consistent condom use and being able to discuss safer sex with your partner. Louw et al. (2012) also found that high self-efficacy for men were associated with knowing your HIV status. For women on the other hand, high self-efficacy was strongly associated with life goals.

Pettifor et al. (2007) found that a national youth programme, which reached the adolescents through different national media and local support programmes, indicated an impact of more frequent condom use among adolescents.

Namisi et al. (2013) showed that communication on sexually issues between adolescents in school, and for them, important adults, is related to safer sexual practice, such as consistent condom use. Behavioural interventions within the group of high-school adolescents are a high priority to reduce new HIV infections. To influence a consistent behaviour it takes bidirectional communication, accepting attitudes and social responsibility training as well as training being responsible for consequences following one's action.

Substance abuse

Palen et al. (2006) showed in their study that 39 percent of the adolescents in 8th grade, who reported to have had sex, were using alcohol or marijuana. It was also found that the students who reported to have used any of the substances also reported to a greater extent having had sexual intercourse. Further on Palen et al. (2006) showed that of those who utilized the substances, 23 percent claimed it affected their decisions about whether to have sex. The researchers also found that there were a strong connection between the uses of the substances and sexually risk behaviour, such as not always using condom when having sexual intercourse and have more than one sexual partner.

Prevention work

Prevention means proactive work to preserve health and prevent disease and injury from occurring or aggravating (Nationalencyklopendin, 2014).

Behaviour change

In South Africa 13.9 percent of the infected population is 15-24 years old females, this compared to the 3.9 percent within males in the same age (UNAIDS, 2012). In UNAIDS report on the global AIDS epidemic (2008) the primary cause of HIV in women is stated to be sexual transmission. The complexity of HIV prevention for women in this area is emphasized because of the number of influencing factors, such as biological, behavioural and structural factors. Women in this area often have to engage in sex for survival, they are socially instable and are victims of gender-based violence. Abdool Karim, Sibeko and Baxter (2010) suggests short-term interventions to prevent HIV transmission in women, such as; reducing poverty, encouraging greater male responsibility and increasing the access of sexual and reproductive health services.

In an article by Reddy and Frantz (2011), it is suggested that prevention programmes should focus on multipart cultures and beliefs since the differences in the country can put people in risk of contracting HIV due to different perceptions of sexual behaviour. Due to the authors, women have a central role in countering the spread of the HIV infection. Through a structured education of HIV, AIDS and gender empowerment for all citizens, the authors argue that this will be something positive for the next generation as they become more aware and protected through knowledge and education.

Medical male circumcision

Medical male circumcision [MMC] is a procedure done to prevent the spread of infections such as STI's and HIV. The risk of transmission reduces due to the surgical performance of removing the foreskin or parts of it, which makes it easier keeping the penis clean. By removing the foreskin the sebaceous glands, that contains target cells for HIV, disappear. The procedure also makes it more difficult to catch genital ulcer infections and makes rashes or ulcers easier to discover and reduces the risk of HIV for men by 60 percent. It is however not a substitute to the use of condom (Centers for Disease Control and Prevention, 2013).

In accordance to Perera, Bridgewater, Thavaneswaran and Maddern (2010), male circumcision is often done non-medically, due to different religious- and cultural believes, in the Sub-Saharan area. Non-medical circumcision is nothing Perera et al. (2010) consider

as a safe procedure, but notes that these men, on the other hand, are at less risk of HIV infection and STI's.

Antiretroviral therapy

Antiretroviral therapy [ART] is not a cure for HIV. It can however slow down the process by controlling the viral replication and contribute to the immune system's capacity to regain strength and fight other infections. It can also lower the viral lever so that the person becomes less contagious. If ART is started in the early progression of the disease, the person can live a healthy productive life for many years. A standard ART therapy consists a combination of at least three antiretroviral drugs [ARV] with different manufacturing areas to receive the highest possible suppressing effect of the HIV infection. Great reductions in rates of deaths and suffering have been seen when ART is used and especially in the early stages of the disease. Access to ART also contributes to the reductions of HIV transmission and preserves families when fewer adults die, leaving their children orphaned, which is also a major problem within the HIV issue (WHO, 2013).

Quinn (2008) claims that the asset to ARV in the developing world is slowly improving and that the availability of ARV is one of the major factors in reducing the HIV pandemic. Quinn (2008) means this is mainly because ARV does not only prolong lives but also helps to prevent the spread of infection. Further on, the author states that this is foremost the effect of the counselling and information the person receives in connection to initiating the ART, which contributes to a greater understanding and knowledge of their disease.

Research question

In South Africa 6.1 million people are living with HIV. Among female adolescents in the age of 15-24 years old it is estimated that 13.9 percent is infected of HIV. Compared to the male adolescents in the same age group, where the percentage is 3.9, female adolescents 15-24 years old is a severely affected group (UNAIDS, 2012). However, the incidence of new HIV infections in the total population of South Africa has been reduced with 41 percent between the year of 2001 and 2011 (UNAIDS World AIDS Da
y Report, 2012). Department of Health Republic of South Africa (n.d), states that "*prevention of illnesses and promotion of healthy lifestyles*" are the key areas for improving the health status in South Africa. Furthermore is "*Combat HIV and AIDS and decrease the burden of disease from TB*" one of the target areas within the South African healthcare (Department of Health Republic of South Africa, n.d). In the present study the authors want to examine the prevention work for adolescents in South Africa. The authors want to find what is done to prevent the further spread of HIV infection and how. Additionally the authors want to examine what other factors affect the prevention work and what role education play.

AIM

The aim of this study was to examine the HIV prevention work for adolescents in South Africa.

METHOD

A qualitative method with a semistructured design has been used in the present study. This method was used to obtain a broad picture of the prevention work against HIV for adolescents. Data were collected through interviews and where as new data emerged, the

authors sifted out relevant material in order to answer the aim of the study. Polit and Beck (2012) describes a qualitative study as an evolving process, giving the researchers freedom to interpret collected data as the study progresses. Interpretation is a commonly used concept within qualitative method since qualitative method to a large extent is focusing on the interviewee's subjective perspective of the subject. It is then the researchers' function to interpret this subjectivism of reality.

A semistructured interview design consist an amount of elaborated subjects that the researchers need to cover during the interview. Questions do not need to be asked in a specific order; if only the main topic is covered. The researchers are relatively free to ask following questions to further illustrate the topic. These following questions should however be elaborated in advance based on the theme (Polit & Beck, 2012), which the researchers have implemented during the interviews.

Sample

The aim was to use participants with a wide spectrum of experience to find different aspects and perspectives on HIV prevention work for adolescents in South Africa. A sample group that could provide as representative results as possible was desirable for the study and participants were selected with care for that. Interviewees were partly found by searching on the Internet, using search terms as; *HIV*, *prevention*, *adolescents* and *South Africa*, for actors operating within the HIV-area. Initially the researchers mainly turned to organisations but later on turned to other instances to search for interviewees to broaden the spectrum of experience and expertise. The currently used method is called "purposive sampling" because the sample within qualitative methods is not often based on coincidence. Moreover, contacts were received through previous respondents by the method called "snowballing". Snowballing means that early study participants can refer to other potential participants they believe could contribute with something valuable to the study. Within purposive sampling a share of the participants can even be added through snowballing (Polit & Beck, 2012).

A first contact with the interviewees was established by electronic mail (email) or phone call, this was done when planning the study and during the study progress. An invitation to participate in an interview was sent by email together with information in a letter with a request of participation (ANNEX A). In accordance to the Nuremberg Code (U.S Department of Health & Human Services, 2005) the researcher must have provided the participant with all necessary information before accepting any consent to participate in a research study. In order to this information about the aim of the study, where, when and how the study would be implemented was given. Moreover, the potential participant must be in a position to determine for her- or himself without being coerced or feeling extruded. All study participants possessed the right to end participation at any time, and no participants in the present study have been in a situation that forced them to participate unwillingly.

Interview guide

The researchers developed a guide with topics and questions that was addressed during the interviews. The interview guide, or topic guide, contained questions, based on topics, in a certain order that was logical to the researchers. However, in accordance to Polit and Beck (2012), these topics did not have to be discussed in a specific order and the researchers were prepared to rather ask a question or change the topic if that was considered reasonable for the flow in the interview.

According to Polit and Beck (2012), topics and questions should be formulated in a way that allows the participants to freely speak about the subject. In order to this the researchers have to promote an open environment and gain trust so that the participant feels that he- or she can speak openly. The researchers of the present study were concerned that participants would feel comfortable and safe. Therefore each interview was initiated with some small talk and some background information about the study. The participants had also the opportunity to ask questions that the researchers answered. In accordance to Polit and Beck (2012) another prerequisite for achieving more informative answers was that the questions in the interview guide were not closed, meaning the participants would have to answer more extensively than "yes" or "no".

The interview guide was formulated with intentions to use as few and comprehensive questions as possible (ANNEX B). The first question in the interview guide was broad and comprehensive and gave the information of the prevention work that each participant performed. Six other questions were asked in order to cover all purposed themes. These touched topics about what was carried out in their workplaces. In addition to this, questions were asked that could provide answers about the situation in the country, affecting factors, such as; different social aspects and the effect of education. Further on, the responses gained of the interview guide provided a deeper understanding of the respondent's subjective experience of the performed HIV prevention work for adolescents that the researcher later had to interpret.

Pilot interview

Initially to the present study a pilot interview was made in order to try out the feasibility of the questions and how well they responded to the purpose and issues. A pilot study, also called a feasibility study, is a small trial, which intends to test the method for the real study. The major purpose of doing a pilot study is to detect problems with the planned study method and thus prevent a failure (Polit & Beck, 2012). Through the pilot study the authors perceived the interview questions as feasible and well responsive to the research questions. According to this, the pilot interview was also included in the results.

Data collection

Data were collected through interviews. According to Polit and Beck (2012) the most frequently used way of gathering data within qualitative method is through interviews. The respondents had different expertise within the area of HIV prevention work. In total six interviews were fulfilled with people operating within organisations, schools and health care instances. Five of the interviews were accomplished in the participant’s workplaces and one interview was held by a videoconference (Skype). During the interviews one researcher asked the questions and one assisted and took notes and handled the recording equipment. The researchers took turns in interviewing and assisting.

In all interviews the researchers used recording equipment, in order to ensure that the interviewees' answers were correctly quoted during the process of transcribing. This ensures that the researchers based their interpretations and results on right foundations, not only what was remembered from the interviews (Polit & Beck, 2012).

Data processing

Transcribing

The accomplished interviews were transcribed verbatim. To ensure the accuracy of the transcribed material, the material was repeatedly listened through and compared with the notes taken during the interview. Transcribing an interview experience is a very important step in the qualitative study process and it places high demands on the researchers' accuracy when transferring an interview to paper. Everything that happened during the interview was marked in the text, such as; background noises, laughing, coughing, hesitations, sighs, and etcetera. According to Polit and Beck (2012), it is of great importance for the researchers to later on be able to make a valid interpretation of the collected data. Certain awareness were in accordance to Poland (1995) taken to the concordance of punctuation, since it is a common error within qualitative method that the results gets misleading due to incorrect use of punctuation.

Data analysis

Before the data analyzing began, the researchers read the transcribed material repeatedly together in order to learn the content of the material. According to Polit and Beck (2012), it is important for the researchers to know their data before they can start interpreting the material and compile a result. Qualitative data analysis is a delicate process that requires a lot of understanding from the researchers.

When good knowledge about the data was achieved, the researchers started to organize the data by coding it into categories. In accordance to Polit and Beck (2012) this was mainly done by working out a category scheme, in which data could be sorted in under the concerned category. A first draft of a category scheme was done in advance, when developing the question guide, before the process of collecting data was started. Within qualitative method this is often done to simplify for the researchers when they develop the interview guide (Polit and Beck, 2012). After the material was being processed, additional categories occurred and these where included in the category scheme.

Researchers were both involved in the development of the category scheme and the interviews were read and coded together in accordance to Polit and Beck (2012), who notes that it increases the researchers credibility if both researchers are active in the coding to ensure the accuracy. Categories like; prevention, education, situation and affecting factors were used from the beginning. As the coding progressed the categories changed and additional sub-categories were distinguished and implemented for the result presentation. An example of the data analysis and the development of a category scheme can be seen in ANNEX C.

Credibility

The authors intended to accomplish the present study with high credibility. In order to ensure credibility of a certain study the researchers must have a clear aim through the whole research process and use the current method with accuracy (Vetenskapsrådet, God forskningssed, 2011). To ensure high credibility the authors have used recording equipment during all interviews, which made it possible for the authors to listen to the interviews repeatedly. Through transcribing and analyzing the data the researchers secured that important information was not overlooked. The interviews was listened to and transcribed by both researchers. In accordance to Polit and Beck (2012) the researchers who accomplished the interview are likely to have gained a deeper understanding and

knowledge about the content of the interview, so that it becomes easier to perceive additional information when listening to the recorded interviews again.

Validity

A study's validity increases if the researcher specifically examines what the study aims to examine. To considering results as valid they need to be based on correct interpretations of the collected data (Henricson, 2012). By consistent use of the interview guide the researchers aimed to perform the present study to be highly valid. To ensure that the researchers have interpreted the collected data on right basics, the audio-recorded interviews were transcribed with accuracy and the researchers listened to the material several times. Also the transcribed material was read several times to identify potential gaps in the conformance between the spoken- and the written word. Both authors of the study were present at all interviews but the major part of interviews was transcribed by one of the researchers. To assure themselves about the transcriptions conformance, both researchers read the written interview and listened to the recording simultaneously. This was done with all interviews. In accordance to Polit & Beck (2012) both researchers were involved in the coding to keep a consistently accuracy over all interviews.

Transferability

The present study aimed to capture a holistic picture of the country's prevention work against HIV for adolescents, and due to the broad expertise of the respondents, and the geographical spread, the study will be presenting a rough overview for the preventive work in South Africa. However, the results that emerged were quite similar regardless of where the respondents worked and in what way. Within qualitative research very few results are considered transferable due to the subjectivity in qualitative studies. Nevertheless, transferability is an interesting concept to discuss since a consciousness about the issue can increase the authors credibility (Polit & Beck, 2012). The results of the present study may be transferable to a certain extent, although it is unclear how much the sampling has influenced the results of the study. Even though all participants have been involved with adolescents and HIV prevention work and they all have discussed the same topics, the sample group and likewise the results, could have varied a lot if other researchers would have accomplished the study.

Ehical considerations

The participants were informed that participation was voluntary, about the aim of the present study, when it was going to be accomplished, where the results might appear and in what purpose the results may be used (ANNEX B). In accordance to the Declaration of Helsinki (World Medical Association, 2013) all personal information were handled confidentially and all data that could refer to the person's identity were destroyed afterwards. Confidentiality in a study is necessary if anonymity is not possible. Confidentially means that personal information will be known for the researchers but must not be shared. Transcribed interviews were not stored with any personal information that could be linked to the respondents' identity and were destroyed as soon as the interviews were transcribed and coded (Polit & Beck, 2012).

The authors have intended to work as confidential as possible to not divulge the study participants' identities. No names were used in the transcribed material or during the transcribing process and the recorded materials were deleted right afterwards. The data was also processed in such a way that no results would be able to derive to the participant, in accordance to Polit and Beck (2012). Study participants have moreover been informed

about the right to end participation at any time and that their shared information then would be excluded from the thesis (Henricson, 2012). An informed consent has been received in written or orally after the respondents have read the written information letter with a request of participation (ANNEX B). According to this, the present study has been accomplished with confidentiality to a large extent.

RESULTS

One question within the interview guide was about ambitions regarding HIV prevention for adolescents in South Africa, to this question a mutual goal clearly appeared; *"Our ambition is to have zero new infections among young people"*. The authors will here present the results of the present study, the prevention work and the affecting factors that emerged. The results will be presented in different categories that appeared during the data analysis. Under each category there are sub-categories, which also emerged during the process of data analysis. The present study's aim was to examine the prevention work, therefore prevention is a consistent theme through all categories, and is not presented under a separate heading.

Life orientation	**Education**
Gender empowerment	
Knowledge	
Contraceptive use	**Healthcare**
Know your status	
ART	
Behavioural differences, cultural- and religious beliefs	**Affecting factors**
Poverty	
Substance abuse	
Peer-pressure	
Political	

Education

In all accomplished interviews it has been claimed that education of the population about HIV is *"pretty much what it all is about..."* and *"It's the best tool that we have"*, to reduce the HIV transmission. Further on, it was mentioned during all interviews that to get as many adolescents as possible to go to- and remain in school as long as possible, would be an important factor for achieving a change in the transmission. School was said to be a protective factor, not only because of the education provided but also due to the increased future opportunities it brought with it. *"We would like if more and more people would be educated or stay a little longer in school so that the protective aspects kick in..."* one respondent said. Having life goals was a protective factor as well, since it empowered the adolescents' self-esteem and motivation to certain behaviour.

One participant were talking about the education that comes from the adults at home, and stated that *"Among us black people it is taboo to talk about sex, like my mother never sat down with me and said; this and, and this, and this is what's going on, so now when we say that education, sexual education, should be used in school, the parents say why?"*. Another

respondent, on the other hand stated that *"We get enough support from the Departments, we get support from the parents as well and the teachers attend workshops, we got a Wellness committee, a Wellness committee at the school that attends regularly sessions on health, on staying healthy, on staying healthy wherever you are"*. These quotes are contradictory in terms of the received support of implementing sexual education in school, but could perhaps be explained since one of the participants was active in school and one was not. The difference between the school education and the information provided at home was exemplified by one respondent *"For instance I was talking to my son about usage of condoms, and he said; I get enough of that in school, so he don't listen. They do touch it in school but they don't go in detail, you understand, and they do Life Orientation and there it is just mentioned, not in detail. So he says; I got enough Life Orientation in school. But the teacher talks to 40 kids, at room I talk to you. That makes the difference"*.

One respondent claimed that there would be *"more advantage dealing with young people because mainly you create demand before they are sexually active. So because the average sex age in South Africa is around 15-16 so you want to reach them before they become sexually active so by the time they become sexually active they use condom..."*.

Life Orientation

Teachers in Life Orientation felt that time might have been the factor that mainly limited their work and that the course was not as highly prioritized as other important subjects in school *"Time limit, because Life Orientation is like, not so important as math, or other academically subjects"*. One participant, who was not involved within the school system, said when talking about the affect of education that *"But it is, it is getting better. And as I understand it the majority of time spending in life orientation is on sort of safe sexual practice and prevention of HIV and other STI's..."*. Education about HIV, STI's and prevention strategies were however said by other respondents, who were active in schools, to only be a small part of the Life Orientation programme, not something they worked with all year. The Life Orientation course was additionally claimed to be quite general so that the schools could structure "their own" course. However, the respondents in the schools said that, likewise most schools, they simply worked through the workbooks, which were supplied from the Department of Education. These books were available in different languages and costumed for all grades.

Through all interviews it appeared that how to make good life choices were perhaps an even more important part in the Life Orientation programme than the pure sexual education. This was said to be because making good choices in life could, in general, be as preventative as teaching how to practice safe sex, *"In order to prevent HIV effectively, you have to address other life skills, in other areas of the teenagers life also"*. Avoiding substance abuse was mentioned as one example of things where life skills training also could work preventatively. One teacher noted that it was very important to feel comfortable when teaching life orientation, because, in order to warn the adolescents about HIV and AIDS, you needed to have confidence.

In one school the respondent answered the question about how the prevention work was done by explaining that they had an AIDS policy that all students were informed about, which content possible actions if there would be an accident with bleeding and the obligation to tell the school counsellor if you were HIV positive. The respondent said that there was also a first aid kit with gloves to protect yourself in case of an accident with bleeding. It was also claimed in one interview that there was no need for handing out

condoms at their school because the problem was not that big. However it was also said that it might be necessary in other areas.

Gender empowerment

Empowering young girls to stand up for themselves and enforce their rights over their own body was something the respondent brought up during the interview. *"for us preventing any teenager from becoming HIV positive is our key in empowering young girls to take ownership of their bodies. And to have the knowledge and the resources available to them in the community. And if they do become HIV positive for them to not live in fear, for them not to be any stigma attached to be HIV positive. Because it is no longer a disease you have to die from"*. The concept of stigma was also something that emerged in most of the interviews as an obstacle in the prevention work.

One participant claimed that young girls played a big role for the further HIV transmission. It was said that sometimes young girls had to engage to older men who could support them with necessities for survival. Girls are not always in the position of saying no to sex, it was said. Younger girls' engaging to older men was a problem because it allowed the infection to spread across generations. Further on, one respondent claimed that gender empowerment was of great importance since "*girls get raped all the time! That remains a huge challenge...*" and *"teenage pregnancies is one of the biggest problem in our country...*".

Knowledge

One of the respondents said *"I don't think we talk about it.., or WE DO talk about it all the time! But you know, HIV is everywhere, condoms are everywhere, but I just don't think we are doing it the right way..."*. This might contradict the general belief that HIV transmission only is a question of knowledge and access of condoms. The respondent sounded almost dejected when saying this.

Healthcare

A share of the respondents talked about the previous political situation in South Africa when the topic about affecting factors was discussed. With that they brought up the affect this might have had on the country's healthcare. The two different sectors in the South African healthcare, the private and the public, have very different approaches. The private sector is highly valued. The public sector on the other hand, is suffering from staff shortages and is overburdened with patients. One participant claimed that *"We are still catching up with a huge epidemic, so we spend our money on treating; all our time and money is going into treating very ill patients..."*. Further on the participant also said *"if you spend money in healthcare, in terms of the return that you get, it is much better to spend money on prevention, because you spend a little money, and you get a lot back. And we are unfortunately not at that stage"*.

Getting people to trust the healthcare was also mentioned as a challenging factor in the progress of making the population conscious about the HIV epidemic and its spread, and it was said that *"South Africa has been on the fall front of a lot of the HIV research and every couple of years a new paper is published and then we change all our policy's to align with the new research's saying. So getting people to trust the health services and to make them understand that research changes, and we are trying to stay as up to date with the new research as possible, and that is also sort of a challenge"*.

Contraceptive use

The fact that condoms and use of contraceptives is not accepted within all cultures in South Africa was mentioned by several participants as an aggravating circumstance, rather than the access of contraceptives. Although, schools in South Africa do not necessarily hand out condoms, and as one participant said *"We believe that HIV prevention is not only just about young people getting condoms..."*. However, one of the respondent pointed out that there is a big difference in access of condoms between urban and rural areas; it is not always simple to access condoms in a rural area, *"and then you find that the young person cannot access the condom because the school doesn't allow, the clinic is too far and probably not youth friendly and they cannot afford to buy or do not have access to places where they can buy condoms"*. Additionally rural areas tend to be more culturally controlled than urban areas, in an urban area you can often be anonymous in a greater extent which makes it easier to buy contraceptives and the use is more accepted due to less cultural influences.

Contraceptive use was also claimed to be an issue between genders; it was not always an equal decision of when to use contraceptives and therefore it was not always a consistent use. Several of the study participants claimed that women sometimes had difficulties with convincing men about condom use. This was something that the participants wanted to work further on with the women, so women learned how to take control over their own bodies. "*I won't have sex with you, unless you use a condom!*" was one example of how the girls could empower themselves. However there also seemed to be other influencing ideas about the contraceptive use, "*If you eat the sweet, you don't eat the sweet with the paper on*", one interviewee said a young man had once told her, referring to that having sex with a condom was not the same thing as having sex without a condom. In one interview it also appeared that it sometimes might do more harm than good for the adolescents that the condom use was emphasised to such a large extent. One example of this was a slogan that had been widely used a few years ago that had said *"Be wise – condomize"*. It might have given the wrong impression to the adolescents, like they then would have thought they were harmless for infection if they only used a condom.

Know your status

Testing and knowing you status played a large role to prevent new infections, half of the respondents claimed. Encouraging people to test themselves was said to be important, because if you were conscious of your own HIV status you would avoid infecting others and today it is possible to live many healthy years on ARV treatment. ARV was also said to reduce the risk of transmission. According to one study participant it would be an important stride in the prevention work if everybody that came in contact with healthcare would be tested, not only the ones who were suspected for being infected. The respondent emphasised that many infections were missed because patients were not tested even if they had an on-going healthcare contact. *"I think we are only sort of, ehm, skimming the surface you know, I think that many, many HIV patients are missed. We miss opportunities, the patients are actually healthy, but their HIV could have been diagnosed and it's missed because they are not tested."*. Further on it was said that If HIV screening would be a routine check for everybody who came in contact with healthcare, a higher number of infected people could be found and helped to start ARV treatment, one of the participants claimed.

ART

One participant claimed that the evidence for early treatment of patients was good. *"There's very good evidence that if you treat patients early they do much better; their immune recovery is much better, the opportunistic infections are a lot less..."*, and that would generate in an positive impact of the national economy, but also in the number of saved lives. It was even claimed that treatment with ARV's were important in terms of coping with the stigma that many times were attached to HIV infection *"I think that it isn't a dead sentence, I think that it still remains a huge challenge because we see a lot of people defaulting from the ARV's and they are getting really, really sick and that it's sort of the image of a really sick person that people think of as HIV. So getting people to realize that if you take your ARV´s every day you won't look unhealthy"* one participant said when talking about getting a HIV diagnose and ARV treatment. Talking about ART and adolescents, it was specifically said that adolescents "*is a very difficult group to reach, because their emotional needs are very different from the adults. We have a lot of problems with them accepting their diagnoses. It's hard, I mean, yeah, you don't want to take medications, you just want to be normal, but you have to take medication every day for life, so we often have problems in terms of poor adherence, and also problems of substance abuse*". Poor adherence to ART was mentioned as a problem in the majority of the interviews.

Affecting factors

Behavioural differences, cultural- and religious beliefs

One respondent answered the question about what affecting factors for the prevention work could be by saying that *"South Africa has a quite complex society with a diverse population and therefore many cultural barriers. Many different cultures and religions lives next to each other in South Africa. People do not think the same about things and there are many different languages. The many languages spoken have also become a huge barrier in the fight against HIV, the knowledge and education needs to be formed so it is reaching the total population*".

One cultural difference was said to be communication between parents and their children about sex, preventing strategies and STI's. "*Other issues are in a family context, where there is no communication about sex and sexuality*", one respondent claimed referring to that in many cultures in South Africa, sex and sexuality was not something parents talked about with their children. The adolescents, or even children, then had to learn about sex on their own which could be kind of misleading and implement many risk factors. These risk factors will probably further on become part of a behavioural scheme, one participant said. Behavioural differences, and the need of behavioural changes, were also something that was addressed during all interviews in one way or another. *"We also work with behavioural change models; we would like people to change their behaviours. But in order for a person to change the behaviour they have to understand themselves and understand the context and understand the behaviour so they are able to change it"*, said one respondent and added that it did not only had to do with sexual behaviour, but also other aspects of life skills.

Myths and cultural believes are common in South Africa, due to the number of different cultures and believes. It was therefore stated in many interviews that to gain the whole populations trust, it was very important to teach *"what HIV do to them, it is like a myth. So it is our responsibility to talk about it and then they will understand, that is not easy..."*. According to one of the participants from one organisation, a good way to reach out and

achieve trust is to educate members of the townships so that they could go out to their families, friends and neighbours and educate them about HIV. They often spoke many different languages and mostly they had the same background as the rest of the community, *"so looking at how, at what level the education happened and who's presenting it, I think can be a challenge, but we sort of overcome that by making it. It's not a doctor or a nurse or someone from the facility telling me, it's my neighbour "*. This was claimed to have given positive responses in terms of gaining trust within the population in the townships. It was said to be easier to listen to a neighbour than to a doctor or a nurse, especially if you were black and the clinician was white. A big part of South Africa's population was additionally said to have no literacy, why this could count as a contributing factor of why educating community members to spread the word and knowledge about HIV could be a good example of prevention work, claimed one participant.

Poverty

"But I think the major problem is the poverty...". That many people in South Africa lived in poverty, was something many of the participants pointed out as one of the major risk factors *"economy might be the biggest one, because of poverty is one of the biggest thrive of risk behaviour among young people...*". The participants also claimed that the prevalence tended to be more extent in areas where the poverty was dominant.

Substance abuse

Many adolescents in South Africa were said to use substances such as alcohol and-/or drugs. The respondents in all interviews claimed this to be a huge problem and a risk factor for contracting HIV. When using different kinds of substances, good judgement and common sense in sexual behaviour was lost, the majority of our study participants stated. Adolescents tended not to use contraceptives when they were affected by alcohol or drugs and unfortunately, one participant said *"the drugs are also something that is popular, because they smoke this drugs and they do anything, they forget even that we emphasis using condom"*. In addition to this, the risk of being raped was also said to be increased when substances were used, and with that came the risk of getting pregnant as well.

Peer-pressure

In several of the interviews it was stated that adolescents are an age group that many times affects by peer-pressure, *"Adolescents are a vulnerable group, they listen to their friends' opinions and often do what they think their friends would want them to do, or do what their friends do"*, asserted one of the participants. This was a subject in Life Orientation that should be addressed and handled a lot more, one study participant said. *"I think peer-pressure also contributes because it influences the behavioural trouble, even if you don't want to be sexually involved but because of the pressure from your friends you end up, you know, being involved. We tell them what to do but the pressure among their friends is strong, so that they end up doing it, because you believe your friends are more important than what has been informed in sexual education."* another participant said.

Political

The previous political situation in South Africa has been mentioned during half of the interviews as a contributing factor to the present situation of HIV infection. One participant said *"for many years the government denied its existence of HIV and AIDS, and HIV as the cause of AIDS, so which harmed the program dramatically..."*, referring to that the HIV prevalence today is one of the highest in the world and that many high-ranking officials

have died and left huge gaps in the country. This was said to have lead to that the country had been suffering from poor leadership on many levels.

The previous political situation was also said to have affected the healthcare and ARV treatment in such a way; *"we only started rolling out treatments, wide spread sorts of treatment, 2004, so that is one problems that we deal with in South Africa."*.

Another respondent said *"I think getting the government to understand all the parts that needs to be understood by promoting safe sex, you are not promoting sex, you know. Young kids are having sex anyway, so for them to be resources available to do it in the safest possible way. I think it's a big challenge..."*. Thereafter the respondent addressed the experienced reluctance from the departments and government, in terms of implementing sexual education in school, prevention programmes and pre-exposure prophylaxis interventions.

It was said to be very important that the government and the departments were visible and supporting. This was mentioned both from the respondents who were active in school and organisations. *"We ask ourselves: are we doing enough to prevent it? Because I think everybody, all the stakeholders are supposed to be taking part, by coming together and try, from the department to the persons on the ground, to fight this"*. Also the respondent working at a hospital stressed the importance of having the governments support when talking about ART. However, the participants involved with education in school claimed that they got sufficient support from the Department of Education.

DISCUSSION

Results discussion

Many interesting results have emerged in the present study about HIV prevention work for adolescents in South Africa. An important part of the results were the factors that affected the prevention work, and what remained for the operators in the field to overcome. However, the greatest findings and factors that appeared in the results have been the importance of education and gender empowerment. All study participants have added weight to these two factors and claimed that they played a major part in the HIV prevention work for adolescents in South Africa. Other factors, such as behavioural- and cultural differences, lack of contraceptive use, stigmatization, poverty, substance abuse and lack of medication adherence among adolescents also appeared in the results.

Common thoughts among the participants have been regarding the importance of education and knowledge, both the right for every child to attend school and the importance of sexual education in school. All the participants thought that it was important to start from the basis in education and start early, since behavioural changes were not achieved so easily. To implement a good and safe sexual behaviour among young people it is important to start before they become sexually active. It also emerged during the data collection, that education could be on many levels and seemed to be needed on many levels; from the group of adolescents themselves, adults at home and teachers in school (Namisi et al., 2013; Smith et al., 2012). To make progress in the prevention work the participants stressed the importance of seeing the holistic picture and how to work from different angles in an adolescent's life, not only from one direction. It occurred in the present study that there have been deficiencies in the education at home, between adults and the children. In terms of working preventative for the HIV transmission, it was said to be important that

sexual practice and sexual behaviour were addressed at home as well as in school (Namisi et al. 2013). Therefore, the researchers of the present study find that sexual education received at home could be something important to implement in the intervention programmes.

The quality of sexual education in schools where discussed and a good example was made, pointing out the fact that the teachers talk to a whole class and it was therefore not possible for the teachers to ensure that everyone understands the information. The authors agree that this might not be the most pedagogical way of learning adolescents about safe sexual practices. Since it could be a delicate subject, and is important on many levels, it might therefore be handled with more care. The large classes may additionally affect the extent to which students dare to ask questions. Also due to the stigma attached to the topic and to the occurring peer-pressure, it can be hard for the adolescents to engage in the subject and take it seriously. To teach the subject in smaller groups could bring positive affects in terms of knowledge and understanding of the subject and the prevention strategies. It may also be beneficial in terms of discussing other life skills areas, responsibilities and decision-making, since it occurred through interviews and the findings in the articles by Louw et al. (2012) and Palen et al. (2006), that making good life choices was believed to be nearly as important as the sexual education itself. The authors of the present study speculates that making good life choices is a fundamental part of the prevention work for adolescents, since it influences their future life. In order to be capable of doing good choices you need the knowledge, right tools and self-esteem to do so.

Life Orientation as a subject in school was something all the participants mentioned in the interviews when talking about education, even the participants who were not active within the school system. However, some differences occurred when talking about the Life Orientation programme. One respondent who was directly involved with the programme, mentioned time as a limitation for the prevention programme. This was said to be because it was not as highly prioritized as the academically subjects. The sexual education was also said to only be a small part of the whole Life Orientation course. This reason for this could be because the schools are relatively free to interpret the content of the programme and develop the education (Department of Education Republic of South Africa, 2003). However, the respondents who were not active in school thought of the Life Orientation programme as a very comprehensive course, mainly focusing on sexual education and prevention strategies. The authors of the present study think this may be a problem since it could gain the operators in the field, who are not active in school, to know what is actually being taught in the Life Orientation course. Otherwise it could result in that the other operators in the field of HIV prevention for adolescents will believe that everything is already being done in school, and that they therefore do not address it in their own programmes, meetings or workshops. For parents, healthcare instances and organisations working with HIV prevention, it could also be of interest to know more specifically what is being taught in school so that they could form their prevention programmes to be more complementary to the Life Orientation course.

To keep the adolescents in school for as long as possible and encourage further studies have also been claimed as an important part of the prevention against HIV since many participants have noted that school does not only provide education in terms of knowledge, it also contributes to life goals. This justifies by the findings in the study by Louw et al. (2012) who found that having life goals often lead to less risky sexual behaviour. Swartz et al. (2012) also stressed the importance of a proper and fulfilled education. The connection

between education and safe sexual practice was explained in "*Condom use and sexually communication with adults*" by Namisi et al. (2013), since discussing safe sexual practice with adults often generates in safer behavioural patterns for the adolescents. Further on, education on different levels, many times open doors in terms of future dreams and the chance of getting a job and secure an income. If the adolescent have belief in the future it may encourage the adolescents to live a safer life with less risky behaviour. Therefore having life goals was said to be a protective factor (Louw et al., 2012).

Consistent safe sexual behaviour, for example condom use, was also stressed and noted as important to reduce the HIV transmission. In order to do so, dialogue between the adults and the adolescents and accepting attitudes was required (Namisi et al., 2013). Attitudes in education was also something Smith et al. (2012) examined and found that teachers attitudes were generally more focused on bad behaviour than actual risk-reducing strategies. One participant said in an interview for the present study that it was important to feel confident when teaching about HIV and AIDS and used the word "warn" when talking about AIDS. This seemed as a remarkable choice of word to the authors of the present study, since that did not quite agree with the general opinion about Life Orientation, which should be about finding secure ways and prevention strategies together with the students (Department of Education Republic of South Africa, 2003). To warn might give the wrong impression about the disease, cause unnecessary fear for infection and also increase the stigma attached to be HIV positive. In that way this could cause more damage than good so the authors of the present study can see that how teachers attitudes plays a role in the education given.

Stigmatization of HIV and AIDS in South Africa was mentioned as a major issue through all interviews. Stigmatization attached to an HIV diagnose was said to be something very strong and an affecting factor when it came to be an ordinary person in the daily life. Several participants claimed that the stigma of HIV and AIDS was specially related to different cultures in the country and that the stigmatization had been strong for several generations so it seemed almost impossible to get rid of the stigma. However, it has been seen that education has a positive effect on stigma when talking about HIV, but unfortunately it is not sufficient. The effect of education was mainly in terms of reducing the prejudice about HIV (Campbell el al., 2005). It could also be since parts of the population were said to still think of the disease as a myth or have a wrong understanding about the disease, its symptoms and the treatments. It was said by one participant in the present study that for many people in the country, the picture of HIV is a very sick person. The participant noted that it was important to erase that picture of an unhealthy person, because today that is not necessarily the actuality. Good adherence when it came to ARV treatment and disease awareness might prevent further development of disease, and HIV is not what it was. It is no longer a disease you have to die from, or even develop AIDS. Campbell et al. also found that the stigma surrounding HIV in a community in Western Cape was high. As a result of the stigmatization the adolescents did not dare to attend HIV prevention meetings because they were worried that their parents would find out about it and that would lead to bad consequences. Stigmatization is one factor the authors of the present study would like to emphasize even more as a limiting aspect of the prevention work. Since it seems to be such a strong power that hindered the adolescents from attending meetings about prevention and to test themselves in order to know their status it is a big issue.

Pettifor et al. (2004) found in a study on young women in South Africa, that 71 percent of the women have had sex with inconsistent use of condoms. The reason for this was reported to be because they had partners they could not argue with. Pettifor et al. (2004) concluded that it was of great need to get women more confidence and power. The authors of the present study have found similar results in the accomplished interviews; gender power is believed to be one of the major issues regarding the HIV epidemic. The authors of the present study believe this could be since the uneven gender roles affect on many levels. In most interviews the issue of the women's lower role in the society emerged and the need to enforce women's rights. By supplying them with tools to empower themselves and make them gain a greater self-efficiency and an increased confidence so that they for instance, could stand up to men and refuse sexual intercourse without a condom. Further on, teenage-pregnancies was claimed to be a big issue among the adolescents in South Africa. The authors of the present study discuss that this issue is, except as a direct cause of not being able to refuse sex, a result of all the flaws in the HIV prevention work since it means that the education is not sufficient, the contraceptive use is not consistent and this can be due to gender imbalance. If gender imbalance is not what causes teenage-pregnancies, it will probably lead to gender imbalance in the long term, since it is the woman who will carry and primarily raise the child. This may additionally lead to that the woman will have limited opportunities to study or work, and therefore, not have a secure income.

That different substances, such as alcohol and drugs seemed to be readily available for the adolescents in South Africa, all study participants claimed that substance abuse was a common occurrence. Many respondents pointed out this as one of the biggest problems among adolescents and their behaviour, since substance use brings many risks. It was said that when various substances affected the adolescents, their good sense disappeared and the usage of condoms did not seem important to them. These findings could be justified by the results in the article by Palen et al. (2006), who reports that 39 percent of the adolescents in 8th grade who reported to be sexually active also were using substances. Further on, Palen et al. (2006) found that there were a strong connection between the uses of substances and sexually risk behaviours. Additionally it was said during interviews that it might lead to unwanted teenage-pregnancies, rapes and transmission of STI's, such as HIV.

Luseno and Wechsberg (2009) claims in their study about "*Correlates of HIV testing among South African women with high sexual and substance-use risk behaviours",* that more needs to be done in order to test women who declares to utilizing substances such as alcohol or other drugs, being victims for violence and reporting to have a high-risk sexual behaviour, for HIV. However did more than a quarter of the study participants initially not want to be tested, due to fear of being rejected or knowing their HIV status. The level of education, however, played a role in the womens likeliness to take the test for the study, the higher education the more likely the woman was to take the test (Luseno and Wechsberg, 2009). This also points to the influence of education and the reduction of stigma it could bring.

Substance use is not the only reason to the lack of contraceptive use, several of the interview participants claimed. Also the fact that condoms and usage of contraceptives were not accepted within all cultures in South Africa. This was said to be an aggravating circumstance, rather than the access of contraceptives. Although it emerged through interviews that there could be big differences between urban and rural areas; it is not always simple to access condoms in a rural area, it might be an unpleasant experience for

the adolescents to buy them in the local store if everybody knows each other. Additionally, rural areas tended to be more culturally controlled than urban areas. In urban areas you could also be anonymous to a greater extent which made it easier to buy contraceptives and the use was more accepted due to less cultural influences. However shows Smith et al. (2012) in their study that the implementation of the Life Orientation programme in South African schools has contributed to that the self-reported condom use has increased.

Several participants of the present study believed that the contraceptives would have to be more accessible for all adolescents, no difference between the rural and urban living. In an article by Muchunu, Pelzter, Tutshana and Seutlwadi (2012) it was also stressed how important it was to teach the adolescents how to be responsible and to use the condoms, because the purpose of handing out condoms were not to advocate sex, it was to prevent diseases and teenage-pregnancies. The importance of being responsible in terms of sexual practise was also stated in the study by Namisi et al. (2013). To prevent adolescents from having sex was no idea, the participants in the present study stated, but to give the adolescents the right tools to work with was said to be a much more generating method. In this way they would learn how to be responsible for themselves and others and practice safe sex. In order to give tools it was also mentioned that to do so, it was important to know details about the adolescents' life; where they came from, where they are and where they are heading, to understand which tools he or she would need.

Poor adherence was mentioned as a problem in the interviews. However did no respondent talk about the asset of ARV as an issue. This justifies by Quinn (2008) who notes that the asset to ARV in the developing world is improving. Many other different aspects of poor adherence that emerged during interviews might have played a role for the problem. It was revealed in an interview that the ARV's could be resold in order to earn some money or given to other family members instead. Not wanting to take the medication because of fear for feeling sicker if taking them, was mentioned as another cause. Additionally, the specific age group was said to be difficult to reach because they tended to have a hard time accepting their diagnosis, they just wanted to be normal and not take medications. Also the stigma attached to the HIV diagnosis played a role for the ARV adherence. Quinn (2008) however notes that the information and counselling received in connection to ART contributes to an understanding about the disease and that this in a long term prevents further spread of the HIV infection. This demonstrates the importance of information and education to those who receive the treatment, how important it is to follow the prescription. If they dispenses from good adherence the side effects will be worse. The authors of the present study therefore believe that good adherence is important to emphasize.

In a study made by Pattern et al. (2013) it was found that many adolescents from a township in Western Cape that had been to a clinic to test themselves for HIV, did not come back to receive the test results. To come back to start ART and to lower the risk of developing AIDS, and the risk of transmitting the virus to others, was of great importance, the researchers claimed. The researchers thought it might have been because of the fact that the adolescents lived in denial or fear of being HIV positive.

In UNAIDS World AIDS day report from the year of 2012, it is stated that, due to that the political leadership and investments have increased lately a decline of new HIV infections have been seen. Different prevention programmes have contributed to behavioural changes, and together with ARV treatment, which reduced the viral level for the infected person, this resulted in reduced risks for further transmission (UNAIDS World AIDS Day

Report 2012). However, it can not be overlooked that HIV, and AIDS as a result of the virus, has been denied for many years by the governing, the prevalence today is one of the highest in the world. Many high-ranking officials have died and left huge gaps in the country. This has resulted to that the country has suffered from poor leadership on many levels, which also occurred in the data collection.

It occurred in one of the interviews that there is a huge difference between the private and the public healthcare sector. The public healthcare is suffering from staff shortages and is overburdened with patients. Overall, the healthcare has a lot to catch up with because of the previous denial of HIV's existence. The consequences have, among many, been that within the healthcare today, most money is spent on treating already ill patients, rather than spending money on prevention work, which does not generate to the benefit of the prevention work in the country. It was said by one respondent of the present study that it is important to get people to trust the healthcare, since gaining peoples trust have been an issue during the late years due to the frequent change of policy documents since there is a lot of research going on in South Africa about HIV. Every time the policies change, the population receives new information about the disease and advices about it, which contributes to the population's decreased trust. Abdol Karim, Sibeko and Baxter (2010) also suggest that the access to sexual and reproductive health services must increase. Further on, it emerged during one of the interviews that in order to respond to the HIV epidemic in an effective way, it would be needed to test everyone who came in contact with health services, not just those who sought for them to be tested or they who were suspected of being infected. The participant claimed that the way the testing was handled today was not enough in order to access the root of the problem. To test people as a routine could be one example of making a difference in the epidemic. The authors of the present study speculates that this might also lead to reducing the stigma attached to the HIV diagnose. However, it could seem a bit intrusive to test everybody who came in contact with healthcare, but on the other hand, nobody would have to feel accused if it was a routine test. If more people would be diagnosed and treated, it could result in a difference of the epidemic, which could bring many positive effects for the country and its population.

The Department of Health Republic of South Africa (n.d) states that one special target in order to combat the burden of HIV and AIDS in South Africa, is to advocate medical male circumcision as a part of the prevention programmes. The participants of the present study have however not addressed this area, which can be seen as remarkable since it is something that the Department of Health state as one of four target areas.

The present study is valuable in terms of presenting the challenges that needs to overcome in the HIV prevention work for adolescents in South Africa. The authors of the present study consider collaboration between national and international instances as something very important for the HIV prevention work. When comparing the results of the present study with other researchers' similar studies, it shows that it exist a pervading pattern around the topic of HIV prevention. Several studies discusses different prevention programmes and affecting factors but the researchers of the present study have not found any research done on specifically preventive interventions for adolescents, why the present study could be of value for operators in the field. There is no secret about the high HIV prevalence in South Africa, and even though there is a lot to do on the in terms of prevention work, South Africa is catching up with the HIV epidemic.

Method discussion

A qualitative method was used in order to gain subjective data about the topic HIV prevention for adolescents in South Africa. Interviews were held with a semistructured interview guide as a base so that the researchers would be able to adjust the flow in the interview where as the respondents spoke and addressed the subjects. The interview guide contained topics, which the researchers had worked out in advance and discussed with the supervisor and tried on each other before using it in a pilot interview (Polit and Beck, 2012). The topics were first thought to be; how the prevention work was done, ambitions regarding the prevention work, how the adolescents were reached, education, and eventually limitations and other affecting factors. The questions and topics were asked in an open kind of way, so that the respondents would be allowed to speak freely about the subject and there were no predictable answers. Even though the researchers' questions followed a thread, the participants did often share own experiences and histories. This contributed to the results of the present study and to a greater understanding for the researchers.

The researchers' experience of applying this method was that it worked out well in most interviews. In a few interviews it sometimes felt like the questions overlapped each other so that the answers therefore would be repeated. The first question could on its own, basically have covered all issues because of its openness. However, this primarily depended on how much the respondent spoke about the topics above and if the researchers interrupted or not, in order to move on to the next question. Also, often when the respondent had to think of the question again, further and deeper information emerged, and this on the other hand, resulted in interesting findings. However, in some interviews one or more topics could have been excluded since the respondents themselves talked about the subject, but the questions were asked in all cases to be sure that no information would be missed. As the researcher adjusted the order of the questions in the interview guide during every interview, it was likely that the interview took the expression of a conversation with one more active part. This was thought to be an advantage for the present study since the received answers seemed subjective, spontaneous and honest. Although, the researchers wonder if the genders of the participants have been of matter for the received results in the present study, for example would a female study participant have shared the same information if the researchers would have been men, and vice versa, since some topics could be considered quite delicate. It might have affected the results in the present study that most of the study participants were women, when talking about men and the issues regarding gender empowerment. The researchers choose, together with the participants, to meet for the interview in their offices or workplaces. Polit and Beck (2012) stresses the importance of a comfortable interview place that the participant can chose if so are possible. The authors of the present study speculates that if perhaps the ground would have been more neutral or maybe even more personal, the answers might have been different, for example, fear of that the colleagues or the operating manager was nearby might have been reflected on the answers.

The researcher did a pilot interview to try out the questions applicability further. It turned out well and was therefore included in the collection of data. In accordance to Polit and Beck (2012), it is not definite how the qualitative research will appear in its final form and it is important to foresee different unexpected events during the process, such as, recording equipment or computer stops working or if the participants want to quit the research. The researchers can never know how it will work out, although it is important to keep this in mind. The participants spoke English, which was the researchers' second language,

although since English was not all the participants' first language either, it was considered to be more accurate to perform the interviews in English, without a translator. However it appeared to be a bit challenging to interpret all the collected material due to the language differences. Even if the researchers had put great accuracy on punctuation it turned out to be quite hard to interpret the transcribed material, due to the language differences. This might be seen in the quotes in the results. Although, some of them can be a bit hard to follow, due to a complicated sentence structure, the quotes are correctly transcribed. The researchers of the present study believe that they are sufficiently understandable for the reader to perceive the context, it could however have affected the results in terms of misinterpretations. Due to Polit and Beck (2012), it is not acceptable to change the participants' words, therefore the quotes must stay the way the participants stated them.

In order to prepare the present study and search for study participants the researchers were in contact with people from non-governmental organisations, companies operating in South Africa, high school teachers, doctors, specialists and nurses from different instances. All contacts did not lead to an interview, however, some early contacts generated in further contacts and eventually interviews, through the method called snowballing. The advantages of snowballing has been less time consuming since the researchers did not need to devote as much time to search or contact participants, this even simplified for the researchers when it came to ensure the new participants expertise (Polit and Beck, 2012). The snowballing method worked out well in general, since the authors earned time and were able to take advantage of other, already approved, respondent's contact net. The authors experience was that one participant was likely to know other potential respondents, active in the same area.

To ensure the reliability of this study, interviewees with specific expertise of the subject HIV prevention for adolescents were carefully chosen and informed in advance about the aim of the study. In total six interviews were fulfilled, including one pilot interview. Although the respondents had a wide range of expertise and were active in different areas of prevention work for adolescents, the results cannot be claimed as a description of the country's national work, since some of the interviewees only have answered for a locally operating organisation, school or clinic. Nevertheless, if the number of interviews would have been larger, then maybe the results could have been nationally representative to a greater extent. The authors of the present study agrees with Polit and Beck (2012) that a possible disadvantage when performing a study and using a method like this, could be that it can be difficult to find the participants with the required expertise. Also in terms of the number of participants can be a disadvantage when talking about the transferability of the results.

The data analysis was performed with accuracy. The researchers deposed relatively much time to transcribe the interviews correctly and thereafter to the coding progress. In accordance to Polit and Beck (2012) the researchers coded the interviews together. The coding in its self, and the in advanced thought categories, did develop during the coding process. Further categories also emerged during the process and were developed and organized where as the data was being analyzed.

To ensure the validity in the present study, the researchers have used other terminologies such as credibility, which in accordance to Polit and Beck (2012) strengthens the qualitative research validity. The researchers have examined what the study aimed to examine, this was ensured by correct use of the interview guide. The use of recording

equipment and accuracy when transcribing proves the researchers' credibility. The researchers of the present study had no intentions to select participants who would be able to respond in a certain way, the participants have been selected along their experiences and positions in the field of HIV prevention for adolescents in South Africa. Further on, have the researchers with a consciousness been aware of that any biases could have occurred during the research. The usage of recording equipment might have affected the answers since the participants might have felt performance anxiety of trying to make the prevention work appear better than what it actually was. To avoid the research from being affected by bias, the researchers of the present study, in accordance to Polit and Beck (2012), have not putted their own values on the emerged information during the study process.

The aim of the present study was addressed and answered in a good way. Perhaps the aim was too widely formulated in the beginning of the study process but as it changed during the progress to ensure the conformity of the aim, and the topics within the interview guide, it turned out to work well. Similar results could have been achieved if the aim, for example, would have been to examine the educational influence on the HIV prevention or if the purpose would have been to address the challenges and difficulties with HIV prevention for adolescents. Even though the interview guide was considered to be applicable, the number of questions could perhaps have been less if they had been re-formulated, but still covered all the topics properly.

For this certain aim a different methodology had been difficult to implement since the character of the aim alludes to a subjective experience of the HIV prevention work. To achieve similar results with a different method, the researchers therefore consider as not so likely. This is mainly because qualitative research strives to be as holistic as possible and the qualitative study method is often flexible, it can be adapted where as the data analysis process (Polit and Beck, 2012). If the aim had been the same as in the present study, but the data for example would have been collected through a quantitative method, the results would probably have looked a lot different. It would not have gained the same depth or understanding for the prevention work. A study with a questionnaire might for example have encouraged the participant to answer more truthfully. Additionally, it would not have left any space for the respondents to contribute with own experiences and further information about the subject. However could another method with a larger number of participants have contributed to a higher transferability of the results.

The results of a study usually have an intrinsic value. The research should be of value for the society and the population, through the possible improvements it could bring, in terms of increased health, environment and life quality. It is not reasonable that a minor injury will prevent important research. However, a person who participates in a study should be protected from major damage and violations (Vetenskapsrådet, God forskningssed, 2011). Although the subject of HIV could be delicate and make people feel uncomfortable, the researchers had however considered the utility of the study of greater value than the inconvenience it might cause. Moreover, the researchers have not experienced that they would have caused any harm or discomfort to the participants.

Conclusion

HIV prevention for adolescents is of great importance to reduce the HIV epidemic in South Africa, there is extensive work that ranges from the governance of the country to healthcare, schools and organisations. However, further education and gender empowerment is needed. Stigmatization and poor adherence to ART is also major issues

that need to be addressed in order make progress in the prevention work and provide a change in the HIV epidemic in the country. An advantage for the prevention work would be that all operators in the field seem to have one mutual goal; to have zero new infections.

Further studies

It would be an interesting further study, to compare how different countries are working with the same dilemma. The countries could probably learn a lot from each other. Also collaborations between different operators in South Africa could bring a lot of positive favouring results of the prevention work. Although it has emerged during the interviews that it seems to be a lot of on going collaborations within the country already. It would be an interesting further study to examine how the adolescents experience the prevention work and what they think of the Life Orientation programme in school, it could also be of interest to ask them what their situation looks like at home regarding the field of sexual education, if the adults at home talk about STI's, safe sexual practice and how these topics are being addressed.

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ANNEX A

Request of participation
Sophiahemmet University
Stockholm, Sweden

October 1, 2013

To whom it may concern.

Hello, our names are Felicia Hassell and Anna Karlsson, we are nurse students in our fifth semester (of six) from Sophiahemmet University in Stockholm, Sweden.

We will be situated in Cape Town during the time period of late September - late November this year to do our bachelor thesis of 15 university credits. In this purpose we want to examine the HIV prevention work for adolescents, 15 to 24 years old, in South Africa.

HIV and AIDS contributes in a great extent to the burden of disease in South Africa (Department of Health, South Africa, 2013) and adolescents is a high risk group due to several different factors and circumstances (UNAIDS, 2012). Therefore we would like to get a further insight in how the prevention work, in terms of adolescents, is performed.

For this thesis we are going to use a qualitative method with a semi-structured interview design. It would be very interesting if we could have the possibility to set up an interview regarding the subject in matter. The interview consist seven questions which all follows a thread about HIV prevention work and will approximately take half an hour. The interview will be recorded and in accordance of the Declaration of Helsinki (WMA, 2013) your answers will be treated confidentially, and will be destroyed afterwards. Data will be anonymised for everyone not directly involved with the interviews, and you have the right to discontinue participation at any time and shared information will then be excluded from the study. The results may be used in our study.

Yours sincerely,

Felicia Hassell
**********@hotmail.com
+46*********
+27*********

Anna Karlsson
**********@live.com
+46*********
+27*********

Student signature: _____

Student signature: _____

Mentor at Sophiahemmet University: Karin Casten Carlberg
**********@sophiahemmethogskola.se
+46*********

ANNEX B

Issues

1. How do you work preventatively against HIV for adolescents?

2. What are your ambitions regarding HIV prevention for adolescents?
(e.g. goals, statistics, results, attitudes, behaviours, changes?)

3. Is there anything you feel limits your preventative work against HIV for adolescents?
(e.g. economics, rules, laws, regulations or policy documents?)

4. How do you reach the adolescents as a group?
(e.g. Radio, TV, internet, schools? Local/regional/national campaigns or investments?)

5. Do you conduct any cooperation with other operators in the field of HIV prevention for adolescents?
(e.g. other organization, company, authority or operation?)

6. How does education affect the prevention work?
(e.g. low/high education)

7. What factors do you believe affects your work against HIV and how?
(e.g. behavioural, aggravating circumstances, potential advantages with the specific age group, etc.)

and then you find that the young person cannot access the condom because the school doesn't allow, the clinic is too far and probably not youth friendly and they cannot afford to buy or do not have access to places where they can buy condoms	The school does not hand out condoms, the clinics are too far away and not often youth friendly or condoms are too expensive to buy in store.	Condoms not accepted or accessible everywhere.	**Contraceptive use**	**Healthcare**
I think we are only sort of, ehm, skimming the surface you know, I think that many, many HIV patients are missed. We miss opportunities, the patients are actually healthy, but their HIV could have been diagnosed and it's missed because they are not tested.	Many HIV patients are missed. The patients could have been diagnosed earlier if they only had been tested.	Many people don't know they are infected because they are not tested.	**Know your status**	
There's very good evidence that if you treat patients early they do much better; their immune recovery is much better, the opportunistic infections are a lot less...	The immune recovery is much better and the opportunistic infections a lot less if treatment is started early.	Early ARV treatment is important.	**ART**	