

Aids-Related Knowledge – Attitudes and behavioural practices among high school pupils



Curriculum Vitae

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"The main purpose of getting this group of students to work together on this survey was to get them interested in research and less afraid of doing it."

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Summary

A survey was done in a high school in Gauteng to assess the Aids-related knowledge, attitude and sexual practices of black high school children in South Africa. The findings endorse the findings of similar surveys done elsewhere in the world, which mainly recommend: use peer groups to develop health messages, start with primary school children and emphasise skills and social norms rather than improve knowledge only.

1. Introduction

As a public health problem, AIDS is an unforeseen phenomenon, provoking reactions of panic, revealing social fissures, inequalities and the discrimination and stigmatization of marginalized groups in society. What had been defined as an emergency became a longlasting problem which we have lived with now for a full decade.¹

"The scale and likely duration of the emergency are not yet even approximately clear. If the gloomiest predictions on the spread of the virus, turn out to be accurate, the past decade will turn out to be the first of many. If, instead, the most optimistic assertions about the scale and efficiency of scientific, educational, and behavioral responses are accurate, then the acquired immune deficiency syndrome will sooner rather than later join cholera and leprosy as an endemic disease, devastating to some individuals in some places but no longer a social, political, and medical drama."²

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For the moment, nothing supports this optimistic hypothesis. Because of its rapid spread, particularly in developing countries, the threat that AIDS represents to the social order takes on international dimensions. Since its outbreak, a decade ago, AIDS has inspired a burgeoning sociological debate over its "social-cultural dimensions".³⁻⁶

The visibility of the disease and the awareness of the extent of the pandemic in Africa and the Third World has grown slowly, various factors hindering this process: Firstly, among those suffering from hunger, malnutrition, poverty, lack of hygiene and sanitary equipment, natural catastrophes, and wars, disease is less visible. Secondly, careful epidemiological census is impossible, due to the anarchy of communications. Thirdly, the distrust and ambivalence of the African authorities and communities have led them to accuse the Western World of having infected them. Fourthly, on the part of the public too, there was a great deal of skepticism on the reality of the epidemic and on the urgency of a change of behaviour. One popular interpretation of the French initials of the disease was "syndrome imaginaire pour decourager les amoureux" (imaginary syndrome to dissuade lovers).⁷

2. Purpose of the study

The primary purpose of this exploratory, descriptive study was to assess the AIDS-related knowledge, attitudes, and risk behavioural practices of black high school pupils, and to make a contribution towards the planning of community health projects addressing AIDS.

3. Literature review

The gap between rational knowledge and attitude

For a significant part of the South African population, the major dimensions underlying reactions to AIDS are

lack of understanding, fear, religion, morality and prejudice.

Clift & Stears⁸ observed, in a sample of undergraduates, an improvement of knowledge over time but a stability in moral reaction. These authors stress the fact that this evolution is hardly surprising as AIDS is interpreted within the personal framework of religious beliefs, political persuasions, sexual experience and identity, all stable dimensions of individual personality.

The main question is how to prevent the disastrous effects of the "third" epidemic, namely diffusion of discrimination, ostracism and attacks on civil rights. Unlike most epidemics, AIDS does not kill its victims in a short period of time. It takes time to evolve. AIDS, as we understand it, "is a chronic disease - long, silent yet still infectious - inevitably lethal in its later acute manifestations"⁹ While every epidemic constructs its own language, there is no precedent for the rapidity or range of terms that AIDS has elicited. "The infected ...are infectious, but, in certain ways, often associated with "immoral" or "deviant" behavior. The "ill" and the "immune" are neither discrete nor useful bipolar constructs when dealing with such a disease.⁹

Beside the "innocent" and the "guilty", a new social character is created: the seropositive, neither healthy or ill, and not at all safe. This activates old fears and creates new ones. The mass media continually propagate the fear of contamination by spreading misinformation and presenting fictitious cases of the frightening contagion of "innocent victims".

There are continual cases of HIV antibody positive people being accused of attempted murder for spitting on or biting someone. There are other cases of people prosecuted for attempted murder for having had sex with a partner who subsequently decided that the accused knew or should have known

AIDS = imaginary
syndrome to dissuade
lovers.

that they were HIV antibody positive.¹⁰ The dominant cultural agenda clearly invites us to regard AIDS as both a well deserved punishment and a justification for further punitive actions.¹¹ Surveys show that people with AIDS are perceived differently than people with fatal diseases. Reactions to AIDS are in part reactions to gay men, drug users, racial minorities or outsiders in general. Therefore KABP surveys (Knowledge, Attitude, Beliefs, Practices) are an important sociopolitical surveillance instrument. Both epidemiology and opinion surveys are essential for managing this major public health crisis. Both these studies help to understand the persistence of repressive attitudes.

HIV intrudes upon a fundamental area of living. It forces individuals to examine patterns of intimacy in the light of infection, and impending chronic illness. The disturbance is manifest at two distinct levels. Firstly, the disease has implications for the person's internal perceptions/experiences of possible inner organic or bodily impairment; and secondly, an image of outer contamination and chaos exists. Therefore self-esteem and self-image, two major ingredients of the sexual experiences, are possible areas of immediate vulnerability, and previous patterns of intimate forms of expression, however adaptive or maladaptive are threatened or jeopardised.¹²

HIV challenges society's sexuality, it challenges both conscious and unconscious material from the past. What makes disease culturally and historically important "is the way in which meanings are attached to illness and death, meanings and interpretations which are refracted through a host of differing, and often conflicting and contradictory social possibilities. These shape the ways we interpret illness, and therefore organize the ways in which we respond".¹³

On the other hand, according to

Paicheler¹, the lack of a vaccine creates a situation in which the only recognized cure of the HIV infection is prevention. Prevention is the only way to cope with the disease. People have gradually learned that what has primarily been labeled as the "gay plague", "GRID" [Gay Related Immunodeficiency Disease], is not limited to a "clear-cut" group. To prevent HIV from spreading people have to fundamentally change their behaviors, including their most intimate ones".

4. The research population

The population for the study was black high school pupils at one high school in the Soshanguve area.

5. Sampling

Accidental Sampling Method was used due to limited access time to the high school concerned. Therefore, all pupils attending classes on a specific day in June 1993 were requested to participate in the study. Participation was on a voluntary basis. Two-hundred and twenty-three [n=223] pupils agreed to participate.

6. Type of study

An explorative-descriptive survey was used.

7. Research instrument

The research instrument was a questionnaire which included structured, semi-structured, and open-ended questions. The instrument was tested by means of a pilot study, which included ten high-school pupils from the Ga-Rankuwa area.

8. Response rate & data analysis

The response rate was 100%, as the questionnaires were handed out by the

**AIDS is a chronic disease:
long, silent, yet still
infectious.**

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researchers at the high school, and completed under the personal supervision of the researchers.

9. Ethical considerations

Permission to include the pupils in the study was obtained from the Assistant Director of Education and Training, and the principals of the different high schools. Participation of the subjects was voluntary and the pupils remained anonymous throughout the study.

10. Data Analysis

Personal Data

1.1 Respondents' Educational Level/ Age/Gender:

Educational level, age and gender distribution: See Figure 1.

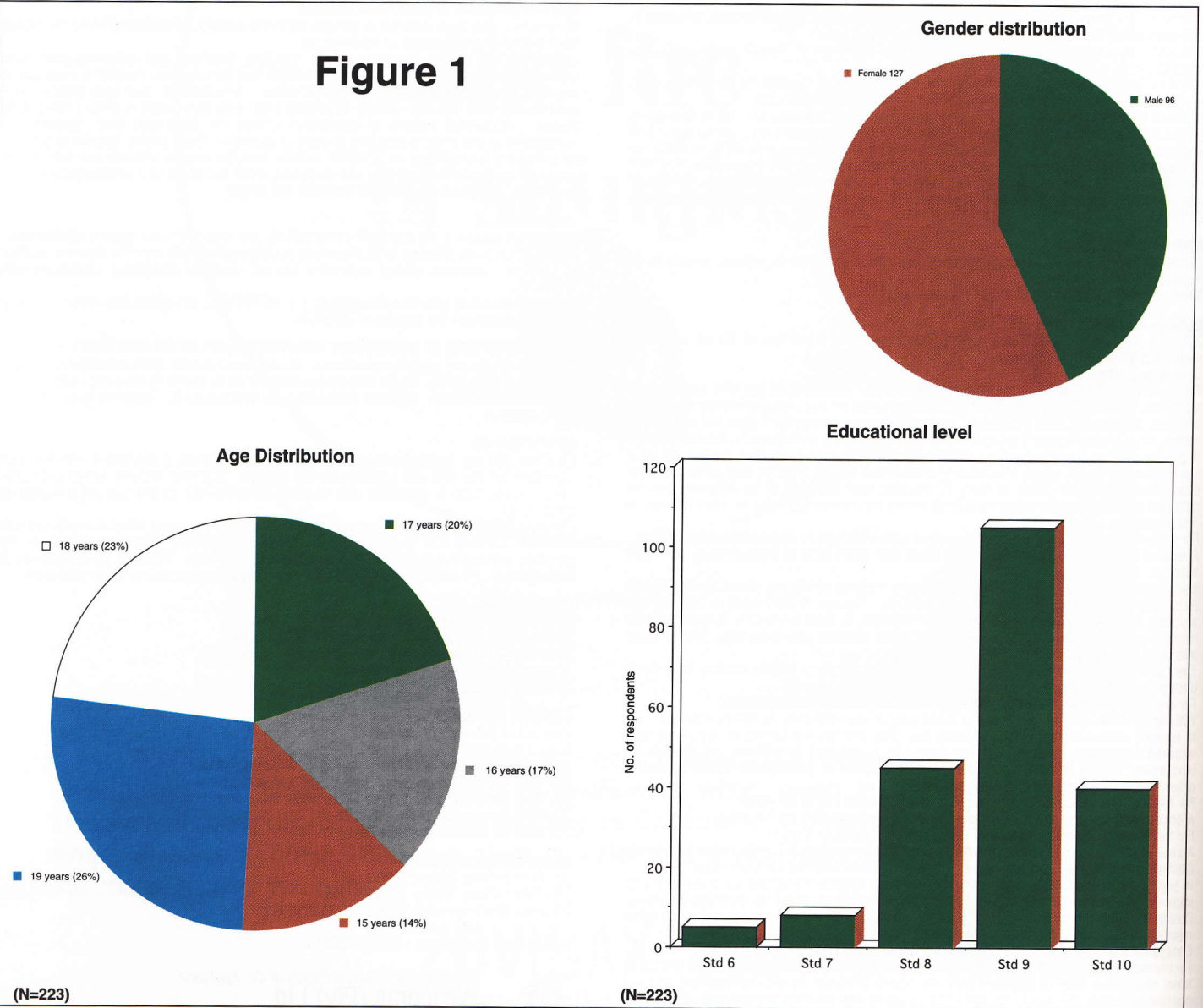
1.2 Sexual Intercourse History:

The respondents [n=223] were requested to indicate whether they have been, or are currently sleeping [having intercourse] with somebody. One hundred and twenty pupils indicated that they were sexually active. Of the sexually active, only ninety five [n=120] were using a condom, on a regular basis during intercourse. See Figure 2 on the next page.

Prevention is the only way to cope with AIDS.

The sexually, intercourse active respondents [n=120], were requested to answer the following questions:

Figure 1



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1.3.2. "According to your knowledge, why should a condom be used during sexual intercourse?"[n=223]

The data revealed that the condom was regarded as a device to prevent pregnancy by one hundred and eighty nine [85,0%] of the respondents. Only fifty four [24,2%] respondents indicated that use of a condom could protect sex partners from HIV infection.

1.3.3. The questions listed in Table 1 (on the next page), were completed by all the respondents [n=223]:

The data indicated that: 78 [35,0%] respondents are willing to share their sexual partner with other people, while eighty nine were uncertain. Only eighty [35,9%] respondents knew that a condom cannot be used more than once.

The data indicated a definite need for appropriate information regarding the advantages and limitations of condoms. Although condoms are widely advertised and distributed, its limitations are not clearly highlighted.

Ninety three [41,7%] respondents had at some stage been sexually involved with a member of their own sex: seventy nine [85,0%] of these respondents are males, and fourteen [15,0%] are females. The respondents were asked to indicate the nature of their relationship, in order to identify possible "dangerous" sexual behaviour between members of the same sex.

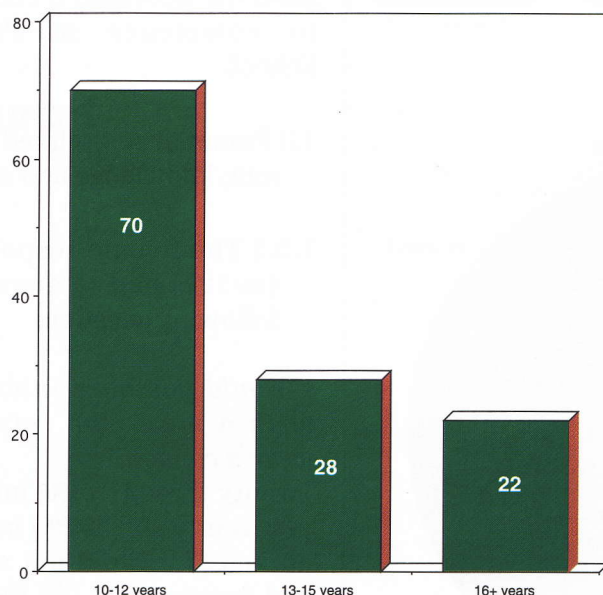
Twenty nine [36,7%: n= 79] of the males indicated that the sexual relationship involved anal intercourse; seventeen males participated in oral-penal-rectal sex; thirteen [13,4%] mutual

masturbation, body rubbing and wet kissing. Twenty [25,3%] males did not indicate the nature of their sexual activities.

Nine [64,3%:n=14] of the females participated in mutual masturbation, body rubbing and wet kissing; and only three [21,4%] indicated that they were involved in oral-genital sex. Two [14,3%] females did not indicate their sexual behaviour.

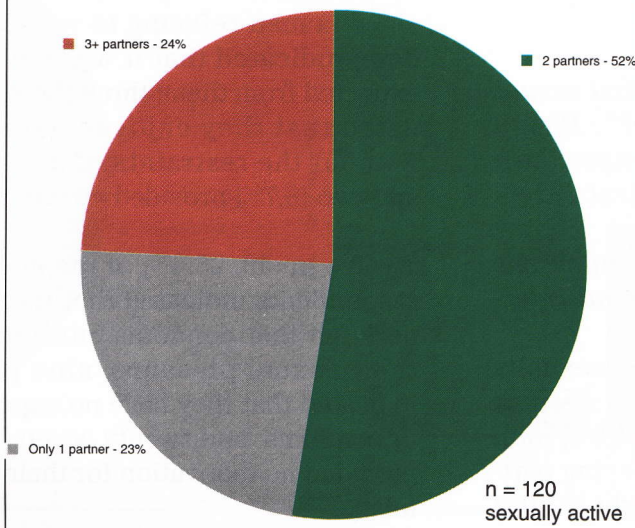
Only 52 [23,3%: n=223] respondents were not willing to go for AIDS testing. The main reason stated was the stigma

Figure 3: Age first sexual intercourse experience



(N-223)

Number of intercourse partners



Empower young people to practice safe sex.

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Table 1: Personal sex-related behaviour, knowledge and attitude

Question	Response					
	Yes		No		Uncertain	
	f	%	f	%	f	%
Would you have sex with a person who has other sleeping partners?	78	35,0	56	25,0	89	40,0
Can a condom be used more than once?	4	1,8	80	35,9	139	62,3
Would you consider going for AIDS testing?	169	75,8	52	23,3	2	0,9
Have you ever been involved in a sexual relationship with a member of your own sex? n = 223	93	41,7	130	58,3	–	–

Desire can overwhelm the known dangers.

associated with having AIDS.

1.3.4. The respondents [n=223] were requested to react on the following statements:

“Masturbation is normal”

Thirty four [15,2%] respondents were uncertain; sixty [27,0%] indicated that it is normal; and one hundred and twenty six [56,5%] indicated that it is abnormal. Three [1,3%] did not react on the statement.

The one hundred and twenty six (126) respondents, indicating “abnormal” were requested to list the main reason for their reaction:

- Twelve [9,5%] respondents were under the impression that masturbation caused bodily harm;
- Thirty five [27,8%] indicated that masturbation caused them to feel dirty and guilty afterwards;
- Fifty six [44,4%] believed that Christians should not masturbate;
- Thirteen [10,3%] indicated that it is socially unacceptable;
- Ten [8,0%] respondents listed no reason.

“It is better to masturbate than to exploit another person’s body”[n=223]

One hundred and fifty [67,3%] respondents agreed with this statement; fifty three [23,8%] disagreed; and twenty [8,9%] were uncertain.

“Pre-marital sex is normal” [n=223]

One hundred and seventy nine [80,3%] respondents indicated that it is normal; thirteen [5,8%] indicated that it is unacceptable; and thirty one [13,9%] believed that it is only acceptable if the pre-marital sex is with the person that you love.

The data confirms literature findings that sexual relationships are an important part of young people’s social relationships. Therefore it is necessary to empower young people to practice safe sex. Sex education must reach youth before their first intercourse experience. Only then they will have a chance to think through some of the issues.

1.3.5. The respondents [n=223] were requested to answer the following question:

“Indicate the person/group of persons, who you personally would prefer to impart knowledge on sex-related issues to you and your peers [motivate why]”

The data revealed the following preferences: Peers/Friends: 178 [79,8%] respondents.

Motivation:

- Feel more comfortable talking to peers about sex-related issues.
- Teachers, adults, parents tend to reject pre-marital sexual involve-

Use youth groups and peers to develop health sex-related messages

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ment.

– Teachers, adults, parents are uncomfortable when sex-related issues are under discussion.

– Professional Health Practitioners

[medical practitioners/registered nurses]: 141

[63,2%] respondents. Motivation:

– Medical practitioners/Registered nurses are not uncomfortable during discussions on sex-related topics.

– Unlike parents medical practitioners/registered nurses do not expect the youth to practice total restraint.

– Health practitioners keep personal matters confidential.

The data confirms Holmshaw's¹⁴ viewpoint, that youth organisations and peers should be seen as a source to develop credible

messages during sex-related education. Safer sex practices can be reinforced by peer-group pressure. Professional Health Practitioners need to mobilise a network of supportive peer groups in health, AIDS, and sex-related education.

2. AIDS-related perceptions/knowledge/attitudes:

2.1 The respondents [n=223] had to indicate from where they obtained most of their information, and knowledge on AIDS: TV/, magazines, radio, newspaper, films, friends, family,

Table 2: Perception of how long it takes for AIDS to manifest after HIV infection

Time period	f	%
Years	129	57,8
Months	21	9,4
Weeks	16	7,2
Immediately	27	12,1
Uncertain	30	13,5
n =	223	100

other. Other had to be listed. The data revealed the following in hierarchical order: TV: 45,0% respondents; Newspapers: 26,0% respondents; Radio: 21,0% respondents; Friends: 17,0% respondents; and Magazines: 7,0% respondents.

2.2 "How long does it take for AIDS to manifest after a person was exposed to the disease/ virus? (How long before a person will become sick and show signs/symptoms of the disease?)." See Table 2.

Table 3: Perceptions on AIDS transmission

Transmission method	f	%
Sexual intercourse	188	84,3
Blood transfusion	150	67,3
Contact infected blood	140	62,8
Sharing IV needles	90	40,4
Kissing	32	14,3
Public toilets	23	10,3
n =	223	100

2.3 "According to your knowledge, how is AIDS transmitted?". Thirty two [14,3% : n=223] respondents were under the impression that AIDS can be transmitted through kissing, and twenty three [10,3%] indicated public toilets. See Table 3.

2.4 "According to your knowledge which groups/individuals are at risk of getting AIDS?". Table 4 reflects the respondents' [n=223] perceptions regarding at risk groups/individuals in hierarchical order. Only thirty two [14,3%] respondents indicated heterosexuals as a risk group.

The data confirms the findings from the literature review, namely that AIDS are associated with "immoral" or "deviant" behaviour.

2.5 Other questions completed by all the respondents [n=223], are listed

Table 4: Perceptions regarding groups/individuals at risk for contracting AIDS

Individuals/groups at risk	f	%
Prostitutes	133	59,6
Bisexuals	74	33,2
Homosexuals	43	19,3
Drug addicts	41	18,4
Heterosexuals	32	14,3
n =	223	100

AIDS is still associated with immoral behaviour.

Sexual activity is especially difficult to change

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in Table 5 (bottom of the page). One hundred and eighteen [52,9%] respondents indicated that AIDS can be treated successfully, while sixty [26,9%] were uncertain.

Sixty nine [31,0%] respondents were certain that AIDS can be transmitted by spitting on someone, while one hundred and three [46,0%] were uncertain. Only fifty one [23,0%] indicated that AIDS could not be transmitted by spitting on someone.

Eighty three [37,2%] indicated that AIDS can be transmitted by biting someone; eighty nine [40,0%] were uncertain, and fifty one indicated that AIDS could not be transmitted by biting someone. The data confirms the findings in the literature review, namely that a change in sexual behaviour will only occur once a significant number of people begin to die from AIDS. As long as people believe AIDS can be successfully treated, they will not change their sexual behaviour! Information alone is therefore insufficient to promote meaningful changes.

Only one hundred and five [47,1%] respondents felt that a person with AIDS should not be removed from society: motivation included that a person with AIDS is: (1) also a human being [93: 88,6% respondents]; (2) it is not necessary as AIDS can only be contracted by having a sexual relationship with the person [7: 6,7% respondents]; and "it would not be a Christian act" [2: 1,9% respondents]; three [2,8%] respondents provided no explanation.

In contrast with the data in the previous paragraph hundred and fifty two [68,2%: n=223] respondents indicated that they would befriend a person with AIDS.

2.6 The respondents [n=223] were requested to react to the following statement:

"Aids is deserved punishment for the 'guilty'". The statement was included to assess the pupils' general attitude toward people infected with HIV. See Figure 4. The data seems to confirm the

Information alone is insufficient to promote meaningful changes

Lay people use homosexuals, drug addicts and prostitutes as scapegoats.

Table 5: AIDS-related perceptions/knowledge and attitude

Question	Response					
	Yes		No		Uncertain	
	f	%	f	%	f	%
Can AIDS be successfully treated?	118	52,9	45	20,2	60	26,9
Is it possible for a person with AIDS to prevent spreading the virus?	138	61,9	52	23,3	33	14,8
Is it possible to recognise a person with AIDS?	128	57,4	32	14,3	63	28,3
Is it possible to spread AIDS by spitting on someone	69	31,0	51	23,0	103	46,0
Is it possible to spread AIDS by biting someone	83	37,2	51	22,8	89	40,0
Should a person with AIDS be removed from society?	21	9,4	105	47,1	97	43,5
Would you be friends with a person with AIDS?	152	68,2	64	28,7	7	3,1
n = 223						

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findings in the literature reviewed, indicating that certain groups such as prostitutes, homosexuals and drug addicts are identified as scapegoats by lay people.

Concluding remarks

Although information and precise knowledge about the risk of HIV infection is a necessary precondition for perceived need for personal change and for change itself, it is not sufficient to induce change. Significant changes are only observed in subpopulations that express concern about their own situation. There is no direct relationship between an individual's knowledge and his/her adoption of safer sex behaviours. Information alone is therefore insufficient to promote meaningful changes. "Because sex is a powerful motive and because sexual practices are maintained by past experiences, immediacy of gratification, reinforced by fantasies and often interpersonal influence or even coercion, it can be expected that sexual activities are especially difficult to change."⁹

Safer sex practices are reinforced by peer-group pressure and social integration in a network of supportive groups that mobilize in favour of adopting safer sex behaviour. Trust and social reinforcement are pre-conditions for

change. The desire to experience and to fulfil sexual needs in specific situations can overwhelm the known dangers of unsafe sex.

Health care practitioners can no longer ignore the social dimensions of behaviours

They have both a unique responsibility and opportunity to assist in health education efforts

aimed at primary prevention. In order to come to terms with AIDS, it is becoming increasingly impossible to ignore the deeply-rooted social dimensions of behaviours.

"Resistance to condom use makes perfect sense once we understand something about the way the persons is socially constructed. We need to take implicit cultural constructs

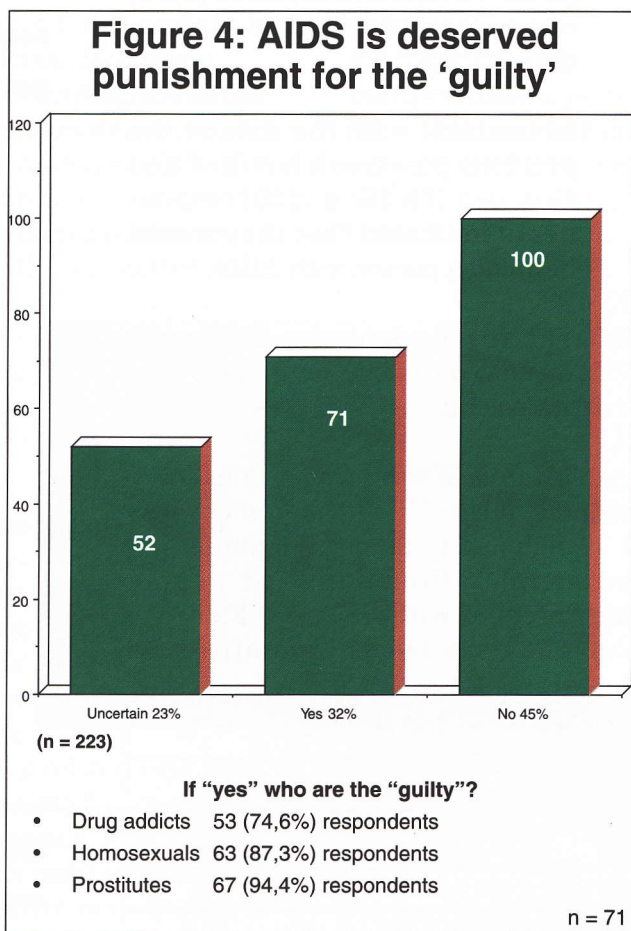
seriously, even though these constructs are not readily discernible as health-related behaviours"¹⁷

Recommendations

- (i). Health/Lifestyle Educators should invite young people to help, plan, implement and evaluate sex education programs. Programs should be developed within the context of the specific cultural beliefs and values of the target group.

Sensitive to the issues of young people.

Emphasise skills and social norms rather than knowledge



- (ii) Sex/Lifestyle education programs should commence in Primary School, and be developmentally appropriate. In order to obtain support of parents and other relevant role players, health/lifestyle educators should take local cultural traditions into account. Parents and other relevant role players should be invited to voice their concerns, attitudes, and suggestions regarding sex education programmes.

In order to ensure open communication between health/lifestyle educators and parents/relevant role players, it is important that educators should actively participate in community activities. Lifestyle educators should know and be known to the people. Working with the specific community is critical to the sex/lifestyle program's success. Programmes that ignore community norms will create unnecessary opposition.

- (iii) Sex/lifestyle education programs should emphasize skills and social norms rather than knowledge. Combining messages about abstinence and safer sex are more effective than emphasizing abstinence alone. A program should advise young people to remain abstinent or use contraceptives. Training should include decision-making and communication skills, and explore the social pressures for having sex.

Abstinence should be made "valuable" to young people, but those who decide not to be abstinent should not be judged by lifestyle/sex educators.

- (iv) To reach young people who are already sexually active, schools and organizations within the community should provide contraceptives such as condoms. According to the literature, access to contraceptives does

not hasten the initiation of sexual activity.^{15,16}

Adolescents often seek contraceptives without parents' knowledge and, hence must cope with transportation problems in reaching clinics, harassment or refusal to be served at pharmacies, and other difficulties. Making contraceptives more easily accessible through outreach efforts help to solve this problem.

- (v) Effective programs offer accurate information, depend on role-play by peers, and adequately train the educators who work with young people. Health/lifestyle educators must be trained to be really sensitive to the issues of young people. If they look at how young people feel about [sexuality], then they can begin to address the real issues.

Access to contraceptives does not hasten sexual activity.

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ABSTRACTS

Contribution of academic departments of general practice to undergraduate teaching, and their plans for curriculum development

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Background: In 1991, the General Medical Council suggested the development of a new undergraduate curriculum, on a 'core plus electives' basis. These departments now face escalating expectations from their medical schools of their ability to provide additional community based teaching.

Aim: The aim of this study was to investigate the present contribution of academic departments of general practice to undergraduate teaching and their plans for curriculum development, including the introduction of community based clinical skills teaching.

Method: A questionnaire was circulat-

ed in June 1993 to all academic departments of general practice in the United Kingdom and Eire.

Results: Twenty seven out of 28 questionnaires were returned. Twenty two departments provided pre-clinical teaching and all provided a clinical practice attachment. Eight medical schools were organising community-based clinical skills teaching, and in two this formed the basis for a community-based medical attachment. Eight planned to reduce the factual content of their curricula and introduce problem-based learning while nine were contemplating a 'core plus electives' option. Fourteen medical schools had primary care input in teaching basic clinical skills and an additional seven planned to introduce this. Problems encountered by the general practitioner tutors in teaching clinical skills included insufficient time and resources and poor self-esteem; they identified a need for good central and peripheral organisation.

Conclusion: Compared with a 1988 study, academic departments of general practice are increasingly involved in teaching both general practice and general medical skills at undergraduate level. Curriculum change is occurring rapidly, with an increasing trend towards community teaching; the implications for both academic departments and general practitioner tutors are discussed.