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TEACHING OF HIV AND AIDS IN SECONDARY SCHOOLS

BY

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Teaching of HIV AND AIDS in Secondary Schools

by

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DECLARATION

I, RUDZANI JUSTICE RANDELA hereby declare that the dissertation for the Masters degree at the University of Venda hereby submitted by me has not previously been submitted for a degree at this or any other University, and that is my own work in design and in execution and that all reference material contained therein has been duly acknowledged.

Signature:..... Date: July 2010

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DEDICATION

This study is dedicated to the loving memory of my grandmother, Mrs. Marubini Munyai, my father, Mr. Nndanganeni Johannes Randela and my son, Tshilidzi Randela. I always love you all.

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ABSTRACT

The focus of this research is on the teaching of HIV/AIDS in secondary schools in Vhuronga 1 (one) Circuit (Vhembe District) of the Limpopo Province, South Africa. The research starts with the background to the research problem. The objective of this research is to show learners, educators and principals current practice or position on the teaching of Life Skills and other learning areas in secondary schools with special reference to HIV/AIDS and the implications thereof.

The literature review undertaken in chapter 2 discuss the following: It was noted that educators have a great responsibility of teaching learners about HIV/AIDS, the most important of which was to provide learners with accurate information regarding HIV/AIDS. Educators should also make sure that effective teaching and learning of HIV/AIDS does takes place in schools. It was discovered that the subject of HIV/AIDS could not be taught in isolation, life skills programs should be included. The study also focuses on the knowledge that children should have regarding the HIV/AIDS epidemic. The basic awareness of HIV/AIDS transmission of HIV, HIV prevention and teaching of HIV/AIDS in some of the African and International States were also discussed.

The research design used is quantitative and data was collected by means of questionnaires Examples of questionnaires distributed to learners, educators and principals are included in this research as appendices. All questions were analysed and interpreted in chapter 4 of this research. Summary, findings, conclusions and recommendations are included in chapter 5 of this research.

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CHAPTER 1

1.1 BACKGROUND TO THE PROBLEM OF RESEARCH

The National Policy on HIV/AIDS for learners and educators in public schools issued by the Department of Education working collaborately with the Department of Health help to fight the spread of the seriousness of HIV/AIDS epidemic as it affects everybody including learners and educators. HIV/AIDS concerns school population and threatens the quality of education and skills development because some of these learners inherited it and some of the educators are infected too. (Department of Education (DoE): 1996, National Education Policy Act 1996, Act No. 27 of 1996)

This Policy is significant as it raises awareness to educators who ignore and undermine the inclusion of HIV/AIDS in the school curriculum. Although HIV/AIDS is an important subject, it is not taken seriously in terms of how it is taught in schools. Currently in the school curriculum, issues relating to sexuality and HIV/AIDS are offered within the Life Orientation learning area. And most of the educators are not trained on how to teach HIV/AIDS. Many educators are not keen to go for Life Skills trainings because it will expose their fears of being HIV positive. Further, once educators are knowledgeable about the disease and also discuss it openly about it, will think people would suspect them of being HIV positive.

Apparently parents develop negative attitude towards educators who include HIV/AIDS in their school curriculum as they think is corrupting their children and encouraging promiscuity amongst learners. Worse still distributing of condoms to learners in schools is prohibited as it is contrasted to the way it is done at workplaces. Some of the educators think that displaying condoms to learners will influence them to become wild. Moreover learners are not taught on how to adhere to the programmes like Soul City over the television.

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HIV/AIDS should have been a learning area which is taught like other learning areas with specialization and summative assessment. Furthermore, this learning area as part of Life Orientation subject has been allocated less minutes in the school timetable and sometimes is usually not taught at all. In some instances, it appears that most schools educators use Life Orientation periods to teach examination subjects. According to Peltzer (1995), many educators hold the view that an HIV/AIDS curriculum is not yet in place and as such it is not necessary to offer it as a subject that require summative assessment.

A study by Mannah (2002:164) on the role of teaching about HIV/AIDS in schools revealed that most educators agree that HIV/AIDS and sexuality education should be an integral part of the school curriculum. However, it points out that many educators have no confidence and are reluctant to teach due to:

- Firstly, lack of knowledge and resources.
- Secondly, a culture of silence and fear that shrouds the disease. This problem is worsened by some parents' attitudes toward sexually education.
- Thirdly, language of training. Training is usually conducted in English and educators cannot translate it into other vernaculars and sometimes when expressed in vernacular it sounds too vulgar whereas on the other hand learners do not understand what educators are talking about in English.

Thus, wherever possible, the language of training and educators support material should accommodate the teacher's first language, as well as the language of teaching and learning in the school.

- Fourthly, gender. It appears that most Life Orientation educators are females and many of them feel embarrassed talking about sexual issues with grown boys in class. Sometimes male students think by teaching

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sexual education female educators are sexually interested in them that is why they are being so open about sex and HIV.

- Lastly, educators as role models. Some communities are against educators because they see educators misbehaving (e.g. drinking and having relationships with school girls). This impact on the effectiveness of educators being implementers of HIV/AIDS programme and their credibility as role models for learners. In some instances, learners are aware of the HIV status of the educator and openly question the appropriateness of educators as role models.

1.2 STATEMENT OF THE PROBLEM

Despite the plethora of information, national policy and programmes available on HIV/AIDS, infection rate continue to soar in South Africa. HIV/AIDS education should therefore not be neglected, as HIV/AIDS will have catastrophic consequences. The epidemic has undisputable negative effects in the education sector particularly on the demand for education, the supply for education (Coombe, 2000). The negative impacts are potentially high especially if nothing is done at an early age of children growth and development.

On the other hand, HIV/AIDS also affect the size of the learner populations. Where prevalence is high, rising death among adults of reproductive age and declining fertility rates results in fewer children being born. Combined with increased mortality among children infected being around the time of birth, this means that there are fewer potential learners then there would have been without AIDS.

HIV/AIDS causes absenteeism especially amongst secondary learners. It has been found that in Sub-Saharan Africa girls tend to have poorer attendance records than boys because of higher household demands for their labour Coombe (2000). In addition, Coombe (2000) argues that there is a broad consensus that most children in AIDS affected

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household in Sub Saharan Africa will have to look after their parents and other relatives and this will have a major impact on their education, as most learners are likely to drop out of school.

AIDS orphans are more likely to drop out of school mainly because orphanhood exacerbates financial constraints (school fees and other expenditure) and increase the demands for child labour for household and their activities.

Finally, HIV/AIDS impacts on the emotional status of educators and young people. Coombe (2000) argues that educator morale is low where impact is high, combined with considerable student and educator trauma. Both educators and learners have difficulty in concentrating in the face of illness, death, mourning and dislocation (Kelly, 2000a).

1.3 RESEARCH QUESTIONS

The study will be guided by the following research questions:

- Is HIV/AIDS being taught at schools? If so, at which grade should it start?
- How is the level of awareness amongst learners and which area of the epidemic has a high or low level of awareness?
- What kind of support services is offered to educators to enhance the teaching of HIV/AIDS?
- What role does the government plays in ensuring the effective implementation of the National Policy on HIV/AIDS with special reference to monitoring of schools?
- What critical role do schools play in relation to other institutions or structures that exist in communities?
- Are there any barriers in the teaching of HIV/AIDS?
- Has there been any impact experienced or noticed as a result of HIV/AIDS?

Based on the knowledge that will be found in this study, new initiatives, particularly education based, can be proposed and developed to deal with the epidemic.

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1.4 AIMS OF THE RESEARCH

The aims of the study are to:

- Establish if the government monitors the teaching of HIV/AIDS at schools including schools compliance with the prescripts of the national policy on HIV/AIDS.
- Determine the status of HIV/AIDS subject and its teaching in schools.
- Examine the impact of HIV/AIDS with special reference to the education sector.
- Identify barriers to the teaching of HIV/AIDS in schools.
- Identify the information sources
- Explore learners, educators and principals level of awareness of teaching HIV/AIDS
- Recommend the appropriate ways of teaching HIV/AIDS in schools.

1.5 SIGNIFICANCE OF THE STUDY

The integration of HIV/AIDS subjects in schools and life saving skills and actions provides the world's best hope of reaching the Millennium Development goal MDG. Therefore, countries are expected to ensure that all young people have access to the comprehensive knowledge, information, life skills, and services they need to protect themselves from infections. It is envisaged that the results of the study will be of significant importance to the policy makers and other active stakeholders in fight against HIV/AIDS.

Finally, the research report will be kept in the University Venda library where it will serve as a source of reference to prospective researchers, students and lectures. It is expected that some researchers will critique the study and possibly base their future studies on this work in their own areas.

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1.6 DELIMITATIONS

The study will be conducted in Vhembe district in the Vuwani area within Vhuronga one circuit. An advantage is that the researcher is familiar with the sites. The study will focus on secondary schools and it will involve learners, educators and school principals. The study will be limited to grade 10 learners who by virtue of their age are 15 yeas old.

1.7 RESEARCH DESIGN AND METHODOLOGY

1.7.1 Research Design

The researcher will use quantitative research design which is a research that involves measuring quantities of things usually numerical quantities. It is based on the natural sciences, with emphasis on empirically quantifiable observations which lends themselves by-means of mathematical tools (Vilakazi, 2005). It relies on the use of representative sample, preferably a bigger sample size, so as to allow for accurate generalization of results. The quantitative approach will produce numerical and factual data that will provide for a numerical analysis of the phenomenon of HIV/AIDS which is being explored in this study.

1.7.2 Methodology

The methodology will comprise the following:

1.7.2.1 Population

In 2007, the total population of Grade 10 learners in Vuwani area under Vhuronga one Circuit in Limpopo Province was 1 520. These learners are served by a total of 15 schools in number. Of the 1 520 Grade 10 learners, girls makes 53% of the total population.

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1.7.2.2 Sampling and Sample

A systematic random sampling method will be applied to draw the sample. This will be done by obtaining a list of all the female and male learners in grade 10. The sample will be bias towards females as they are the majority (53%) of the target population. Thus, out of a total sample of 60 learners girls will constitute slightly more than half of the sample. The following formula will be applied to draw a sample.

N/n

Where N is the target population and n is the intended sample size. Thus every n^{th} learner in the list will qualify to be part of sample. In addition to learners, educators and school principals will also take part, particularly those with knowledge on the subject under research and those involved in teaching the target sample.

For economic reasons (time and budgetary constrains) only six schools under Vhuronga one circuit will be sampled for the purpose of this study. The names of those schools are shown in the Table 1.1 below. Schools were grouped first into three clusters according to the tribal authority under which they belong, and thereafter two schools were randomly selected for research from each cluster.

TABLE 1.1: Sampled Secondary Schools in the Vhuronga 1 Circuit

Nesengani tribal authority		**Tshimbupfe tribal authority**		**Davhana tribal authority**	
Edison Nesengani	Kolokoshani	Tshimbupfe	Ratshikwekwete	Davhana	Muthurwana

Sample

It is difficult to give precise rules on what sample size is suitable. The sample does not depend on the size of population nor does it have to include a minimum percentage of that population. However, Bless and Achola (1995) argue that one of the major issues in

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sampling is to determine samples that best represent a population so as allow for an accurate generalization and in this case the bigger the sample size the better.

The major criterion to use when deciding on the sample size is to choose a representative sample that best represents the population. For economic reason (i.e time and resources) a total sample of 60 learners will be used for the analysis in this study. It is envisaged that this sample will be drawn from six schools in the Vuwani area. A sample of 10 learners will be drawn from each school with two schools representing a particular tribal authority under its jurisdiction. The tribal authorities are, namely Nesengani, Tshimbupfe and Davhana.

According to Meyer (2003) girls are extremely vulnerable to contracting HIV because of social, cultural, economics and physiological reasons and therefore the education of girls can assist in slowing the epidemic by contributing to female economic independence and provide information on family planning. The HSRC study (2004) revealed an HIV prevalence rate of 5 percent amongst 15-18 years old. Of this rate, females contribute the highest prevalent rate of 5.3 percent relative to 4.7 percent of their male counterparts. In addition, Ranchod (2005) reported that there is 8.6 million people age 15-24 living with HIV/AIDS in Sub Saharan Africa and females make 67% of this number of infection. In South Africa, over half of all HIV/AIDS infections are among women. Of the total sample, it is for this reason why the sample will be bias towards females.

The transmission of HIV from mother to child accounts for over 90% of infection among children under the age of 15 years (UNAIDS, 2003).As stated before, questionnaires will be conducted with learners of Grade 10. Research by UNICEF (undated) argues that children get involved in sex actively at a later stage particularly at the age of 15 onwards.

1.7.2.3 Instrumentation

The quantitative phase of the study will make use of questionnaires as a tool through which information can be elicited from the respondents. Questionnaires will be used as a

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suitable data collection instrument and in this case individual respondents will complete questionnaires on their own. According to this technique each respondent should preferably receive the same stimulus and complete his/her questionnaire without discussion with the other members of the group. Questionnaires will be distributed and administered by the respective class educator after school, with the assistance of the researcher. The educator will be given an instruction by the researcher to ensure consistency in all the schools and to avoid bias.

Data collected will be kept confidential and the analysis will not reflect individual respondents as it will be reported at an aggregate level.

1.7.2.4 Data analysis and Interpretation

Data analysis and interpretation of the data collected will be conducted within the parameters of the underlying research methodology. Data will be analysed using Statistical Programme for Social Scientists (SPSS). These programmes allows data to be analysed at different levels, for example by gender, location etc. More importantly, data will be presented in an organized manner that will permit the drawing of conclusions and creation of the basis for thinking about its meaning in terms of research questions.

1.8 DEFINITION OF TERMS

For better understanding of this study, it is important to define certain terms which will be used more often in the study, namely:

a. HIV- is an abbreviation for Human Immunodeficiency Virus. It is a retrovirus that causes AIDS (Longman Dictionary, 1987: 498). It is further defined as a kind of virus enters the body through blood or sexual activity, and cause AIDS.

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b. AIDS- is an abbreviation for Acquired Immune Deficiency Syndrome: very serious diseases caused by a virus which breaks down that body's natural defences against infection.

c. Concise Oxford English dictionary (2002) refers to teaching as a way of imparting knowledge to someone in how to do something especially in a school or as part of recognized programme.

d. Grade 10 learners- by this the researcher means any full time registered person under the formal education system who is in the process of acquiring knowledge and skills in a class which was previously known either as Junior Certificate (JC), form three or standard eight.

1.9 CHAPTER DIVISIONS

Research will comprise five chapters:

- Chapter 1 covers background to the problem of research.
- Chapter 2 will focus on literature review whereby the researcher will review both national and international source materials.
- Chapter 3 will proceed with the methodological issues including population, sampling, sample, data collection and data analysis.
- Chapter 4 will present empirical findings of the study based on the statistical analysis of the questionnaires.
- Chapter 5 of the study will conclude with the summary, findings, conclusions and recommendations.

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CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter researcher reflected on the following:
Historical background of HIV/AIDS, theories of the origins of HIV/AIDS, national policy on HIV/AIDS for learners and educators, what every learner and educator should know about HIV/AIDS, basic awareness of HIV/AIDS, transmission of HIV, how can HIV infection be prevented in secondary schools, teaching of HIV/AIDS in secondary schools, basic requirements for successful HIV/AIDS education, HIV/AIDS education and life-skills training in further education phase, the impact of HIV/AIDS in secondary schools, how HIV prevalence is measured, the role of Education Department in supporting the teachers of HIV/AIDS in schools. The role of Educator Unions in teaching of HIV/AIDS in schools, teaching of HIV/AIDS in secondary schools in some of the African and other countries abroad and conclusion.

2.2 HISTORICAL BACKGROUND OF HIV/AIDS

The first recognized cases of AIDS occurred in the USA in 1981 when a very rare form of pneumonia (caused by a parasite called pneumocystis carinii), cytomegalovirus infections, thrush and Kaposi's sarcoma (a rare form of skin cancer) suddenly appeared simultaneously in several patients. These patients had a number of characteristic in common: they were all young homosexual men with comprised (damaged) immune systems (Adler, 1988). Soon afterwards a new disease, which undermined the immune system and caused diarrhoea and weight loss, was identified in Central Africa in heterosexual people. (Adler, 1988)

Initially, scientists and doctors were baffled because causes and the modes of transmission of this new disease (called 'slim disease' in Africa) could not immediately

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be identified. Only in 1983 was it discovered that the disease was caused by a virus, known at that stage as LAV (lymphadenopathy-associated virus) HTLV III (human T cell lymphotrophic virus type III). In May 1986 the virus causing this condition was renamed HIV (human immunodeficiency virus). (Van Dyk, 2005: 4)

Two viruses are now associated with Aids: HIV-1 and HIV-2. HIV-1 is associated with infections in Central, East and Southern Africa, North and South America, Europe and the rest of the world. HIV-2 was discovered in West Africa (Cape Verde Islands, Guinea-Bissau and Senegal) in 1986 and is mostly restricted to West Africa. HIV-2 is structurally similar to HIV-1, but HIV-2 is less pathogenic than HIV-1, and HIV-2 infection have a longer latency period slower progression to disease, lower viral counts and lower rates of transmission. (Van Dyk, 2005: 4)

The history of the discovery of the HI virus is both interesting and controversial. Dr Luc Montagnier of the Louis Pasteur Institute in Paris, France, discovered HIV-1 in 1983. A year later Dr Robert Gallo of the United States claimed that he had been the first to discover the virus. What followed was a protracted court case about the alleged 'theft' by Gallo of Montagnier's virus, which had been sent to Gallo in good faith for research purposes. The bipartisan feelings aroused by this court case were so intense that they threatened to undermine the 1987 bilateral talks between the French prime minister, Jacques Chirac and the American president, Ronald Reagan. The issue was eventually resolved by a last minute compromise which permitted both Montagnier and Gallo to be officially recognized as co-discoverers of the virus (Connor and Kingman, 1988).

However, the bitter dispute was renewed in 1990 when Pasteur Institute scientists decided to analyze the generic structure of Gallo's virus and compare it with Montagnier's initial isolate of the virus (Schoub, 1999: 10). They found that the two viruses were so similar that it was very unlikely that they were not one and the same (taking into account natural changes in generic structure that would be expected to occur between different virus isolates). It was found that in September 1983 Montagnier had, in fact, as a courteous scientist would be expected to, send his original isolates of the virus

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to Gallo, soon after he had made his first isolation. Before a scandal again threatened to shake the scientific world, the dispute was quashed when Montagnier's laboratory admitted that there had been contamination of strains, and that the French-man had inadvertently contaminated Gallo's strains. It has now finally been accepted that credit should be shared between the two: Montagnier for the original isolation of the HI virus and Gallo for being able to propagate the virus in cell culture. Gallo also was the first person to develop critically needed diagnostic tests for HIV. (Schoub, 1999: 10)

The frightening disease and the dispute between the two countries' scientists grabbed public attention. A journalist, Randy Shilts (who later died of AIDS), wrote a book about it (and the band played on) which in 1993 was made into a film with an all-star cast (many of whom agreed to work for reduced fees).

2.3 THEORIES OF THE ORIGINS OF HIV/AIDS

No other disease has ever fired the imagination of the world as much as HIV/AIDS have done. The following questions are always asked: where did AIDS come from? Is it a new or an old disease? Where did it originate? These are difficult questions, and we may never find out the answers. According to Schoub (1999:13) little is known about the origins of any human virus, let alone HIV. He says the following about the origin of Aids: various scenarios of the birth and development of the epidemic have been built around pieces of knowledge recruited from a number of sources. At present the answers to both the origin of the disease as to the ancestry of the virus remain as unresolved as when the questions were first posed.

There are two main theories about the origin of the AIDS epidemic. One theory is as follows: AIDS is not a new disease, but has been present for centuries in the central Africa. It remained undetected only because of the lack of diagnostic facilities. The clinical symptoms of AIDS such as fever and pneumonia were ascribed to Malaria and TB. The spread of HIV/AIDS was limited because there was little contact with outsiders, and it was introduced to the Western world only when international travel became more

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common. One of the arguments against this theory is that modern testing of archived blood samples from Africa rarely shows any signs of HIV infection before the 1980s (Schoub, 1999:14). In tests carried out on these frozen blood samples, the earliest sample shown to be positive for HIV antibodies was taken in 1959 in Kinshasa in then Belgian Congo. Also, doctors with many years of clinical experience in Africa deny that before the 1980s they ever saw diseases resembling the very obvious characteristics of AIDS. It seems that AIDS is indeed a new disease and that HIV was introduced into the human population in the 1950s

The second theory about the origin of AIDS is that HIV crossed the species barrier from primates to humans at some time during the twentieth century (Korber, 2000). HIV is related to a virus called SIV or simian immunodeficiency virus, which is found in primates. There are a number of SIV strains and each strain is specific to the monkey species that it infects. For example, SIVagm infects the African green monkey; SIVmnd infects the mandrill ape, and SIVsm the sooty mangabey monkey (Schoub, 1999). Under natural conditions, each strain will infect only its own specific species of monkey and it will also not infect humans. HIV also cannot infect any animal other than humans, except under experimental laboratory conditions where infection can be induced in chimpanzees. Immunodeficiency viruses occur in other animals too, for example cats, cattle, horses, sheep and goats, but natural infections with these viruses are also species-specific and will not spread to animals from other species. Within the SIV group of viruses, SIVsm (the sooty mangabey virus) shows the closest relationship to an HIV strain, and specifically to HIV-2. It is interesting to note that HIV-2 is confined mostly to West Africa, which is also the natural habitat of the sooty mangabey monkey. However, the link between HIV-1 and SIV is not so clear.

According to Schoub (1999:15) this missing link may have been discovered by the isolation of a virus from a captive chimpanzee in Gabon in 1989. This virus (called SIVcpz) is far more closely related to HIV-1 than any other immunodeficiency virus, and it is also the only virus that possesses the same set of genes as HIV-1. Scientists still treat this finding with some reserve. This chimpanzee was a captive animal. And it is therefore

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possible that SIVcpz could be a human virus which for some unknown reason infected that particular chimpanzee. The question still remains how simian viruses could have been transmitted from monkeys to humans. It is believed that the virus probably crossed from primates to humans when contaminated animal blood entered cuts on the hands of people who were butchering SIV-infected animals for food. Another possibility is that chimpanzee and monkey blood, which was used for malaria research long ago, could have been the conduit into human species. (Schoub, 1999: 15)

There is also theory that incriminates early oral polio vaccines as the source of SIV infection of humans with its subsequent mutation to HIV (Hooper, 1999). Early trials of oral polio vaccines in the late 1950s were carried out by spraying prototype vaccines into the mouths and throats of several hundred thousand people in Rwanda, Zaire and Burundi, precisely the early epicenter of the AIDS epidemic in Africa. Oral polio vaccines, which contain a suspension of live vaccine strains of the polio virus, are produced on cell cultures derived from the kidneys of African green monkeys. It is believed by some that the vaccines could have been contaminated by SIVagm from the monkey kidneys at a time when vaccines were not tested for contaminating simian viruses. Schoub believes that theories like this may cause untold harm to immunization programmes such as the global effort to eradicate polio.

In summary it can be said that the AIDS epidemic began in humans in the late seventies and early eighties, and that there were only a few isolated cases of AIDS like diseases before then. Although the virus probably crossed the species barrier from primates to humans, it is impossible to say exactly how or when it happened. The initial spread of HIV was probably limited to isolated communities in Africa who had little contact with the outside world, but various factors, such as migration, improved transportation networks, tourism, socio-economic instability, multiple sexual partners, injecting drug use and an exchange of blood products, ultimately caused the virus to spread all over the world. (Hooper, 1999)

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2.4. NATIONAL POLICY ON HIV/AIDS FOR LEARNERS AND EDUCATORS

Background

In August 1999 the minister of education launched the national policy on HIV / AIDS for learners and educators in public schools, and student's educators in further education and training institutions. The national policy emphasizes the vulnerability of young people to HIV infection, and is aimed at educators and learners. The national policy is a voluntary guideline for schools, but many parts of the policy have already become law, e.g protection of rights to privacy. Caregivers, counselors and teachers can use the national policy:

- To discuss managing HIV and AIDS in the school environment ; and
- To support learners and educators living with or affected by HIV or AIDS.

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Guidelines

Some of the premises regarding HIV/AIDS in schools

- Although there are no known cases of the transmission of HIV in schools or institutions. There are learners with HIV/AIDS in schools. More and more children who acquire HIV parentally will, with adequate medical care, reach school – going age and attend school.

- Because of the increase in infection rates, learners, students and educators with HIV/AIDS will increasingly form part of the populations of schools and institutions. Since many young people are sexually active, increasingly numbers of learners at primary and secondary school as well as students attending higher education institutions might be infected. There are additional risks of HIV transmission among learners and students due to sexual abuse and intravenous drug use. Although the possibility is remote recipients of infected blood products during blood transfusions (for instance haemophiliacs) may also be present at

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schools and institutions. Because of the increasing prevalence of HIV/AIDS in schools to have a planned strategy to cope with the epidemic.

- Compulsory disclosure of a learner's, student's or educator's HIV/AIDS status to schools or institutions authorities is not advocated as this would serve no meaningful purpose. In cases of disclosure, educators should be prepared to handle such disclosures and given support to handle confidentiality issues.

- A learner or student with HIV/AIDS should lead as full a life as possible and should not be denied the opportunity of receiving an education to the maximum of his or her ability. Likewise, an educator with HIV/AIDS should lead as full a professional life as possible, with the same rights and opportunities as other educators and with no unfair discrimination against him or her.

- Infection control measures and adaptations must be universally applied and carried out regardless of the known or unknown HIV status of the individuals concerned. Current scientific evidence suggests that the risk of play activities is insignificant. There is no risk of transmission from saliva, sweat tears, urine, respiratory droplets, handshaking, swimming –pool water, communal bath water, toilets, food or drinking water. Adequate wound management must take place if an open, bleeding wound is sustained in the classroom or laboratory, or on the sports field or playground. Contact sports are very low.

- Within the context of sexual relations, the risk of contracting HIV is significant. The school-going population includes many sexually active people. This considerably increases the risk of HIV transmission in schools and institutions for further education and training. Educators should provide sexuality, morality and life skills- education, and parents should be encouraged to instill healthy morals in their children, as well as providing sexuality education and guidance on sexual abstinence and faithfulness. Sexually active persons should be advised to practice safe sex and to use condoms. Learners and students should be educated about

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their rights concerning their own bodies, and taught to protect themselves against rape, violence, inappropriate sexual behaviour and contracting HIV.

- The constitutional rights of all learners, students and educators must be protected on an equal basis. If a learner, student or educator poses a medically recognized significant health risk to others, appropriate measures should be taken (e.g the presence of untreated contagious or highly communicable diseases, uncontrollable bleeding, unmanageable wounds, or sexual or physically aggressive behaviour, which may cause the risk of HIV transmission).

- Learners and students with infectious illnesses such as measles, German measles, chickenpox, whooping cough and mumps should be kept away from the school or institution to protect all its other members, especially those whose immune systems may be impaired by HIV/AIDS.

- Schools and institutions should inform parents of vaccination/inoculation programmes and of their possible significance for the well being of learners and students with HIV/AIDS. Local health clinics could be approached to assist with immunization.

- The United Nations convention on Rights of the Child, and the national policy on HIV/AIDS state that children should have access to information that will help them develop their physical and emotional well-being. This includes information about HIV/AIDS.

- Learners and students must receive on-going education about HIV/AIDS and abstinence in the context of life-skills. Life-skills and HIV/AIDS education should not be presented as isolated learning content, but should be integrated in the curriculum. It should be presented in a scientific but understandable way. Appropriate course content should be available for the pre-service and in-service

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training of educators to cope with HIV/AIDS in schools. Sufficient educators should be available to educate learners about the epidemic.

- The purpose of educating about HIV/AIDS is to prevent the spread of HIV infection; to reduce the fears of the epidemic; to reduce the stigma attached to it; and to instill non-discriminatory attitudes towards persons with HIV/AIDS. Education should ensure that learners and students acquire age-and context appropriate knowledge and skill so that they may adopt and maintain behavior that will protect them from HIV infection.

- In the primary grades, the regular educator should provide education about HIV/AIDS. In secondary grades a guideline counselor would be the sensitive nature of the learning content, the educators selected to offer this education should be specifically trained and supported by the support staff responsible for the life skills and HIV/AIDS education in the schools and province. The educators should feel at ease with the content and should be role models with whom learners and students can easily identify. Educators should be informed by the principal and educators where they can increase their knowledge of and skills in dealing with HIV/AIDS.

- All educators should be trained to give guidance on HIV/AIDS. Educators should respect their position of trust and the constitutional rights of all learners and students in the context of HIV/AIDS. (Department of Education : 2001)

2.5 WHAT EVERY LEARNER AND EDUCATOR SHOULD KNOW ABOUT HIV AND AIDS

2.5.1 The concept HIV

- HIV is the name given to the virus known as the Human Immunodeficiency Virus. This means that the virus causes the human body's immune system to be

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depleted of the immune that give the body the ability to fight illness.

- Our bodies are prone to infection by viruses or bacteria. Bacteria can be treated with medication, but viruses cannot be cured.
- HIV is a very small germ or organism called a virus. A virus illness when it infects and harms the body. HIV specifically affects and interferes with the body's immune system. The immune system is the body's natural defence mechanism against infection and illness. A number of different cells make up the immune system. The most important of these cells is called the CD 4 cell that helps body fight infections and illness.
- HIV attacks the immune system and lowers the body's resistance to many kinds of illnesses, such as flu, diarrhea, persistent pneumonia, TB and certain cancers.
- HIV destroys the immune cells of the body and this makes the immune system ineffective- this is why it is called the Human Immunodeficiency Virus.
- HIV weakens the body so much that it cannot fight sickness and ultimately causes death.
- HIV only survives and multiples in body fluids such as sperm, vaginal fluids, breast milk, blood and saliva (the concentration of HIV is not high in saliva). We can only become infected with HIV through contact with infected body fluids.
- Most people infected with HIV die about five to ten years after becoming infected, but some infected people may live longer.
- Most people infected with HIV feel well and remain productive in their families and workplaces between five and eight years-sometimes even longer-after initially becoming infected.
- Some people start showing symptoms quite soon after they are infected.
- When people infected with HIV start showing symptoms of sickness, this means that they have AIDS.
- The only sure way to determine if you are infected with HIV is to have a blood test at a clinic, local doctor or hospital. (Van Dyk : 2005)

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2.5.2 The concept AIDS

AIDS is short for Acquired Immune Deficiency Syndrome. We say that this disease is acquired because by a virus (the human immunodeficiency virus of HIV) that enters the body from outside. Immunity is the body's natural ability to defend itself against infection and disease. A deficiency is a shortcoming– the weakening of the immune system so that it can no longer defend itself against passing infections. A syndrome is a medical term for a collection of specific signs and symptoms that occur together and that are characteristic of a particular condition. (Van Dyk : 2005)

Although we use the term 'disease' when we talk about it, Aids is not a specific illness. It is really a collection of many different conditions that manifest in the body (or specific parts of the body) because the HIV virus has so weakened the body's immune system that it can no longer fight the disease- causing agents that are constantly attacking it. It is therefore more accurate to define AIDS as a syndrome of opportunistic diseases, infections and certain cancers – each or all of which has the ability to kill the infected person in the final stages of the disease. (Van Dyk : 2005)

2.5.3 The different stages of HIV/AIDS that children should know

There are different stages of HIV/AIDS. Mather (2002: 3) writes as follows regarding the different stages of HIV/AIDS, with each phase usually developing gradually and merging into the next:

The asymptomatic or silent phase. Mather (2002: 3) mentions that after a person have become infected with HIV, that person would most likely remain completely well for a long time. For Mather (2002: 3), this "well" period usually lasts an average of approximately seven years. During this phase, a person would normally look healthy, but might experience swollen lymph nodes.

The phase of HIV/AIDS related conditions. after the initial asymptomatic phase, the HIV infected person commonly starts experiencing various medical problems, including skin rashes, fungal mouthy infection (thrush), fatigue and tiredness, swelling of lymph glands

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in the neck and armpits, mild weight loss and occasional fevers. This phase does not yet signify the onset of AIDS. (Mather, 2002)

The AIDS phase. In the phase Mather (2002: 5) emphasizes that: "as the body's defenses become more depleted, the frequency and severity of infections increase. during this phase, the person usually experiences various conditions, ranging from those in the HIV phase and including more severe infections of the lungs leading to pneumonia, fungal infections of the mouth, intestinal tract, diarrhoeal diseases, marked weight loss and weakness, viral eye infections leading to visual disturbances, rare cancers of the skin and blood, problems associated with infection or damage to the brain, spinal cord causing headaches, convulsions, memory and concentration loss, poor coordination and occasionally personality changes and severe weakness. Usually after repeated illness and resultant weakening of the body, a person with AIDS almost invariably deteriorates and dies from infection, profound weight loss and weakness". (Mather, 2002:5)

HIV/AIDS awareness will be considered effectively if children can have absolute knowledge regarding the disease. This implies that all children must be able to differentiate between HIV/AIDS, know the different stages of HIV/AIDS, what is meant by the window period, etc.

Education and awareness about HIV/AIDS is crucial for the control of the disease. (Mather, 2002: 5)

2.6 BASIC AWARENESS OF HIV/AIDS

Children should be taught the basic awareness of HIV/AIDS. Some children are living with illiterate parents, so they should be taken on board about the effects and dangers of HIV/AIDS. This will assist children in sharing the information with their parents. Various myths and misconceptions about HIV/AIDS stem from an inadequate understanding of the disease. In order to understand the nature and cause of HIV/AIDS, this research aims to distinguish between the two important concepts, namely HIV and AIDS. Different authors have different views on the concepts HIV and AIDS. (Van Zyl, 2002)

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2.6.1 Children who are HIV positive

Van Zyl (2002: 14) mentions that when a child is known to have HIV infection, as confirmed by a positive HIV blood test, that child is termed an HIV positive child. In other words, an HIV positive child is infected with the virus but does not necessarily feel or look sick, and does not yet have AIDS. At a later stage of HIV infection, usually after approximately 8-10 years, the HIV will destroy enough of the body's immune system to render that individual susceptible to infection from an unusual harm organism in the air, water and food. A child with a normal body defense would not normally become ill from these infections. This explains why children with HIV are susceptible to unusual infection and clinical conditions.(Van Zyl, 2002: 14)

Edwards (2002: 12) states that: "being HIV positive is not the same as having AIDS. Having HIV means that a child has the virus in his/her body. However, such a child can feel perfectly fine and healthy for a long time. Some children have lived as long as ten years without being sick. This stage is called being asymptomatic, which means having no symptoms". Whiteside and Sunter (2000: 5) states that: "HIV is like any other virus except that the virus attacks the immune system itself. Someone who is HIV positive does not have enough kinds of cells needed to protect the body from infections". Whiteside and Sunter (2000: 5) further state that some HIV positive individuals do not develop AIDS. The fact is that the average period from infection to developing AIDS is 8-10 years in the absence of treatment. It follows that there will be individuals who for some reason live for longer than average periods with HIV infection. Some may be fortunate to survive indefinitely without treatment. But there are exceptions. The vast majority of people will not be so fortunate and will eventually fall ill. (Whiteside and Sunter, 2000)

2.6.2 Children who have AIDS

Having AIDS is described by Nourse (2000: 7), "Indicate that a child has some kind of illness, sometimes a series of illness because the body no longer has what it needs to fight

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off diseases or infections". Nourse (2000: 7) further states that: "often, children with AIDS who develop serious illness get better, and then get sick again in a recurring cycle. Eventually children with AIDS die because of these illnesses". In supporting this idea, Manaka (2002: 3) states that: "a child is described as having AIDS, when the immune deficiency caused by HIV is so severe that various life threatening infections and/or cancer occur. These infections are called 'opportunistic diseases', because they take the opportunity to invade into the body which is provided by the weakened immune system". (Manaka, 2002)

2.6.3 What children should know about the way the virus works?

In this research project, HIV/AIDS will be discussed in detail so that children have accurate information about the disease. Whiteside and Sunter (2000: 7) summarizes as follows:

- "In order for infection to occur, the virus has to enter the body and attach itself to host cells.
- HIV attacks a particular set of cells in the human immune system, known as the CD4 cells, which organize the body's overall immune response to foreign bodies and infections. These T-helper cells are the prime targets of HIV.
- In order for a person to become infected, the virus particles have to enter the body and attach themselves to the CD4 cells and macrophages. Once the virus has attached itself to the cells surface it penetrates the wall. Thereafter it is safe from the body immune system and cannot be destroyed by the body's defense mechanism. Inside the cell, it copies its RNA into DNA. The copied DNA integrates easily into the company of the host's genes and by manipulating the proceedings of the nucleus causes the cell to churn out new HIV viral proteins. These are reassembled into viruses, which break out of the cell. In the process, the cell is destroyed and the virreminia go on to infect more CD4 cells. Thus the immune system of infected people is gradually weakened until they fall prey to a host of diseases, which they would normally fight off.

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- During the early stages of infection, the antibodies to the virus may not be identifiable. This is called the "window period". An infected person will be very infectious during this phase. Equally at this time, a person may experience a short bout of illness. The cause is the rapid multiplication of the virus and a correspondingly rapid response from the body. During this stage, the viruses and the cells which they attack are reproducing rapidly and being destroyed as quickly by each other. Eventually, the virus is able to destroy the immune cells more quickly than they can be replaced and slowly the number of CD4 cells decreases.

- In a healthy person, there are 1200 CD4 cells per micro liter of blood. As the infection progresses, the number will fall to about 200 or less. At this point, new opportunistic infections begin to occur, and a person is said to have AIDS. This infection will increase in frequency, severity and duration until the person dies. It is therefore the opportunistic infections that cause the syndrome referred to as AIDS".

2.7 WHAT LEARNERS SHOULD KNOW ABOUT TRANSMISSION OF HIV

Children should be taught about the various modes of HIV transmission. HIV is hard to transmit. In order for a person to be infected, the virus has to enter the body in sufficient quantities. The virus must pass through an entry point in the skin and/or mucous membranes into the bloodstream. Nourse (2000: 33-39) mentions the following modes of transmission. In order of importance, they are:

- sexual intercourse: vaginal, oral (mouth) or anal sex from:

- male to female;
-male to male;
-female to male;
-female to female;

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- mother-to-child transmission;
- intravenous drug use with contaminated needles;
- Use of infected blood or blood products.
- Sexual intercourse: vaginal, oral (mouth) or anal sex:

According to Nourse (2000: 33), "the vast majority of HIV infections are the result of sexual transmission. It does not matter whether the sex partners are male homosexuals (men who have sex with men) or male bisexuals (men who have sex with either women or men) or heterosexuals (men who have sex only with women or women who have sex only with men). Anyone who has sex with an infected person takes a chance of getting HIV infection". Nourse (2000: 33) also mentions that " there is a high concentration of the virus in blood, semen and vaginal fluid and the linings of the genital areas, when they are not intact, allowing the virus to enter the body. The presence of sexually transmitted infections (STI) increases the chances of transmitting or being infected with the virus. This is because open sores and the presence3 of inflammatory cells (which fight infection) increase the possibility that the virus will be transmitted. Women are more likely than men to be infected with the virus through heterosexual sex, because the lining of the vagina is very receptive to the virus"

- Mother-to-child transmission

Regarding mother-to-child transmission, Nourse (2000: 34) mentions that after sexual transmission, the next most important cause of HIV infection is mother-to-child. The child can be infected with HIV prenatal, at the time of delivery, or postnatal through breastfeeding. Nourse (200:34) also indicate that infection at delivery is the most common mode of transmission. A number of factors influence the risk of Inflection, particularly the viral load of the mother at birth- the higher the risk. A low cd4 count is also associated with increase risk

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- Intravenous drug use with contaminated needles

In this mode of transmission, Nourse (2000:35) indicates that: "the infection can be spread through needles used by infected person.These needles are likely to carry the HIV and when used by another person, they may transmit this virus in to him or her"

- Infection through blood and blood products

Regarding use of contaminated blood or blood products, Nourse (2000:38) mentions that "this is a very effective way of transmitting the virus directly into the bloodstream, blood bank seeks to discourage those who might be infected from donating blood, and they have the technology to test all donations. However, because of the window period, when people are infected but the antibodies are not detectable the risk of infection cannot be eliminated entirely. Sometimes HIV can be transmitted when an infected blood is passed directly in to the body these can occur when an uninfected person has an open wound which comes into contact with infected blood".

Mather (2002: 16) also mentions that HIV might be transmitted through other modes of transmission, namely:

- Medical or other instruments that are contaminated can transmit the virus. Examples include dental equipment, syringes and tattoo needles. however, standard sterilization procedures should ensure that this does not happen;
- Accidents through needle stick injury or surgery are a concern for medical staff,
- The virus is found in all body fluids including tears, saliva and sweat, but the quantities are minute and risks of transmission are minimal.

There can be no prevention of HIV transmission without maintenance of behavior that will protect children and other people. The only way of ensuring this is through education, regardless of the circumstances, the age of the individual, and the nature of the intervention. Having discussed the transmission of the disease, it is now necessary to discuss other factors promoting the spread of HIV/AIDS. (Mather, 2002: 16)

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2.7.1 Factors promoting the spread of HIV infection

2.7.1.1 Illiteracy and lack of knowledge about HIV/AIDS

Children should be provided with knowledge that will inform them about the basic facts of HIV/AIDS, i.e. how it is transmitted and how it can be prevented. Due to the lack of knowledge about HIV/AIDS, the disease is still a matter that brings shame and judgment on people. In supporting this idea, Pick (2003: 43) indicates that: "there is presently no vaccine or cure for HIV/AIDS, the most effective way to slow down the spread of HIV, is to reduce the rate of transmission from infected to uninfected people. The first step towards lowering a person's risk of becoming infected is providing knowledge and awareness of HIV. Knowing about and practicing safer sex is the best way of remaining HIV negative, since the most common way of being infected with HIV is through sexual intercourse".

The above is true. Awareness and information on related issues in the HIV/AIDS field within the spectrum of cultural background, age and gender remain important. Health professionals, HIV/AIDS counselors and educators are well positioned to educate children about HIV/AIDS. It seems that education programs on HIV/AIDS should go beyond just providing information through campaigns. It should also aim to provide people with skills that can help them adopt behaviors that will protect them from HIV and STI's, e.g. negotiation and assertiveness skills. It is also imperative that educational programs on HIV/AIDS be ongoing rather than a once-off or annual training course. This allows the effectiveness of the programs to be monitored as it takes place and the content to be changed as necessary. It also keeps people thinking about HIV/AIDS, so the issue remains accepted and visible in the communities. Mather (2002: 7) emphasizes that: "the more you know about HIV/AIDS, the more you can protect yourself, your family and friends".

A substantial number of cases of HIV/AIDS infection are due to illiteracy. Children with more knowledge about HIV/AIDS are expected to live healthier and more productive

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lives. This is supported by Mather (2002: 89), when he states that: "better educated children have greater access to HIV/AIDS information than those who are not. Educated children are more likely to make well informed decisions and act on that information. In addition, educated people generally have better jobs and greater access to money and other resources which can help them to live better lives".

2.7.1.2 The presence of Sexually Transmitted Infections (STI'S)

According to the World Bank report (2004: 99), sexually transmitted infections are diseases that one can contract from someone who is already infected with the disease. These diseases can cause severe illness, sterilization and even death in the case of HIV/AIDS. Michele (2000: 50) writes that: "the presence of STI's, particularly utters and discharges, will greatly increase the odds of HIV infection". This implies that the presence of STIs indicate that there is a bigger chance of the skin or membrane being broken, thus allowing the virus to enter the body. Furthermore, the very same cells that the virus is seeking to infect will be concentrated at the site of the STI, because these cells are fighting the STI infection. Michele (2000: 51) also mentions the following types of STI's that contributes to HIV infection:

- Herpes. According to Michele (2000: 51), this disease is chronic and has no cure. Symptoms of herpes are flu, mouth sores, itching and burning genitals. Herpes sufferers get small painful blisters on the sexual organs and mouth. The itching and burning usually occur before the blisters actually appear. Sufferers can get a slight fever and experience pain when urinating. Herpes can also be spread to new born babies during a vaginal birth. If the mother has herpes sores during child birth, the baby must be delivered by a caesarean section.
- Chlamydia. It is a bacterial infection treated with antibiotics. the disease causes girls to be unable to have children"
- Genital wants this STI is a virus boys usually have small bump all over penis, scrotum or in around the rectum. girls usually get the small
- bumps in or around the vagina, or on the opening to the uterus (cervix)
- Gonorrhea this is a bacterial disease, treatable with penicillin. the disease produce

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a thick yellow or white discharge from the vagina or penis

- People experience burning or pain when urinating. Girls may have painful periods or cramps in lower pelvic area.
- Sexual organs may become red and itchy. If not treated, this disease can heat trouble, infertility, skin disease, arthritis and blindness.

Syphilis is caused by bacteria and is treatable with large doses of antibiotic. The disease has three stages namely:

Stage 1: during this stage painless red dish brown sore appear on the mouth, genitals or rectum

Stage 2: a rash appears anywhere on the body, with a fever and sore throat during these stage flu symptoms, weight or loss may occur.

Stage 3: at this point the disease has spread to the brain or heart the disease can be spread to unborn babies, and they die at berth. The disease can also cause heart disease, brain damage, blindness and death

Vaginitis. this is yeast infection. Symptoms of the disease are yellow, creamy discharge in the underwear, bad odor from the vagina itching genitals when urinating and a discharge running on the clothes

Pelvic Inflammatory Disease (PID). Symptoms of the disease are severe pelvic pains, bad odor from the vagina vomiting and tight and painful abdomen. The disease usually spread to the ovaries, causing the inflammation

Hepatitis B. this is the disease that causes cirrhosis and it sears the live permanently disease is a hundred timed more contagious than HIV. The diseases spread by infected blood or body fluids and through cuts or sores in the mouth or sex organs. Hepatitis B can also be contracted from sharing razor blades or needles during drug use only use a blood test can show that the disease is present. Symptoms of the disease are jaundice, nausea, tiredness and darkened urine.

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From the discussion of the different types of STIs cited above, it is evident that there is a link between STIs and HIV/AIDS. Although STIs can be treated by injections or pills, they are sometimes hard to cure. It is very important for children who have STIs to get the best treatment as soon as possible. Children should be taught to avoid self medication, treatment by untrained personnel and sexual practices that increase risk. The early and correct treatment of STI is an important weapon in the armory against HIV transmission. STIs can cause HIV/AIDS to spread faster. (Michele, 2000)

2.7.1.3 Gender inequality and female subordination

Throughout the world, gender inequalities are a major driving force behind spread of HIV. Stewart (2002: 16) claims that. "It is the inequalities in relationships that often make people unable to act according to what they know". According to McGeary (2001: 33), "gender inequality has been identified as the number one obstacle to women protecting themselves from HIV infection". This indicates that gender based inequalities often overlap with other social, cultural, economic and political inequalities between men and women. The different attributes and roles that societies assign to males and females profoundly affect women's ability to protect themselves against HIV infection. (McGeary, 2001: 33)

Black women living in rural areas in particular are the most adversely affected by HIV/AIDS. This does not always translate into safe sexual behavior that will reduce the risk of HIV infection. Conditions of poverty, patriarchy and violence seemingly seal their vulnerability to and powerlessness against HIV/AIDS. Many women, not only in Limpopo Province but all over South Africa as well, face the risk of abandonment and abuse, if they disclose their HIV status. Women also find themselves discriminated against when trying to access care and support after they have been infected with HIV (Employment Equity Act 1998:5).

Sometimes, men are more likely to be admitted to health care facilities. Family resources

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are also likely to be devoted to buying medication and care for sick males than females. "Men may also have difficulty accessing HIV/AIDS services because these services are typically located in health facilities that are primarily aimed at women, such as antenatal and family planning clinics" (UNAIDS Report 12, 2001). In most cases, the burden of caring for sick relatives rests mainly with women and girls. As the impact of HIV/AIDS grows, girls tend to drop out of school in order to cope with the tasks of caring for siblings and sick parents. Women traditionally provide care, especially in single parent households or when one parent has already died. Widows may become dependant on a husband's male heir for economic support under customary legal arrangements, which may increase their vulnerability to HIV. Women and children should be empowered to seek justice, knowledge and fair treatment. Simultaneously, the role of men and young boys needs to be investigated to diminish the impact of cultural misconceptions in relations leading to rape, unsafe sex, coercion and violence against women. (McGeary, 2001)

2.7.1.4 Poverty

The persistently high levels of poverty impact on children in particular, leading to stunted growth and high levels of child and infant mortality (Manaka 2002). In rural areas, subsistence farming on marginal lands in the absence of expandable income to buy adequate food supplies is also related to poor nutrition of infants, children, pregnant women and breastfeeding mothers. This situation contributes to the spreading of HIV infection. In Limpopo Province, it is especially the poor that suffer the negative health effects of a subsistence lifestyle, whether in rural or urban areas. (Manaka 2002)

Kelly (2000: 11) indicates that: "HIV/AIDS aggravates poverty; it does so by thrusting households back on ever more limited resources, reducing employment opportunities inhibiting economic growth because of loss of skilled human resources, and the use of resources for consumption rather than investment". Mather (2002:114) also supports the notion that poverty is one of the factors contributing to the spreading of HIV/AIDS, by saying that: "it is poverty that forces poor women and young girls into prostitution, thus

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placing them at high risk for unwanted pregnancies, HIV infection and AIDS". This is supported by Nourse (2000: 145), when he stresses that the "sugar daddies" phenomenon means that young girls render sexual favors to affluent men known as "sugar daddies" in exchange for money and other material goods. Men and girls both become carriers of HIV and they in turn spread the virus.

The Doctor responsible for running HIV clinic in a Johannesburg hospital, Doctor Howard Sacho, indicated in the Sowetan Newspaper (24 June 2003) that: "the AIDS epidemic is leading to increasing poverty and whenever poverty increases, children's health get worse. When poor children get sick, they may not get adequate treatment because their caregivers cannot afford transport charges and medication cost". According to Sacho, orphanage girls from poor households are vulnerable to HIV infection because of sexual exploitation by relatives or neighbors. Sometimes, they may have to work as prostitutes to earn money to feed or educate the children in their care. Sacho concluded by saying that: "the principal cause of prostitution is undeniably poverty, compounded by a combination of factors such as poor education, family background characterized by neglect and poor socialization".

From what has been mentioned above, it is clear that HIV/AIDS pushes people deeper into poverty. Households loose their breadwinners to the disease, and livelihoods and compromised savings are consumed by the cost of health care and funerals. The implementation of a provincial poverty eradication strategy to address the impact of HIV/AIDS should be of the highest priority in Limpopo Province, not only to address the impact of the epidemic, but also to curb the spread of HIV infection. (Sowetan Newspaper, 24 June 2003)

2.7.1.5 Social norms and cultural practices

Factors that increase the vulnerability of girls and women to HIV include social norms that deny women sexual health knowledge. Some cultural practices prevent them from controlling their bodies or decide the terms on which they have sex. In some of the rural

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areas in Limpopo Province, women are still brought up to be subservient to men, especially in matters of sexual relationships. Even when a woman wants to protect herself from HIV, she is often confronted by an entrenched culture of male dominance that renders her powerless. For instance, in many cases it is common for men to beat their female partners when the latter refuse intercourse or request a condom (Manaka 2002).

In supporting this idea, McGeary (2001: 110) mentions that:" social norms in many African communities apparently dictate that real men do not use condoms, so women who want their partners to use condoms often have to fight deeply ingrained taboos. Even when women know what their partners might be at high risk of HIV infection, many do not raise the issue of condoms, because doing so would 'impugn their husband's manhood'." this is true and common among black communities. lobola, a long standing tradition in the African communities whereby men "purchase" a wife by paying her family a dowry, makes it almost impossible for women to leave their husbands, as this would require the fathers to repay the dowry. (McGeary, 2001)

Jackson (2002: 134) points out that harmful cultural practices and traditions that were adaptive and fulfilled important functions in the past may today carry serious health and welfare risks with regard to HIV transmission. These are summarized as follows:

- The practice of levirate (inheritance of a wife by the deceased husband's brother), where the women is supposed to become the brother's wife even though her husband may have died of AIDS;
- Initiation rites in parts of Malawi, which involve adolescent girls being secluded for training to be a wife. this training includes having sex with anonymous man selected from the community;
- Polygamy, which is particularly risky if men are allowed to have many girlfriends while seeking further wives without using condoms;
- The view that a boyfriend must use force in the first sexual encounter with a new girlfriend. The fact that the girl is not aroused, increases the risk of tearing and hence HIV infection.

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Jackson (2002: 135) further indicates that there are various myths and incorrect information that can lead to the spread of HIV, such as:

- The belief that wives cannot contract STIs from unfaithful husbands, because STIs do not affect "nice" woman;
- The belief that the first sexual act with a new partner cannot cause pregnancy or HIV infection;
- Fears that condoms actually spread HIV, or that they can become stuck in the vagina.

In combating these negative cultural norms, it is imperative to educate children to refrain from high risk behavior such as multiple partners and unprotected sex.

2.7.1.6 Sexual violence, child abuse and exploitation of women.

In Limpopo Province, there is growing evidence that a substantial number of new cases of HIV infection is due to sexual violence in homes, schools, workplaces and other social environments. In the province, the proportion of women who report physical assault by an intimate partner varies from 5% to more than 10% (Limpopo Department of Safety and Security Report 2003). Physical violence the threat of violence and the fear of abandonment act as significant barriers for women who have to negotiate the use of a condom or leave relationships that they perceive to be physically unsafe. This dramatically increases their chances of acquiring HIV (Manaka 2002). This is supported by Louw (2002: 36) when she states that:" domestic violence reduces women's control over their exposure to HIV. In settings where violence is regarded as a man's right, women are in poor positions to question their husbands about their extramarital encounters, negotiate condom use or refuse to have sex. Sub service in marriage, often reinforced by violence, can compromise women's ability to protect them against HIV infection". This is true. Women are sometimes reluctant to report sexual violence. Even when it is extremely common in the community, they take no action. Some of the women are shy to report sexual abuse cases because some might be raped by a family member or relatives. (Louw 2002: 36)

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A growing number of sexually exploited children have contributed to the spread of HIV infection among this population. HIV/AIDS is regarded as one of the major causes and consequences of the sexual exploitation of children, because of the dangerous myth that says "sex with a virgin will either cure or prevent AIDS". This has contributed to the spreading of the disease. A report in the Limpopo Child Protection Unit's (SAPS) publication (2003: 9) also highlights child abuse and its links to HIV/AIDS. In the report it was indicated that according to cases received in the year 2004, the number of sexually abused children has risen. Forty percent (40%) were girls under three years and 60% were under ten years. Ninety percent (90%) of perpetrators were biological family members and only 10% were strangers.

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From what has been said above, it is clear that young women and girls face a greater risk of HIV infection because they are perceived to be free from HIV infection. In order to address this situation, the government, private sector and communities, in partnership, should increase the visibility of violence against women and children.

2.7.1.7 Rape

Rape and gang rape have become extremely potent methods of spreading HIV in Limpopo Province. considering the high prevalence of HIV in Limpopo Province, the high risk sexual behavior of rapists, the high levels of violence against rape victims, and the risk of acquiring HIV transmission, since the victim is more likely to bleed as a result of being forcibly violated (Manaka 2002). In supporting this idea, McGeary (2001: 82) indicates that: "women raped suffer not just immediate physical injury and the risk of pregnancy, but are also exposed to a higher risk of HIV infection and other sexually transmitted infections than they would be through other unprotected sex. Not just because rape can result in torn tissue and hence create an easy entry point for HIV, but because rapists have higher risk of being infected"

The above implies that rape and HIV go hand in hand. If a woman is raped, she is already

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at risk of HIV infection because rapist does not come to her with a condom. In fact, the woman is not in a situation where she can easily negotiate using a condom because she is not in a relationship. Finally, it is important to realize that rape can happen to anyone, regardless of age, income, appearance or personal reputation. It is true majority of rape victims are single women and children. However, there is no way to predict which women are likely to be selected as victims. The one common element is that rape is a frightening and degrading experience, and victims require a period of time to recover (Louw 2002).

2.7.1.8 Teenage pregnancy

Teenage pregnancy and birth rate are unacceptable high in Limpopo province, and they show a steady increase in black communities
(Department of Health 2000:10). Teenage pregnancy indicates the non-use of condoms and this can also be associated with the transmission of HIV. This problem can be viewed in the context of poverty and unemployment, because some of the orphans have no-one to look after them and they turn to prostitution for survival. Aggravating the problem, is the fact that condom use as a contraceptive method is very low and inconsistent amongst the youth (Department of Heath 2003).

It seems that poverty causes adolescents to face health risks of child bearing unintended pregnancy and parenthood, sexual coercion and exploitation, STIs and HIV infection. The high rate of teenage pregnancies calls for HIV and AIDS awareness campaigns that emphasize, condoms use and the need for family planning. At the same time and of equal importance there is the need for programs aimed at addressing esteem issues that drive adolescent girls to become pregnant to confirm their woman rights of many teenage girls are infringed through acts of sexual violence and exploitation. (Department of Heath 2003)

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2.7.2 Other important information that children should know about HIV/AIDS

2.7.2.1 Factors that do not cause HIV/AIDS

HIV/AIDS is a condition that continues to generate fear, misunderstanding, misinformation and discrimination. Children should be taught that there is no need to unfairly discriminate against children living with HIV/AIDS, since there are other factors that do not cause the disease.

According to the Department of Health (1999: 11), "HIV/AIDS cannot be transmitted in the following ways:

- Casual contact: scientific studies have proved that HIV infection is not spread by casual, everyday contact with an HIV infected person. A person cannot catch the disease by simple skin contact such as handshaking, hugging, touching. A person cannot catch the disease by riding a bus with an infected person or sitting beside him. the virus does not live very long outside the body;
- The disease cannot be spread via airborne routes such as coughing, sneezing, laughing or talking;
- The disease cannot be transferred in food, water, or eating utensils, on tools or machinery or from baths basins, towels or toilet seats;
- The virus is also not found in respiratory droplets, or floating in the air around an infected person. Saliva and tears contain minute amounts of the virus but not enough to cause infection unless these body fluids also contain blood;
- Mosquito bites: HIV infection is not spread by mosquito bites, or by any other kind of insect bites. No-one has ever found any sign that mosquitoes can spread the disease.

The virus is not present in high enough quantities in the urine to cause infection, unless blood is also present.

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2.7.2.2 Confidentiality and HIV/AIDS counselling

Manaka (2002: 66) states that: "confidentiality means not disclosing private or personal information without consent. Confidentiality of medical information about people living with HIV/AIDS is important because of the risk of stigma and discrimination in respect of HIV/AIDS". according to the Department of Health (June 2003:4),"privacy over health matters is human right and a fundamental principle of ethics of medical practice however even without consent information can be disclosed to third party in the case of specified modifiable diseases under Public Health Act where appropriate public health intervention can be applied" excessive emphasis on the issue of confidentiality, all the potential advantage and disadvantage of disclosing HIV must be discussed. Shared confidentiality on medical information about one's HIV status may be shared with a spouse or partner and caregivers has been recommended (Nursing Update 2003).

Williams (2000:20) assert: "counselling is vital component of HIV/AIDS prevention control and care it is an interpersonal interaction between the counselor and the client that enable the client to deal with and make information decision about his\her situation" Williams (2000:20) also mention that that :"HIV counselling has two main functions that often interrelated. The first function is to offer psychological and social, support to enable those infected and affected by HIV\Aids to deal with a wide range of emotional, social, economic and medical problems the diagnosis of HIV infection or the realization that one has been exposed to HIV infection has emotional and social and medical consequences. The second function of counselling is to enable the concerned person to prevent HIV infection". This is done to help people so that they assess and understand risky lifestyle and define their potential for behavior change. Dalrymple (2000:16) states that in order to overcome of the problem associated with HIV testing and the traumas of receiving a positive HIV test it is necessary to counsel an individual adequately before the test counselling should determine. First where there is indeed any need for the HIV test to which he/she will tell the result of the test who will be available for emotional support, will the sexual partner be told and so on". Dalrymple (2000:17) also emphasizes that "pre-test counselling and post-test counselling is very important in helping the client to

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understand and cope with the HIV test results" People should be encouraged to go for HIV counselling before and after testing for HIV.

2.7.2.3 Testing for HIV

Children should be taught about various tests that have been identified for use in HIV testing. According to Manaka (2002:66). "HIV testing is the only certain way to tell if a person has been infected with HIV or not. An HIV test detects antibodies to the virus blood. Antibodies are produced by immune system in response to infection within the virus. If there are no antibodies the person is antibody negative (seronegative or HIV negative)"Manaka (2002:52-53) mention the following three different tests used in South Africa and they are summarized as following:

ELISA TEST

The Elisa test is most widely used by public and private hospitals/clinics to test for HIV. It tests for the presence of antibodies (an immune system response) to HIV.

An Elisa card test (resembling a home pregnancy test) should be treated as purely as a screening test. Results should be confirmed with a doctor.

The Elisa laboratory test has a 99, 9 % validity rate; that is, about one in every 100 results is wrong.

HIV tests are much more reliable and accurate than tests for most other infectious disease like tuberculosis, malaria and measles.

POLYMERASE CHAIN REACTION (PCR) TEST

The PCR test is used to check other results or when specifically requested by a patient. It detects the specific genetic material of HIV and amplifies it. Detection is as early as ten

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days after infection and will pick up the virus consistently from then on. It is therefore the best available test for HIV.

The PCR is the most accurate test and does not require a confirming test. However, the PCR test costs about R320 as opposed to R30 for the Elisa test, in the public sector. The private sector charges more for both tests, i.e. about R407 for a PCR and over R100 for an Elisa.

WESTERN BLOT TEST

This is an expensive and time - confusing test, which involve filtering the patient's blood for specific viral proteins. The western blot test re-valuated for a number of reason. It is technically demanding, in inexperienced laboratories it is difficult to standardize, different laboratories have different ways of determining results and it is expensive (about R400 in the private sector) the new generation of enzyme immunoassays are at least as sensitive as western blot, much cheaper, and not as subject to observer bias, and would therefore be more economical and more beneficial for HIV diagnostically purpose in developing countries.

People in their communities should be encouraged to go for HIV testing, so that they can be in a position to know their HIV status. People should not take the wait and- see attitude in knowing their HIV status. One thing is certain as HIV infection spreads, it will be more important to find quick, inexpensive ways to detect it as early as possible. This is true for two reasons. Firstly, the earlier an infection is spotted, the earlier it may be slowed down by new treatment. Secondly the earlier it is spotted, the better chance there is to prevent its spread and keep blood banks free of infected blood. (Manaka, 2002:52-53)

2.8. HOW CAN HIV INFECTION BE PREVENTED IN SECONDARY SCHOOLS.

HIV/AIDS are spreading like a veld fire, and that prevention is the only way to defeat the

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disease. Edwards (2002: 10) write that: "AIDS is the most democratic thing in South Africa. It takes no sides. Anyone can get it, But the good news is everyone can prevent it by being careful, informed and aware". This implies that, although there is no cure for IDs, the disease can be prevented

2.8.1 Important information that children should know about prevention of HIV/AIDS

Van der Merwe (2002: 62) mentions that HIV/AIDS could be prevented in three primarily ways, namely:

- Abstaining from sex;
- Practicing safe sex;
- Staying in a monogamous (having just one partner) relationship.

2.8.1.1 Abstaining from sex

According to Van der Merwe (2002: 62), "abstinence means having no sex at all and is the only real safe method."

2.8.1.2 Practicing safe sex

Van der Merwe (2002: 62) indicates that: "practicing safe sex means using a latex condom every time when a person is involved in sexual intercourse, including vaginal, oral or anal sex". Van der Merwe (2002:62), further states that: "condoms provide a barrier to the virus, and if properly used are effective. There are both male and female condoms available. However, because many men refuse to wear condoms, female condoms represent an important alternative as a safety measure for women". Van der Merwe (2002: 62) emphasizes that using a condom during sexual intercourse is important, because the vagina or anus could have a tiny cut or tear where blood can seep through. Concerning the correct use of male condoms Van der Merwe (2002: 62) mentions the following points:

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- Check the expiry date, and make sure that the condom is SABS approved;
- Unroll it over an erect penis all the way down to the end;
- Leave a little space at the tip for the semen to be caught;
- After ejaculation, hold on to the condom until it is completely out of your partners body to avoid spilling semen;
- After that throw it away, it can only be used once;
- Female condom: the woman inserts the condom into her vagina, thereby preventing any contact with semen or vaginal fluid.

2.8.1.3 Staying in a monogamous relationship

Van der Merwe (2002: 64) indicates that staying in a monogamous relationship means having a long-term relationship with a faithful uninfected partner. in supporting this idea, Louw (2002: 200 states that another approach to safe sex is "outer course". this means caressing, kissing and massaging someone on the outside of the body, with no penetration and no exchange of body fluids. for those who are already infected and affected by HIV/AIDS, Louw (2002: 21) stresses the following points:

- It is very important for people living with HIV/AIDS to protect themselves and others. If they are not careful, they can become re-infected by someone else who is HIV positive. This can weaken the immune system further and can be harmful to them. for the best intersect, and to safeguard others, people living with HIV/AIDS should avoid the transmission of the virus at all costs;
- People living with HIV/AIDS should also seek immediate medical attention if they fall sick, to prevent the onset of complications such as pneumonia and other diseases;
- A sensible diet can help delay the progression to full blown AIDS among people living with HIV. It is important for them to eat healthy food that will boost their immune system.

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2.8.1.4 Altering sexual behaviour

According to Whiteside and Sunter (2000: 19), "altering sexual behavior is the second set of interventions that seek to prevent people from being exposed to HIV. These are the knowledge, attitude and behavior interventions". This indicates that first; people need to have knowledge, then change their attitudes and finally alter their behavior. The problem is that even if people have the knowledge, they may not have the incentive or power to change their behavior. (Whiteside and Sunter, 2000: 19)

2.8.1.5 Practicing universal precautions

Louw (2002: 20) defines universal precautions "as means and ways of preventing the transmission of HIV, and a set of internationally agreed upon steps that can be taken to prevent cross infection". Practicing universal precautions will always protect children from being infected with HIV. Information concerning universal precautions is summarized as follows:

- Sometimes HIV can enter the body through sores, deep cuts or thin membranes;
- If someone is helping a bleeding person, he/she must cover any cuts and sores with waterproof plasters;
- Avoid touching people's blood and pus;
- Use rubber gloves or cover the hands with plastic bags when helping a bleeding person;
- Wash the hands with soap after you've been in contact with blood or pus;
- Blood spills on floors or other surfaces should be treated with a disinfectant (e.g. bleach) before being wiped up with absorbent paper;
- Clean blood stains off clothes and fabrics by rinsing the blood off, and then washing them normally;
- Do not share toothbrushes, blades or other sharp objects that could have been in contact with blood;
- A first aid kit should be always available and contain the following:

- Four pairs of latex gloves (two medium, two large);

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- Four pairs of rubber household gloves;
- Materials to cover wounds, cuts or grazes, waterproof plasters', disinfectant (e.g. household bleach), scissors, cotton wool, tape for securing dressing, antiseptic (Dettol or Savlon);
- A mouthpiece, for mouth-to-mouth resuscitation.

From what was said above, Children must be taught the means and ways of protecting themselves from HIV/AIDS. In most cases, HIV infects the sexually active population. This implies that children need to be well informed about AIDS, so that they can clearly understand how the virus can be prevented. Children in the communities also need to be provided with skills that can help them adopt behaviors that will protect them from HIV infections. Children need to be well informed about the necessity and advantages of using a condom.

2.8.2. Implementation of universal precautions as a way of preventing HIV in secondary schools

Principals have to ensure that universal precautions are applied in their schools. The National Policy Act (No.27 of 1996) provides for the implementing of universal precautions in schools. Professor Kader Asmal emphasized that: "The MEC's should make provision for all school and institution to implement universal precautions to eliminate the risk of transmission of all blood–bone pathogens, including HIV, effectively in the school or institution environment". Universal precautions are summarized as follows:

2.8.2.1. Blood Transfusions and Blood Products

- Every fist aid kit should contain rubber gloves and these should be worn at all
- Times when attending to a person who is bleeding from injury or nosebleed;
- Anyone who cleans blood from the floor should wear gloves;

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- If there are no gloves available , plastic shopping bags can be out on the hands as long as they have no holes,
- All learners should be taught not to touch blood and wounds, but to ask for help from a member of staff if there is an injury or nosebleed.
- If a learner is bleeding, the first action must be try to stop the bleeding by applying pressure directly over the area with the nearest available cloth or towel.
- If the learner has a nosebleed, he or she should be shown how to apply pressure to the bridge of his/her nose himself/herself.

2.8.2.2. Cleaning wounds

- Once the bleeding has been stopped, the injured learner should be helped to wash their grazes or wounds in a clean water with antiseptic;
- Wounds must be covered with a waterproof dressing or plaster; and
- Learners and educators must learn to keep all wounds, sores, grazes or lesions covered at all times.

2.8.2.3. Managing accidental exposure to another person's blood, or exposure during injury

- Skin that becomes exposed to blood must be cleaned promptly;
- Cleaning should be done with clean water

2.8.2.4. Cleaning contaminated surfaces and materials

- Educators must ensure that contaminated surfaces or floors are cleaned with bleach and water;
- Bandages and cloths that become bloody should be sealed in a plastic bag and incinerated (burned to ashes);
- Any contaminated instrument should be washed, soaked in bleach for an hour and dried; and

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- Educators must ensure that toilets are clean, hygienic and free from blood spills.

2.8.2.5. Disposing of sanitary towels and tampons

- Every school must ensure that there are arrangements for the disposal of sanitary towels and tampons. All female staff and learners must know of these arrangements so that no other person has contact with these items.

2.8.2.6. Prevention of HIV during sports

- First-aid kits with rubber gloves should be available during every sport session;]
- No-one should play a sport with uncovered wounds or fresh injuries;
- If a graze or injury occurs during play, the injured player should be called off the field, given first aid, and only allowed back with their injury clean and covered;
- Blood stained clothes should be changed; and
- Educators and learners with HIV are advised to discuss with a doctor any possible risks to their health and of transmission during sport.

Educators should emphasize the fact that HIV is never transmitted through casual. They are supposed to teach learners on how HIV/AIDS cannot be transmitted to alleviate fears among learners. Educators need to explain that it is difficult for learners of any age to get HIV from everyday social contract at school. Therefore, the risk of infecting other children cannot be used as a reason to exclude children with HIV from a school. Peer education strategies in the prevention of HIV should be implemented in secondary schools. School learners should also be encouraged to play dramas in AIDS education that will spread messages of HIV transmission and prevention. Learners should always be taught not play with razors or injections, and also not to touch someone's wounds or blood.

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2.8.3. Practical aspects of prevention programmes

The purpose of HIV/AIDS education is not only to disseminate information, but also to change attitudes and behavior, to equip people with the necessary life skills, to empower them to prevent the spread of HIV infection and to help them care for people who are already infected. The following practical aspects should be kept in mind when developing HIV/AIDS prevention programmes (based on UNAIDS, 2000c, 2002; Van Dyk, 1999, WHO 2000A):

National support

HIV/AIDS prevention programmes can be successful only if they are backed by political will and leadership. No prevention programme can be successesful without the support, Commitment and high – profile advocacy of a country's leader. A single comprehensive, powerful national AIDS plan involving a wide range of role players ranging from government to the private sector is necessary. Successful programmes should impart knowledge, counter stigma and discrimination, create social consensus on safer behavior, and boost HIV prevention and care skills. These can be cost–effectively accomplished though peer or outreach education, through life skills programmes in schools and workplaces, and by ensuring that voluntary counseling and HIV testing are available.

Partnership

Partnerships are essential for effective prevention programmes. Because multiple programmes in multiple populations are needed, it is crucial to create partnership between different role players and stakeholders, including people with HIV/AIDS.

Peer support

Behavior change is most likely if peers educate and support each other. Youth programmes run by the youth, or programmes run by groups that comprise street

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children, injection drug users or refugees, are all extremely effective in promoting practices and behavior leading to reduction of HIV transmission. Sexual practices, drug – taking and other risk behaviors are much more likely to be openly discussed, explored and understood within such safe group environments.

Peer education programmes both empower and educate people. According to Harrison et al. (2000:287), a successful peer education programme transfers the control of knowledge from the hands of experts to lay members of the community, thereby making the educational process more accessible and less intimidating. Peer educational process more accessibility and less intimidating. Peer education also allows group debate and the negotiation of messages and behaviors that lead to the development of new collective norms of behavior rather than attempts to convince individuals to change their own behavior on a basis of rational decision making.

All over the world there have been powerful examples of the success of peer involvement in preventing strategies. Peer counseling has, for example, been very successfully applied by the South African mining companies. Willing and enthusiastic people should be identified and then trained to work as care professionals, teachers and religious leaders can play an important role in facilities the formation of these groups and in facilitating the formation of these groups and providing expert knowledge where necessary.

Involving people living with HIV / AIDS

People living with HIV/AIDS are often the best advocates and activities for social behavior change and they should be included in the developmental and implementing stages of HIV/AIDS prevention programmes. The personal story of someone living with HIV presents a powerful message. These messages can mobilize people and recourses and so initiate successful prevention programmes. The personal story of someone living with HIV presents a powerful message. These messages can mobilize people and recourses and so initiate successful prevention programmes. Involving people living with HIV/AIDS in prevention programmes in their own communities helps to ensure that the

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programmes are relevant and meaningful to the community or population group in question.

Cultural, religious and social sensitivity

There is no standard programme that will be meaningful, relevant and effective for all people in all times and places. Preventions programmes must be contextualized so that they are sensitive to local customs, cultural practices and religious beliefs and values, as well as to other traditional norms and practices. Traditional African beliefs and customs should be taken into account when developing HIV prevention programmes.

Facilitating empowerment

Empowerment can be facilitated by involving and encouraging individuals, groups and communities to address their own health and to find solutions to their own problems. People who are empowered to come up with their own plans and solutions are likely to implement effective HIV prevention programmes. Individuals (especially women in disadvantaged position, and young people) should be empowered by being taught communication skills, a negotiation skills, assertiveness, decision making strategies , self efficacy, life skills and the basics of complement sexual behavior, problem solving and conflict resolution. Although the personal and social disempowered of women in Africa is often emphasized (and is indeed sometimes a serious problem), the inherent strength and autonomy of African women, especially in women's groups (where such qualities are more than evident), should not be overlooked by health care professionals working in Africa. Ulin (1992) commented that rural African women have always been able to mobilize and organize themselves informally to meet the need of their communities by making the best use of the advantages and opportunities for solidarity of women in rural African communities may be their greatest source of strength for coping with the AIDS epidemic.

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Condom distribution

Condom distribution should be an important component of any HIV prevention programme. Condoms should be easily accessible to men and to women. They should be available and distributed in places where people will feel a maximum senses of privacy and a minimum of embarrassment – through self – services (i.e. where people can simply help themselves to however many they need) in clinics , hospitals , factories mines and bars and on campuses/condoms should also be distributed free of charge if possible, health care professionals need to know where free condoms are available and they should keep a supply themselves, if possible .

A holistic approach

Counseling, education, support and care services and resources should be combined to provide a holistic continuum of HIV prevention and care.

2.8.4. The role of educators in decreasing the spread of HIV in secondary schools

There are several things that educators need to do in decreasing the spread of HIV secondary schools. The HIV/AIDS Emergency Guidelines of Educators (2000:1) call for a concerted "struggle" against the pandemic by all organs of society, for openness, for recognition of the dignity of those who are infected, and care for those who are affected by HIV/AIDS. It sets out the role of educators, namely:

- Exemplifying responsible sexual behaviors;
- Spreading correct information on HIV/AIDS;
- Leading discussions on HIV/AIDS among learners and parents;
- Creating a work environment that does not discriminate against those who are infected or affected;
- Supporting their ill colleagues and learners; and

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- Making the school a center of hope and care in the community.

The HIV/AIDS Guidelines for Educators (2000:2) target male educators especially and stresses that male educators have a special responsibility. It is mentioned that: There must be an end to the practice of male educators demanding sex with school girls or female educators. It shows be an end to the practice of male educators demanding sex with school girls or female educators. It shows selfish disrespect for the rights and dignity of women and young girls. Having sex with learners betrays the trust of the community. It is also against the law. It is their responsibility to help the young ones protect themselves from becoming infected. Educators are supposed to play their part in the struggle against HIV/AIDS and secure a shining future for this and the next generation.

Edwards (2002: 89) mentions some of the guidelines that will help educators in ensuring that all learners (HIV infected or not) are not exposed to unnecessary HIV infected. These are:

- Making sure that all learners immunizations are up to date;
- Making sure that water is for drinking and food preparation;
- Making sure that universal precautions (means and ways of preventing HIV and infection) are implemented in the school ;
- Keeping the school environment in clean and hygienic condition ; and
- Maintaining optional health and hygiene.

Manaka (2002: 110) argues that HIV / AIDS can be prevented in secondary schools by avoiding sexual abuse in children. This can done by teaching them:

- To stay from situation where they feel uncomfortable;
- Never to go home with a stranger or walk in the street alone, nor to go to the fields with a stranger and not to get in the car of the stranger;
- To report cases on sexual abuse;
- Never to allow anyone to touch their genitals;
- Skills on how to protect themselves from sexual abuse / rape; and

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- To avoid dangerous places that might lead to rape.

In the light above, it can be argued that educators have a great responsibility of making sure that those learners who are not infected with HIV remain uninfected. It is also their responsibility to teach secondary school learners not only facts about HIV/AIDS, but also survival, protective and behavior skills that will protect them from STI'S and HIV infection. All secondary schools should implement the HIV/AIDS programs. Learners who have already been sexually abused or infected with HIV must be assisted to prevent further abuse or infection

2.9 TEACHING OF HIV/AIDS IN SECONDARY SCHOOLS

Education is one of our most powerful weapons against HIV/AIDS, it is also a sector that is human resource intensive and therefore most vulnerable to the disease. As the AIDS pandemic ravages, it becomes imperative for countries to rethink education and education systems in order to curb the onslaught of the disease. Kelly (2000a) argues: 'education in a world with AIDS must be different from education in an AIDS-free world. The content, process, methodology, role and organization of school education in a world with HIV/AIDS must be radically altered. The entire educational edifice must be dismantled.'

The school therefore becomes a crucial site for the battle against HIV/AIDS. The school is most appropriate due to the following:

- Daily contact with learners;
- Staffed by skilled personnel;
- It is the area with the faster growing infection rate and houses the most vulnerable society;
- Schools have the opportunity to reach young children during the 'window of hope';
- It is best located to establish correct practice;
- The position of educators in the community, especially in rural areas, is influential.

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Educators are currently one of the largest occupational groups in the country .they are educated, mobile and relatively affluent, and thus fall into a population category shown to be especially at risk of HIV/AIDS. The incidence of HIV infection among educators is likely to be above that for the population as a whole. Furthermore, recent research has reported that government employees in South Africa (a significant number of who are educators) follow closely behind mining employees, who have registered the highest infection rates. It is estimated that 26% of employees in the government sector will be affected by 2010 and that 17% are already infected (Vally, 2000). This has grave implications for the teaching sector.

2.9.1 HIV/AIDS and education

HIV/AIDS has radically transformed our world. In Africa HIV/AIDS touches all our lives and requires us to shift our boundaries and to transform our world drastically in order to meet this challenge. It certainly cannot be business as usual! Coombe (2000a) indicates the following conclusions and areas of impact of HIV/AIDS and the education system:

- Fewer children will enroll in school because: HIV+ mothers die young, with fewer progeny; the children themselves are dying of AIDS complications; and children who are ill, impoverished, orphaned, caring for younger children, or earning and producing stay out of school.
- Qualified educators and officials will be lost to education through death, illness or departure for other jobs. The capacity of teacher education programmes to keep up with attrition will be undermined by their own staff losses. Rates of enrolment in post-secondary institutions will decline as secondary school output and quality goes down, and as higher education institutions lose academic staff.
- Management, administration and financial control over education system are already fragile, and AIDS may make it even more difficult to sustain the structures necessary to provide formal education of the scope and quality envisioned by the democratic government's policies

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- The costs of illness, burials and death benefits are rising, along with additional costs of educators training. However, financial contributions from parents and communities will decline as poverty deepens and many households will no longer be able to keep children in school. Demand on the state to increase education budgets will intensify.
- Uncalculated psycho-social trauma will overwhelm educators, children and their families.
- At the very least, school effectiveness will decline where a significant proportion of educators, officials and children are ill, lacking morale and unable to concentrate.
- Ultimately, there will be a real reversal of development gains, further develop will be more difficult, and current education development goals will be unattainable within the foreseeable future. (Coombe, 2000a)

2.9.2 The building blocks for successful HIV/AIDS education

HIV/AIDS should never concentrate on the dissemination of information on HIV and AIDS alone. To make responsible decisions, a child must have knowledge that is firmly based on healthy values, norms and attitudes, and skills to implement these decisions. For an HIV/AIDS education programme to be successful there should be a balance between knowledge, life skills, values and attitudes. Basic knowledge, attitudes values and skills (not exclusively HIV/AIDS-related) should be established, promoted and reinforced in all the phases of a child's school career. The content, and the way in which this knowledge and these attitudes and skills are taught, should be adapted to the child's age and developmental phase (Edwards & Louw, 1988).

Knowledge

An effective HIV/AIDS education and life-skills programme should provide the following knowledge in a manner that is appropriate to the age of the child:

- How to conduct relationships with significant others, and with friends of the same

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and the opposite sex, and how to cope with strangers.

- How to deal effectively with peer-group pressure.
- What sexual abuse or molestation is, how it can be prevented, and where to find help in the case of actual or attempted sexual abuse or molestation (teach young children to distinguish between different kinds of touching).
- How to use leisure time to creatively and in a way that brings satisfaction.
- How to keep the body safe and healthy and how to avoid harmful behavior (such as sniffing glue, drinking alcohol or taking various kinds of drugs.)
- Adequate knowledge about germs, viruses, HIV and AIDS.
- The ability to identify health problems and seek appropriate help.
- Awareness of the universal precautions to be taken when handling blood.
- How to care for someone at home who is ill (e.g. how to make tea or run errands (a younger child) or how to feed a sick person (an older child).
- How to cope with death in the family.
- Facts about sex, sexuality and gender and sexuality education that are appropriate to age and developmental stage of child. (Edwards & Louw, 1988)

Attitudes and values

The following attitudes and values, which are accepted by all cultures and religious as important for the survival of individuals and communities, should be included in HIV/AIDS education and life-skills programmes:

- Building a realistic, positive self-concept;
- Respect for the self and others as unique and worthwhile beings;
- Self-control;
- The right to privacy;
- The right to protect oneself;
- The right to say no to an older person or someone in authority;
- The right to chastity;
- Loyalty and commitment in relationships;

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- Honesty;
- Taking responsibility for one's actions;
- Respect for life;
- Non-discrimination towards and tolerance of anyone who is different from ourselves;
- Forgiveness;
- Loving and caring;
- Social justice; and
- Friendliness, kindness and sensitivity.(Edwards & Louw, 1988)

Life skills

We should help children develop the following life skills so that they can implement the knowledge, attitudes, values and decisions they make during the learning process:

- Self-awareness;
- Critical thinking;
- Responsible decision making;
- Problem solving;
- Assertiveness;
- Negotiation skills (e.g. negotiating abstinence, the postponement of sexual intercourse and safe sex practices such as using condoms);
- Communication skills (including listening skills);
- Refusal skills (also called 'how-to-say-no' skills);
- Planning for the future: goal setting;
- Conflict resolution;
- Handling emotions (such as fear, uncertainty, anger, etc.);
- Handling failure and coping with related feelings;
- Tolerance towards others whose values, behavior, manners or appearance may differ from your own; and
- A positive self-concept. (Edwards & Louw, 1988)

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For HIV/AIDS education to be successful, it is important to know how children of different ages perceive illness in general and HIV/AIDS in particular. We know that children's perception of illness depends on their developmental characteristics. In order to arrive at a clearer understanding of what we should include in HIV/AIDS education and life-skills programmes, therefore the developmental characteristics of children in grades 10 and12 will be reviewed. (Edwards & Louw, 1988)

2.9.3 HIV/AIDS education programmes, relevance and context

Despite the plethora of information available on HIV/AIDS, infection rates continue to soar in South Africa and there appears to be little change in behavior. Kelly (2000b) links the problem to the way in which different individuals interpret and relate HIV- education programmers' to their everyday reality. He states that a major problem with these programmers' is that their listeners are hearing messages at different levels. Most education programmers' carry a scientific message about physiological causes of the disease and how it is transmitted. This may be a superficial way of dealing with the disease. In order to make the most impact and encourage behavioral changes, these education programmers' must address the personal and cultural issues that motivate individual behavior. Learners are eager and anxious to talk about sexuality. This is because of lack of information available and reluctance of parents to talk to their children about sex. Sex is a taboo topic in most homes and they believe that 'children don't need to know about adult stuff'. In some instances, the parents resist HIV/AIDS education programmers because they believe that the educators are corrupting their children and encouraging promiscuity amongst the learners. Kelly (2000b)

In addition, in some cultures it is the responsibility of the elders to teach learners about sexuality. This unfortunately only occurs in late adolescence when youngsters are already sexually active and these sessions do not include HIV/AIDS issues. In the absence of information, most learners turn to their peers for information, which is usually incorrect or distorted. 'This can be very dangerous; since it perpetuates myths and stereotypes of

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sexuality and HIV/AIDS' many learners believed that they can only get HIV if they had sex with a girl who was menstruating. Since there was blood present, the risk was high!' Furthermore the lack of correct information about sexuality and HIV/AIDS is of particular concern when one considers the escalation of sexual abuse among children. In the process of abuse, many children become infected with HIV and become potential transmitters of infection to their classmates or teachers (Kelly, 2000a). It therefore becomes vital for the school to provide appropriate information because it is not readily available elsewhere. It is equally important that this be done with a clear understanding of the cultural context from which learners come. 'In many instances, the HIV education programmer is biomedical and academic in form. It does not "speak" to the culture of the school community.'

Many people, even if they are educated-including teachers-still hold traditional views of the disease. They get traditional when they don't have answers and modern when it suits them. This view is supported by Kelly (2000a) who states that traditional views are much more influential in the way the disease is interpreted. He points out that in some communities the cause of the disease is understood in terms of the cultural taboos, obligations and sorcery. Many people see HIV/AIDS as something coming from the outside. It is seen as some kind of "spell" that has been put upon them by an enemy with the help of a witch doctor. While others believe that the ancestral spirits are angry with them and are punishing them.

Most educators agree that HIV/AIDS and sexuality education should be an integral part of the school curriculum. However, many teachers have 'no confidence' and are reluctant to teach for some of the following reasons:

- Lack of knowledge and resources
- A culture of silence that shrouds the disease: many educators are afraid of their own status, many educators are afraid to go for life skills training because it will confirm their own fears of being HIV positive. They begin to diagnose themselves. Many educators would rather not know their own status.
- A culture of fear. Once educators become knowledgeable of the disease and begin

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to discuss it openly in their schools, they are then suspected of being HIV positive – 'how come she knows so much about the disease; she must be HIV positive.'

- Language of training. Training is usually conducted in English and educators cannot translate it into other African languages. Some African languages are not adaptable to English terminologies. 'Sometimes when expressing it in our language it sounds too vulgar, so we don't talk about it.' Some of us convey the message in English, but our learners don't understand what we are talking about.'
- Gender. 'It appears that most life skills educators are females. And many of our learners are males. We feel embarrassed to talk about such issues with grown-up boys in the classroom,' reported one female educator. Some of the male learners in the high school think we are sexually interested in them and that's why we are being open about sex and HIV. Some of the older boys start getting "forward with us after the lessons. Others just don't take us seriously.' Said another school educator.
- Educators as role models: many communities are against educators because they see educators getting drunk and having relationships with school girls. These impacts on the effectiveness of educators being implementers of HIV/AIDS programmes and their credibility as role models for learners and members of the community. Furthermore in some instances learners are aware of the HIV status of the educators and openly question the appropriateness of educators as role models, 'it becomes a laughing matter amongst learners in the school.'
- Values and skills: in many instances training workshops are mere "talk-shops" with the trainer attempting to squeeze everything into two days. Educators are often overwhelmed by the content. In addition. The values and skills necessary for implementation are barely touched on or completely absent in the training. Training does not allow sufficient time for teachers to orientate themselves, deal with their fears and confront their prejudices and stereotypes. Under apartheid, we lived in a country devoid of moral values. Today, even in our new democracy we are still experiencing the impact of the dehumanization of our people. Change in attitudes and behavior cannot happen in a vacuum. We need to develop values and attitude that would bind us together as a nation in the fight against this monster

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disease. We cannot afford to neglect this crucial area when educating ourselves and our children about HIV.AIDS

2.10 BASIC REQUIREMENTS FOR SUCCESSFUL HIV/AIDS EDUCATION

HIV/AIDS education should comply with the following requirements and standards if it is to be successful in schools:

- HIV/AIDS education should never be presented in isolation this is to say, in a special AIDS period. If HIV/AIDS education is presented in isolation children may acquire an irrational fear of this disease such a distorted emphasis may interfere with the child's healthy sexual development because the child may become accustomed to equating sex with disease and death (Centers for Disease Control, 1988; post, 1988).
- HIV/AIDS education should preferably form part of a life skills education programme that includes sexuality education as well as information on HIV and AIDS.
- HIV/AIDS information can also be integrated into the existing school curriculum, either as part of other health-related subjects, or within one or more subject areas such as Biology, Science, Social Science, Mathematics and Religious Studies.
- HIV/AIDS education should begin as early as the foundation phase (or grade R). At this early age, children's behavior patterns have not yet been established and they are very receptive to the principles that govern healthy behavior.
- HIV/AIDS education should be ongoing process. A single lecture or video, or an 'HIV/AIDS information week' in the senior phase, is not sufficient. The life skills required to prevent HIV infection must be learnt at a young age. These lessons should be reinforced continually as the child grows older.
- It is important to include parents, community leaders and spiritual leaders for active input at all stages of programme development. If HIV/AIDS programmes are to be successful, they have to have the active support of all stakeholders in the community- and they must also reflect the whole spectrum of religious, cultural and moral values found in any particular community.

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- The Centers for Disease Control (1988) recommends that the class manager should handle the HIV/AIDS education of children in the lower or primary grades, because the educator is familiar to the children and probably best equipped to use those teaching strategies that are appropriate to the children's age group. In the more senior grades HIV/AIDS education and life-skills training should be carried by specially trained educators (such as guidance counselors). The educator should feel at ease with the content of the HIV/AIDS curriculum and should be a role model with whom learners can easily identify.
- Information about HIV/AIDS should never be presented in a way that frightens children. Research has shown that anxiety-orientated approaches in HIV/AIDS education are counterproductive because anxiety escalates to a point where people are inclined to evade of deny the truth of the information (Wyatt, 1989).
- HIV/AIDS education that focuses on problems while ignoring sexuality as a normal aspect of all human life may well retard the normal sexual development of the child. The positive and delightful aspects of sexuality should never be ignored, children must be made aware that sexual feelings and impulses- which re present from birth- are both pleasant and normal. They must nevertheless be helped to understand that, although sexual feelings are normal, the active expression of sexuality is not appropriate behavior for young children (Quackenbush & Villareal, 1988).
- Sexuality and HIV/AIDS education should always be tailored so that it is appropriate to a child or young person's particular developmental stage. It is therefore important for us to have a clear idea of the degree of cognitive, emotional, social, moral and sexual development in children in specific age groups so that the sexual education we offer to children will be exactly appropriate and suited to the developmental stage through which they are passing. Educators should always remain sensitive to individual and cultural developmental needs and differences and adjust their education programmes accordingly.
- Programmes must take into account of traditional beliefs and value systems, as well as the popular myths that circulate among young people and their wider

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communities.

- All education programmes should be based on protecting and promoting the rights of the child, including the rights to information, education, health and health care, freedom from rape and sexual coercion and cruel and inhuman treatment, and the right of girls to equality in education, employment, inheritance, marital law, and sexual and reproductive decision-making (UNAIDS, 2002: 73).

2.11 HIV/AIDS EDUCATION AND LIFE-SKILLS TRAINING IN FURTHER EDUCATION PHASE

HIV/AIDS education for adolescents in grades 10-12 (further education phase) does not really differ from adult education. However, it is important to remember that adolescents respond better to messages that emphasize their rights rather than their responsibilities. Assure adolescents that it is their right to have information, and it is also their right to protect themselves. The right to information and protection indirectly implies responsibility.

Davidson (1988: 454-455) offers the following guidelines for HIV/AIDS education in grades 10-12:

- Revise the information given in the senior phase, and make sure that the learners have correct information about the definition of AIDS, the effect of the virus on the immune system, the transmission of HIV, the symptoms, the management of infection and testing.
- Reinforce the knowledge that adolescents can prevent HIV/AIDS by abstaining from or postponing sex; by having sexual relations within the context of a mutually faithful relationship with an uninfected partner; by always using latex condoms (even in combination with other birth control methods); by not using drugs; and by never sharing needles or syringes.
- The needs for young people who are not heterosexual are often ignored or avoided, and they lack access to information about same sex practices. Sexuality education must deal with the needs and questions of all young people, and if educators feel uncomfortable about discussing safer sex with gay or lesbian

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adolescents, they should refer them to an organization where they can access the appropriate information.

- While we should make HIV/AIDS issues as real and vivid as possible, we should try not to frighten learners.
- Movies about HIV-positive people or classroom visits from people with HIV infection often help students to overcome their denial of the disease and give HIV/AIDS a human face.
- The focus should be on healthy behaviors rather than on the medical aspects of the disease.
- Help adolescents to examine and affirm their own values.
- The ability to plan ahead is often a powerful deterrent to unsafe behavior. Adolescents who have future plans (e.g. to study, to have a career, to have children) are often less inclined to engage in high-risk behavior, especially young women when they know devastating effects HIV can have on babies.
- Students should rehearse making responsible decisions about sex, and powerful and definite responses to risky situations.
- Students should know that they have a right to abstain from sexual intercourse or to postpone becoming sexually active. They should be helped develop the skills they need to assert those rights.
- It must be assumed that all students will choose abstinence.
- Information about HIV/AIDS should be presented in the context of other sexually transmitted infections.
- It is important to be honest and to provide information in a straight forward manner. Be explicit. Use simple, clear words. Explain in detail. Use examples.
- Sexual vocabulary can be expanded to include the slang expressions or words used by teenagers if that helps to get the message across more effectively.
- It is important to be non-threatening and to work in a way that alleviates (rather than creates) anxiety.
- Students should be given the opportunity to ask questions anonymously. They usually very much like the idea of a 'question basket'. (Put a basket somewhere in the class and invite them to put anonymous questions in this basket. Answer the

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questions in the group.)

- Discussion of dating relationships can provide opportunities and pretexts for teaching decision-making skills.
- Teaching about HIV/AIDS can often be effectively enhanced by:
    - Movies and other visual aids;
    - Role plays and other participatory exercises;
    - Same-sex groupings (to encourage more candid discussions) followed by sharing in a mixed-sex group (to increase comfort level discussing sexual subjects with members of the opposite sex); and
    - Involvement of students in planning and teaching–let young people (whenever possible) speak the message to each other.
    - The importance of using adolescent models and peer educators should never be underestimated. Adolescents learn best when they learn from their peers.
    - HIV/AIDS education should include discussions of critical social issues raised by the HIV/AIDS epidemic, such as protecting the public health without endangering individual rights, orphan care, the provision of antiretroviral treatment to all, etc.
    - Educators should have resources to help students find answers to detailed medical questions.
    - Students should be taught the kind of research skills that will enable them to continue to evaluate the HIV/AIDS
    - Students should know where to go for help if they need it, and they should be taught how to access medical services if they need them.

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2.12 THE IMPACT OF HIV AND AIDS IN SECONDARY SCHOOLS

HIV/AIDS is most likely to stop population growth in provinces. Nor will it cause total population numbers to fall it will slow population growth rates and alter the structure of the population. As the proportion of potential parents (20-40 years) declines, the number

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of orphaned children will increase and poverty will deepen, school enrolment rates will and dropout rates will rise. There may be negative school population growth in some places. This is true. Dropout rates due to poverty, illness, lack of motivation and trauma are clearly set to increase in the province. Absenteeism among children who are caregivers or heads of households, those who help to supplement income and those who are ill, is bound to rise. There may be an increased demand among sick parents for early childhood education and an increase in preschool intake. There may be greater demand for second-chance education by learners returning to education after absence from the system, or for more flexible learning opportunities for those who are ill, caregivers, or wage earners. On the other hand, these demands may be offset by fewer births and more deaths of under-fives, and the fact that the families will have less disposable income for school fees, voluntary funds, transport cost and uniforms. Kelly (2000 : 66)

In the next three years to come, fewer children will enroll in schools because of HIV positive mothers dying young and children dying of AIDS complications. Children who are ill, impoverished, orphaned, caring for younger children, or earning and producing, stay out of school. Kelly (2000: 66) indicates that: "because of its many impacts, HIV/AIDS has adverse effects on the quality of education, since it is unlikely that learning achievement will remain unaffected by factors such as:

- Frequent educator absenteeism;
- Repeated bouts of educator's sickness;
- Increased reliance on less qualified educators;
- Sporadic student attendance;
- Low educator morale;
- Considerable student and educator trauma;
- Inability on the part of both educators and students to concentrate on schoolwork because of the concern for those who are sick at home;
- Repeated occasions for grief and mourning in the school, in families and inn the community;
- Fear by girls and young that they may be sexually abused or maltreated;
- Unhappiness and fear of stigmatization and ostracism on the part of both

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educators and learners who have been affected by HIV/AIDS; and

- Educator's uneasiness and uncertainty about personal HIV status.

HIV/AIDS is eroding the supply of educators and thus increasing class sizes, which is likely to dent the quality of education. The disease is eating into family budgets, reducing the money available for school fees and increasing the pressure on children to dropout of school. This indicates that HIV/AIDS has a great impact on the education sector. (Kelly, 2000: 66)

2.12.1 Challenges facing secondary school learners

The HIV/AIDS epidemic is directly affecting learners in Limpopo province. Learners in secondary school level are able to attend school, but those in 'child headed households', where the entire family is made of children, cannot manage to attend school. Sometimes the elder ones have to stay at home and look after the young ones. This indicates that fewer learners will be able to complete their education due to the disease HIV/AIDS. Girls in the age of 7-14 are six times more infected by HIV than their counterparts the boys, because of the belief that they are HIV free. They face increased risk of sexual harassment on their way to and from school. This affects their access to schooling. At another level, this has led to increased defilement cases. Whereas most all of those impoverished by AIDS and the orphans are able to attend secondary education, the majority cannot proceed to tertiary level.

Some learners dropout of school to engage in income activities. Some may drop out of school to nurse sick parents or siblings. In a long-term perspective, this may reduce there hard-worn return on efforts to increase girl's education (Kelly 2002). This is supported by Jackson (2002: 230), when he states that: "uneducated girls will themselves become vulnerable to HIV/AIDS due to lack of or reduced income possibilities. If the breadwinner of the family is taken ill, some children leave school because of financial crisis". The underlying reason for this dropout rate is the inability to pay school fees. This inability is AIDS related. In most cases, AIDS causes the loss of an extra dependable source of income to take care of the sick members of the family (Kelly 2000).

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In supporting this idea, Manaka (2002: 78) writes that: "in some of the rural areas, AIDS illness in the family demanded greater participation from children in seasonal agricultural work. Children are kept at home in these periods, missing out on weeks of schooling". Most of the learners from AIDS affected families are under constant emotional strain, worrying about their sick family members, or the family's financial situation, etc. these are not optimal conditions for learning. In addition to this, prejudice and stigma may cause social exclusion. This in turn deprecates their emotional well-being and thus interferes with their ability to learn. Manaka (2002: 90) stresses that: "some learners from families affected by AIDS see little value in education as a way of surmounting their problems. This has tremendously increased the number of street children in the communities. Some of the learners orphaned by HIV/AIDS have left schooling, and joined risk undertakings like prostitution and theft in order to earn a living"

Most secondary school learners that are being abused, may live in families that are over-extended and are under pressure to contribute to family incomes and poverty deepens. This is supported by Kelly (2000: 150), when she states that: "children are losing parents and siblings due to HIV/AIDS and may have to travel long distances to find new homes. For others there are no homes at all. They are increasingly absent from school and distracted". This implies that HIV/AIDS has an impact on learners.

2.12.2 Challenges facing the orphans

Orphans are likely to experience many problems, some of which will be more acute in certain circumstances. These may include access to education and school performance. According to World Health Organization report (2004: 13), problems of the orphans in secondary schools are classified into the following categories:

- Inability to provide school equipment and clothing;
- Reduced capacity for individual families to provide their own food and other needs;
- Susceptibility to health risks and vulnerability to HIV infection with high

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morbidity conditions; and

- Loss of property due to unclear and cumbersome inheritance procedure.

Kelly (2000: 89) mentions some of the sources of psycho-social problems encountered by orphans. These include:

- Anxiety about abused from adults;
- Witnessing the slow, miserable death of one, and possibly both parents;
- A move to unfamiliar home and pattern of life, with no choice in the matter;
- School educators unsympathetic to their difficulties and often too ready to punish them for being late or ill equipped, without looking for explanations;
- Experiencing relatives haggling over division of their dead parent's property, sometimes immediately after the funeral;
- Multiple losses, first of parents and then of the caregivers who had taken them in; and
- The prospect for some of having to live by themselves.

On the quality of care received, Nourse (2000: 108) has observed that:

- Foster children suffer from a lack of affection, exploitation of labor, denial of food or other necessities of life, and lack of educational facilities;
- Some caretakers take on orphan-caring responsibilities in the expectation of material gain, inherited property, or the relief of items donated by AIDS organizations.

In the light of the above, it is clear that HIV/ AIDS have a great impact on orphans. It can be argued that orphans are more vulnerable to psychological problems soon after the loss of parents, such as depression, withdrawal and low self-esteem. Such conditions have long-term effects on child development and active participation in the school. Orphans are sometimes difficult to care for by their fostering parents, because they display antisocial behavior due to their underlying feelings of anger and resentment. Social and emotional conditions of orphaned children sometimes become worse upon losing their parents, for example the loneliness and financial crisis. Orphans, for example, fail to

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develop positive attitudes and relationships with other learners in the school (Manaka 2002).

2.12.3 Challenges facing the educators

Educators are also affected by the epidemic. It has affected the supply of education due to increased death and sickness of educators. Productivity of particularly the sick educators has decreased, and the quality of teaching and learning reduces. This is true. Educators infected and affected by HIV/AIDS will sometimes be absent from work or become exhausted during the day and need to lie down for some time. During these times, other members of staff will have to cover for them, and this will have an impact on their work and well-being. Educators often feel overburdened already and find it hard to do more work. In an article in the department of education HIV/AIDS publication (2000: 8), Professor Kader Asmal states that: "many schools will be crippled by the impact of the disease on educators, learners and their families". This is true, since due to this reason, the education system will loose experienced educators and this will affect teaching and learning in schools. In supporting the above statement, Manaka (2002: 99) writes that: "AIDS cases and death among teachers have had various perceived negative impacts". These are summarized as follows:

- Teachers have become concerned about their health and therefore become nervous and depressed;
- Teachers are frequently absent;
- Teachers' attitude to work deteriorates, and they become unable to perform well;
- Teachers have a lot of stress; and
- They become unconfident and unmotivated

People living with HIV/AIDS are often periodically ill. When educators are absent due to illness or medical treatment, the learners are often left without schooling due to teacher replacements (Kelly 2000). When an educator dies from AIDS, he/she is seldom replaced immediately due to cumbersome administrative structure and general teacher shortage. This will diminish the pupil's returns from schooling and reduce the quality of education

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as such. This reduction of quality will, in a longer-term perspective, reduce parents' willingness to enroll their children (Department of Education report 2003). There are funeral ceremonies in the communities, which are the dimensions that claim educators' time. This may be more serious if the rates of death are a result of HIV/AIDS increases from what has been said above, it seems as if HIV/AIDS have a traumatic impact on educators. Stigmatization of infected educators is a deeply rooted response, although discrimination is illegal. (Department of Education report 2003)

2.13 HOW HIV PREVALENCE IS MEASURED

National estimates of HIV prevalence in countries with HIV/AIDS epidemics are based on data about pregnant women tested for HIV at antenatal clinics (UNAIDS, 2003:6). This assumes that HIV prevalence among pregnant women is similar to that of the rest of the adult population (aged 15 to 49). This assumption was tested in studies conducted in a number of African countries. HIV prevalence among pregnant women at antenatal clinics was compared with the prevalence detected by voluntary HIV testing surveys among the adult population (men and non-pregnant women) in the same community.

These studies confirmed the assumption that HIV prevalence among women is roughly equivalent to the prevalence among the adult population in urban and rural areas. Both sources of data (pregnant women and voluntary testing surveys) have advantages and disadvantages, and there is no absolute standard for HIV surveillance. All HIV estimates need to be assessed critically, whether they are based on a national survey or on sentinel surveillance data (on pregnant women).

Data from antenatal clinics are especially useful for assessing HIV trends, and national surveys help to fill out the picture of the epidemic. Such surveys, conducted every three to five years, can be valuable components of surveillance systems and can help improve estimates of the levels and trends in HIV prevalence.(UNAIDS, 2003:6)

2.13.1 The determinants of HIV/AIDS in South Africa

The prevalence and spread of the epidemic is largely determined by many powerful

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social, political, structural and economic factors, which are described to some extent below. An understanding of these factors is critical not only to develop appropriate surveillance system instruments but also to understand the epidemic and implement appropriate intervention programmes.(UNAIDS, 2003)

HIV and young women

Females are more vulnerable to HIV and it has been established that the lower status and disempowerment of women contribute to their infection rates. Younger women, especially teenage girls, are especially vulnerable to HIV infection, due to the immaturity of their reproductive systems as well as likelier exposure to sexual coercion, the potential to overcome immediate needs through 'survival sex', the potential to utilize sex to provide access to consumer items through 'transactional sex', and the relationship between sex and violence, which includes vulnerability to rape. Children fostered as a result of death of their parents may also be exploited sexually, and poverty generally may also contribute to children being 'bartered' to exchange for other goods or money. (UNAIDS, 2003)

HIV and labor migration

Migration and mobility of people contributes to HIV infection. Migrants are vulnerable to HIV infection because they are away from their regular partners for long periods at a time, and this increases the probability that they may have multiple partners. There is a long history of labor migrancy in South Africa, and reducing this labor pattern may help to curb the spread of HIV.

Among migrant mine workers in West Africa the rate of HIV infection is 25%; and at some mines in South Africa the HIV rate reaches 50%, many times more than the rate among the population as a whole. Studies in Uganda in high-prevalence areas show distinct association between frequency of travel out of village, HIV infection and distance people travel from home. In South Africa, the high rate of rape cases among traveling

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women render them a very vulnerable group to HIV.

Labor migration is also linked to rapid urbanization, and urban informal locality types were found to have the highest prevalence in 2002. (UNAIDS, 2003)

HIV and occupation

HIV is not distributed evenly among all occupational groups. Some groups are more at risk than others. In a study on pregnant women in Zaire, the infection rate among women with husbands who are farmers was 2.3% compared to 14.6% among women whose husbands were in the police or military. Commercial sex workers and long-distance truck drivers have been identical as core groups in the spread of the disease.

HIV, cultural and religious norms

It is important to point out that some aspects of culture inhibit HIV infection rates while others exacerbate the disease. Customs that discourage initiation of sex at an early age and promote abstinence from sex are inhibitory. Cultural factors related to rites of passage to adulthood, marriage and death are related to HIV/AIDS. Religion also plays an important role promoting marriage and faithfulness between sexual partners. (UNAIDS, 2003)

HIV and sexually transmitted infections

Individuals with STIs have been shown to be at increased risk of acquiring and transmitting HIV infection. Therefore, because the burden of STI disease in South Africa is high, it is believed that this directly contributes to spread of the epidemic. The national Department of Health has acknowledged this and substantial resources have been committed to STI control. There is now evidence that certain STIs, syphilis in particular, have declined in recent years and efforts need to be made to continue to reduce the new infections. (UNAIDS, 2003)

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HIV, alcohol and drug abuse

Alcohol, also known to be an important factor contributing to HIV infection. There is very little information on HIV risk in relation to drug use in South Africa, although associations have been shown international literature, and it is known that inject able drug use is growing in South Africa.(UNAIDS, 2003:)

2.14 THE ROLE OF EDUCATION DEPARTMENT IN SUPPORTING THE TEACHERS OF HIV AND AIDS IN SCHOOLS

Arising out of the issues it would seem appropriate to focus all our efforts on the following areas: curriculum, teacher training, gender hierarchies and power relations. According to Kelly (2000b), a crucial role for an education system that seeks to form attitudes and practices that will minimize HIV transmissions to work strenuously and systematically for greater gender equality, the championing of women's rights, and the empowerment of women, many countries have attempted to deal with gender issue from the perspective of life skills. However, there is still a need for education systems to address the gender issue more fundamentally. This would ensure that, over time, new cultural understandings and practices may emerge that will show more respect for the rights of women and girls, and more ready to accept that they should be in control of their own lives.

The life skills and HIV/AIDS education programme initiative of the Department of Health and Education was implemented in 1995 targeting secondary schools in certain grades. However, implementation on a large scale in all grades is providing to be difficult. The programme has experienced limited success in some schools, with the better-resourced schools experiencing the most benefits. Currently in the school curriculum, issues relating to sexuality and HIV/AIDS infection are offered within the Life Orientation Area and are expected to cover a wide range of issues, from environmental education, sexuality education. HIV/AIDS, career and the world of work,

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etc. furthermore, this learning area has been allocated the least amount of time in the school timetable and is usually not taught at all. In most schools teachers use Life Skills period to teach other examination subjects. Kelly (2000b)

Research on the inclusion and quality of HIV/AIDS education courses for student-teachers was conducted in departments of education at universities, and in colleges of education in South Africa. Findings indicate that the development of appropriate courses is still inadequate in the face of the growing epidemic (beyond awareness campaign, as cited by Coombe, 2000a). Life Skills remains a neglected area in the training of new teachers in training of new teachers entering the profession. Life Skills courses are on offer but HIV/AIDS compulsory for all teachers in training. One of the aims of the EI/WHO collaborative project is to address this issue and make recommendations to the Council for Higher Education and training to ensure that HIV/AIDS becomes a compulsory part of the core curriculum for the pre-service training for new teachers. (Coombe, 2000a)

HIV/AIDS must be given priority in the nation's school curriculum including the curriculum for teacher training (both in-service and pre-service). This would be translated into more time allocated to teach Life Skills, more teachers trained in the area and all principles, school-management teams, schools governing bodies being work-shopped and trained to provide the support required to implement the Life Skills curriculum effectively. Furthermore, the Life Skills programme should cut across all levels of education, from pre-school to secondary levels. (Coombe, 2000a)

International research and the South African experience have shown that complicity between teacher and learner facilitates the success of education programmes in schools. Encouraging learners and teachers to assume ownership of the learning in the school is crucial. Including teachers and learners in the conceptualization, design and implementation of the Life Skills and HIV/AIDS education programmes and the development of learning support material can foster this. (Coombe, 2000a)

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Learners themselves are one of the most underutilized resources in our schools. Research has overwhelming indicated that learners learn best from their peers, especially o issues of sexuality and health. Teachers should be encouraged and empowered to adopt peer education techniques when implementing the Life Skills programmes. This approach recognizes the powerful socializing influence that young people have over each other and seeks to win the potency of peer pressure over to its side. (Coombe, 2000a)

Current research indicates that very few programmes on HIV/AIDS education seek to contextualize messages about HIV/AIDS within the cultural discourse of traditional ideas. Hence, they do not acknowledge and build on the understanding and beliefs of those they seek to influence (Kippax, Smith & Aggleton, 2000). It would therefore be appropriate for Life Skill programmes to be developed within contextual boundaries of the school community. The health-promoting schools concept attempts to bridge this gap between community and the schools within a rights-based framework. This concept includes parents, community leaders, health workers and traditional healers who will work alongside the school, share their experience and expertise with the school, and shape the school curriculum to meet the needs of the community. These programmes must include counseling for those who are infected and affected, as well as community outreach programs for AIDS orphans. (Kippax, Smith & Aggleton, 2000)

The huge challenge of HIV/AIDS demands that, where possible, all teachers should be equipped to fight the disease on a personal and professional level. According to researcher 'Life Skills as a subject in schools suffers a "Cinderella" status and therefore usually falls to a female teacher.' The subject suffers a lack of credibility because it is viewed as a 'woman's issue' by some male learners and male teachers in the schools. 'male educator in most secondary schools teach high-status subjects like Maths and Science, while Life Skills, which is viewed as a low-status subject, is given to the female teachers.' It therefore becomes essential to shift this perception by ensuring that there is a gender balance in the spread of teachers teaching Life Skills and implementing HIV/AIDS education programmes. (Kippax, Smith & Aggleton, 2000)

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Women continue to be under-represented in the leadership and high-profile positions in the education system and in the teachers' unions. This practice needs to be urgently addressed in order to challenge the low-status of women and break down the male 'buddy' system which fuels the epidemic. Teacher unions in South Africa are now employing a quota system that promotes gender equality. Quotas are established to ensure that women are present in all activities of the unions, including representation on its constitutional structure. The education system, on the other hand, is governed by the Employment Equity Act, which requires the employment hierarchy to reflect the demographics of the country. Although these are progressive actions that could empower women, they are far from actually being implemented. There needs to be greater commitment from all sectors to ensure that these obligations are met. (Kippax, Smith & Aggleton, 2000)

The training programmes for Life Skills and other HIV/AIDS education programmes must be holistic and comprehensive – they should include the following issues:

- The role of teachers in implementing Life Skills or HIV/AIDS education programmes;
- The role of educators in fuelling the pandemic;
- Work-related issues with regard to HIV/AIDS, e.g. absenteeism, confidentiality, etc.;
- Policies, legislation and codes of conduct;
- Building partnerships in the fight against HIV/AIDS, especially establishing community schools for AIDS orphans;

According to Kelly (2000a), many educators resist teaching about HIV/AIDS because they doubt whether issues of sexuality or appropriate sexual attitudes form part of their work as educators, since their entire educator training and orientation were directed towards academic areas. It is therefore important for training programmes to challenge these perceptions by impressing upon educators their crucial role in fighting the pandemic. The training programme must balance knowledge, skills, values and attitudes i.e. content on HIV/AIDS (e.g. transmission, prevention, etc.), teaching methodologies

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(e.g. use of participatory techniques, drama, theatre, small-group discussions, etc.), and values and attitudes (abstinence, respecting the rights of others, etc.) HIV/AIDS training programmes must include basic lay counseling as an integral part of training. This will assist educators to deal with the trauma these learners face, including issues of grief and bereavement. AIDS orphans are most in need of this kind of counseling.. (Kelly, 2000a)

Training in this area must address underlying issues, like value systems and power relations. Value clarification is also a necessary component of any HIV/AIDS training programme. This gives teachers a safe space to confront their prejudices and stereotypes, examine their values and the effects these have on their teaching and relationships with the learners. In addition, it assists in developing values and attitudes that respect the rights of all individuals. Furthermore, the issue of gender should not be confined to teaching girl's communication skills and how to be assertive-there is also a need for boys to make paradigm shifts too. This cannot be done in the classroom alone, but needs to involve parents and the community. Training should develop in teachers the skills to negotiate these challenging issues with a sense of confidence. (Kelly, 2000a)

The trainers and the models for training must ensure that the programme achieves maximum impact. Teachers prefer to be trained by peer educators, rather than people who have had no experience in the classroom – they have rapport and relate to each other making it easier to deal with controversial issues. The cascade model has proved to be ineffective in equipping educators' to deal with HIV/AIDS. (Kelly, 2000a)

The training model should reduce the number of training tiers and include a special cadre of trainers that move from one cluster of schools to another. This cadre of trainers must include school-based educators. The training programme should be on-going, and include support, monitoring and evaluation components. Furthermore, all trainers should be accredited (where possible); training programmes should be quality assured and reflect the contextual challenges facing educators and department officials in their fight against HIV/AIDS. Wherever possible, the language of training and teacher-support material should accommodate the teacher's first language, as well as the language of teaching and

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learning in the school. (Kelly, 2000a).

The training programme and support material should not be limited to scientific and medical components of the disease, but should include the broader social, economic and cultural components. In this way, responses can resonate with people's real experiences. Such programmes become relevant and therefore more effective in changing behavior and attitudes. To state an example: EI, WHO, SADC teacher unions and other partners have developed a training and resource manual on school health and HIV/AIDS prevention. This manual is unique in the sense that the activities and learning experiences were organically developed by teachers and union members who gave the manual its authenticity by capturing their true-life experiences in their schools and communities. 'It is crucial for support materials and training programmes to resonate with the socio-cultural and socio-economic context of the learners. Nobody is going to listen to anything that makes no sense in the lives. (Kelly, 2000a)

2.15 THE ROLE OF EDUCATOR UNIONS IN TEACHING OF HIV/AIDS IN SCHOOLS.

HIV/AIDS on educators is of special concern to organized teacher union.
The first union to be discussed is

2.15.1 South African Democratic Teachers Union (SADTU)

South African Democratic Teachers Union (SADTU), which is the largest member of COSATU represents two-thirds of the teaching population in South Africa. As such, the union has tremendous influence amongst learners, parents and the educational authorities- and the government of course! The union is strategically located and well organized to influence policy and implement effective strategies in combating the virus, as well as supporting learners and educators living with AIDS. Research carried out by SADTU on membership deaths (Educator's voice, Vol.5 no.8) indicates that:

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- As many as two educators are dying everyday
- A significant number of these death are considered to be AIDS related
- Our educators are dying young with the average age at 38.95
- More female educators are dying as compared to male educators in the same area range. (SADTU : 2000)

These conclusions were supported by the thirteenth International Conference AIDS in Durban (July 2000), which reported that there is a high prevalence HIV/AIDS among school administrators and teachers in South Africa. SADTU has also played a crucial role with governmental and other key stakeholders in developing and implementing an anti-democracy HIV/AIDS policy for learners and educators. SADTU actively supported the minister of education. (9Hooper : 2000)

SADTU aims:

- To increase awareness of effects of HIV/AIDS
- To campaign for a change in lifestyles of SADTU membership and the community at large
- To ensure that educators, learners and employees embrace a caring and supportive attitude towards PLWHAs
- To work towards curbing the spread of HIV/AIDS in our communities
- To defend on members, staff against all forms of prejudice
- To campaign for the provision of affordable treatment in the public health sectors.
- To educate educators, learners and other stakeholders on HIV/AIDS.
- To inculcate HIV/AIDS education into the curriculum of the school i.e. life skills guidance and other learning arrears.
- To ensure that the management of education institutions is conscientised about the epidemic.

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- To ensure that conditions of service are adjusted to cater for educators and non- teaching staff who are living with HIV/AIDS.
- To step up the implantation of sexuality education programmes in particular STIs, HIV/AIDS and establishes Health and Safety Committees in every school.
- To actively campaign for the increased role of school governing bodies in the campaign against HIV/AIDS in the schools and education institutions.
- To work jointly with SGBs in popularizing measures that can prevent the spread of the virus or the diseased.
- To negotiate for improved employee benefits of PLWAS and their families.
- To establish care and support structure, which will encourage disclosure at all levels of SADTU
- Ensure the establishment of workplace policies in every school and education institution
- It is against this background that SADTU decided that it could not leave the fight against HIV/AIDS to the Department of Education alone. It has a moral obligation to its members and to the whole educator fraternity to contribute in the fight against pandemic. (ELRC – PCTA II : 2008)

2.15.2 National Progressive Teachers Organisation of South Africa (NAPTOSA)

Its policy recognizes the significant threat to education in this country and commits NAPTOSA to conducting programmes which will promote HIV and AIDS awareness, prevention and support, not only to its affiliates, but to its entire membership.

Objectives:

- To reduce the number of new infections through its workplace awareness and support programmes.

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- To ensure that the rights of its infected/ affected membership basis are protected.
- To promote a culture of non-discrimination and support for its infected/ affected membership base.
- To promote a universal value system that would ensure an enabling environment for HIV-infected/educators and learners. (ELRC-PCTA II: 2008)

Purpose:

- Non- Discrimination.

All members infected with HIV/AIDS shall be treated with the same dignity as any other member.

- Confidentiality, Disclosure and Testing

If a member discloses his/ her HIV/AIDS status, this MUST be treated as confidential. Breech of confidentiality may result in legal action.

Voluntary counseling and testing (VCT) in a supportive environment is to be supported but not enforced.

- Right to representation

NAPTOSA may not deny the HIV/AIDS infected member the right to representation.

- Education

Continuing HIV/AIDS awareness/Education programmes must be implemented by all affiliates.

NAPTOSA will review its HIV/AIDS policy annually to accommodate any changed circumstances. (ELRC- PCTA II : 2008)

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2.15.3 National Teachers Union (NATU)

NATU and AIDS policy

Preamble

HIV and AIDS epidemic in South Africa is among the most severe in the world and it continues to increase at an alarming pace.

Observations, research and statistics reveal that this epidemic disrupts the lives of people from all walks of life. Many individuals, families, communities and organizations world wide are crippled by the impact of the disease on them. NATU as an organization is quite aware that no cure for HIV infection is available at present. This fact, so far, cannot make NATU sit on her laurels but instead stand up and fight against HIV/AIDS epidemic.

It has been noted that educators play the influential role in the society. Through HIV/AIDS education people will make informed decisions that will contribute positively towards the reduction of: New HIV infections, prejudice, stigmatization, discrimination, insecurity and violation of human rights when it comes to HIV/AIDS issues.

NATU welcomes all forms of legislation aimed at protecting people who live with HIV virus.

Vision

To take huge strides in the fight against the HIV and AIDS scourge to protect NATU members, employees, their families, members of the community that are infected by the virus and in partnership with government especially through the Department of Education and Heath and Non- governmental organizations and other organizations doing work in the field of HIV/AIDS i.e. TAC, NAPWA and others.

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Aims and Objectives

- To promote behaviour and living style that will prevent the transmission of HIV/AIDS and Sexually Transmitted Infections (STI's).
- To prevent the spread of new infections among NATU members, employees and their families.
- To raise awareness and spread knowledge about the pandemic among her members.
- To protect her members from any form of discrimination and stigmatization based on their HIV/AIDS status.
- To ensure care and support of members, employees and their families who are infected and affected by encouraging the establishment of support groups.
- To ensure that her members get exposure of new developments and updates on scientific research in the field of HIV/AIDS.
- To engage in strategies to interpret and implement the country's strategy in dealing with the pandemic.
- To promote advocacy of government strategic plan by cascading accurate and appropriate information to members.
- To facilitate treatment access to members and their families through recognized public and private institution.
- This policy will be reviewed and amended from time to time to accommodate updates and current scientific research and developments in the field of HIV/AIDS. (ELRC- PCTA II: 2008)

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2.15.4 Federation of Union of South Africa (FEDUSA)

The Suid-Afrikaanse Onderwyserunie (SAOU)

Preamble

The Federation of Unions of South Africa (FEDUSA) and the SUID-Afrikaanse Onderwysersunie (SAOU) acknowledges the seriousness of the HIV/AIDS epidemic. The HIV/AIDS epidemic has claimed many lives and will continue to do so if we do not seek ways to minimize the social, economic and developmental consequences to FEDUSA and its affiliated members.

HIV/AIDS is a disease surrounded by ignorance, prejudice, discrimination and stigma. In the workplace, unfair discrimination against people living with HIV/AIDS has been perpetuated through practices such as pre- employment HIV testing, dismissals for being HIV/AIDS positive and the denial of employee benefits.

HIV/AIDS knows no social, gender, age, or racial boundaries, however it impacts severely in an environment of poverty. Women are particularly more vulnerable to infection in cultures and economic circumstances, where they have little control over their lives.

The federation of Unions of South Africa and the Suid-Afrikaanse Ornderwysersunie thus commits itself to providing leadership to implement on HIV/AIDS and STI Workplace Policy and Programme for use by all its affiliates. (ELRC- PCTA II : 2008)

Objectives

- FEDUSA and the SAOU re-affirm that it's HIV/AIDS Workplace Policy is based on:

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- The promotion of equality and non-discrimination between individuals affected and infected with HIV, and between HIV/AIDS and other comparable health/medical conditions.

- The creation of a supportive work environment to ensure that HIV- infected employees are able to continue working under normal conditions in their current employment for as long as they are medically fit to do so.

- The protection of human rights and dignity of people living with HIV or AIDS and to prevent and control the spread of HIV/AIDS.

- Consultation, inclusively and encouraging full participation of all stakeholders, are key principles for developing the HIV/AIDS Policy and Programme.

- The HIV/AIDS Policy is guide for employees and for the Federation of Unions of South Africa (FEDUSA) and the Suid-Afrikaanse Onderwyserunie (SAOU), on how to manage HIV/AIDS within the workplace. This policy applies to all staff members of FEDUSA and the SAOU, as well as its current and future membership.

- No employee/ worker shall be required to undergo HIV testing without the authorization of the Labour Court.

- Information about an employee's HIV status will not be reason to exclude him/her form employment or any employment policy or practice.

- Confidentiality about an employee's HIV status will be kept at all times;- if confidentiality is breached, the existing grievance procedure will be available to resolve the dispute. If the existing grievance procedure is not conducive to such disputes, then the current procedure should be reviewed to make it accessible and include principles of confidentiality and privacy. (ELRC- PCTA II : 2008)

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2.16. TEACHING OF HIV/AIDS IN SECONDARY SCHOOLS IN SOME OF THE AFRICAN AND OTHER COUNTRIES ABROAD

2.16.1 Kenya

Teachers suggested that the best way they can give HIV/AIDS education, information and messages is by giving advice to girls one by one, make AIDS education separate subject instead of integrating it into other subjects and availing materials to schools for the teaching of HIV/AIDS. People infected with the virus, should be invited to give talks to pupils. And most of the educators do not have adequate information of HIV/AIDS and do not therefore feel competent to talk to students. There were also suggestions to have educators trained on how to teach HIV/AIDS within pupils' cultural context. Materials on HIV/AIDS need to be updated and parents need to be given education to support HIV/AIDS programs in schools. (UNICEF: 2000)

A baseline survey conducted by Kenya Institute (KIE) in 1994 to identify appropriate sources and channels of communicating HIV/AIDS education so as to interviewed consisted of educators, students, sponsors and community leaders from eight districts found that, the sources and channels for communication HIV/AIDS education were as follows:- radio, television, educators, friends, siblings and newspapers. This survey further pointed out that most youth express confidence and openness among their peers and this was also considered an important avenue for conveying the messages to the youth facilitate the AIDS education project for the youth in and out of school. (KIE: 1994)

The Kenya Institute of Education's (KIE) AIDS Education project for youth has been proving and publishing HIV/AIDS educational materials for primary and secondary schools. They also publish facilitators' handbook, good health magazines and curriculum for the same. However, these materials have not yet been disseminated at national level to all education institutions. Furthermore, the project although also intended for youth out of school does not address how similar HIV/AIDS education messages can be get

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communicated to this Group. Children also get information from specific locations or sites, which include, school, health institutions, home church and mosque. (KIE: 1994)

According to UNAIDS (1997), in a briefing paper "learning and teaching about AIDS at school" the constraints to HIV/AIDS education in school included, the subject is considered controversial, the curriculum is already over crowded, education may be limited to certain age groups, behavioral skills are not taught- only facts about HIV/AIDS and that it maybe only partially covered in a country. Ways to overcome these constraints include, designing a curriculum adapted to local culture and circumstances, establishing a partnership between policy makers, religious and community leaders, educators and parents and setting of sound policies on AIDS education through partnership. (UNAIDS: 1997)

2.16.2 Malawi

Ministry of Education, Science and Technology (MoEST) is responsible for all formal education and teacher training in Malawi. The ministry is also involved at a policy level with all other key areas of education. The secondary education cycle is four years in duration, and is sub- divided into junior and senior levels. Access to secondary education remains highly competitive. (Kadzamira , et al : 2001)

The MoEST began to develop Life Skills Education under Youth Reproductive Health in conjunction with UNICEF in 1997, although this was not introduced into primary schools until early 2000. Life Skills is a stand-alone subject. Its goal is to equip students with key competencies in problem-solving, decision-making, stress and anxiety management, conflict reduction, interpersonal relationships, planning and entrepreneurship, self-esteem and assertiveness as well as HID/AIDS prevention. Teaching and Learning materials for HIV/AIDS were being developed and introduced in 2002. The new secondary curriculum also recognizes Life Skills as a core subject. The syllabus and appropriate materials for all grades are being prepared. The intention is also to provide

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some inputs in teacher training to enable to effective teaching of life skills. (Kadzamira, et al : 2001)

The WHY WAIT educational programme (funded by a consortium of NGOs) is based on Christianity principles and has been particularly influential in both the formal curriculum and in Anti-AIDS extra curricula activities. It was introduced in secondary schools in 1995. Its overall aim is to sensitize youth to abstain from premarital sex. It has trained around 600 educators to deliver a four- year programme, which seeks to address the problems facing youth concerning sexual decision making and HIV/AIDS. (Kadzamira , et al : 2001)

The first year focuses on the physical, socio- cultural and environmental factors that lead to premarital sex and explains the needs for a monogamous faithful marriage. The aim is to encourage youth to avoid HIV/AIDS and 'harmful' behaviour. The second year involves a greater focus on psychological and emotional factors, which influence the sexual behavior of youth. The third year demonstrates life principles and encourages students to follow a path informed by biblical principles. Acknowledging that many students come from homes that offer poor models of parenting, the fourth year focuses on positive parenting. (Kadzamira , et al : 2001)

Most educators have major concerns about both the design and delivery of the HIV/ADIS curriculum. Only 20% of Secondary school teachers agreed with the statement that this curriculum is well designed. Educatos have the following objections to the way in which the HIV/AIDS curriculum components have been designed:

- Educators have not been involved in the development of the curriculum
- Educators have been given little or no orientation on HIV/AIDS
- Educators feel they need IN-Service Training on how to deliver sensitive topics.

There are major problems with how the HIV/AIDS curriculum is being delivered in most schools in Malawi. Most of these relate directly to the commitment competence of teachers to teach what sensitive and difficult topics are. (Kadzamira, et al: 2001)

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In secondary schools the carrier subject is Life Skills and HIV/AIDS topics are only covered under the topic 'sexually transmitted disease'. It is possible that a number of students do not even take this subject. Some educators actually skip the HIV-related topic and ask the students to read on their own because they feel profoundly uncomfortable and unprepared to teach this subject. Mosteducators are ill prepared to teach the HIV/AIDS curriculum. Furthermore, more than 25% of the secondary school teachers were too embarrassed to talk about AIDS-related issues and were put off by both students' laughter and lack of material. Even when educators had attended orientation seminars, they still felt uncomfortable talking about sexual issues. The only systematic training of teachers with regard to HIV/AIDS components in the secondary curriculum seems to be provided through the WHY WAIT programme. (Kadzamira, et al: 2001)

2.16.3 U.S.A

In spite of the recent downward trend in national and state-specific rates of pregnancy and some sexually transmitted diseases (STDs) many adolescents continue to engage in high-risk sexual behaviors, such as unprotected sexual intercourse and intercourse with multiple sexual partners. These behaviors increase the risk of unintended pregnancy and STDs, including HIV/AIDS. School–based programs can help promote child and adolescent health and reduce the morbidity and mortality associated with health-risk behaviours, including behaviors associated with HIV infection. To guide the development of effective HIV prevention programs, the U.S Centers for Disease Control and Prevention (CDC) published its Guidelines for Effective School Health Education to Prevent the Spread of AIDS in 1988 (32).

According to these guidelines, school systems should obtain broad community participation to ensure that school health education policies and programs to prevent the spreads of AIDS are locally determined and consistent with community values, education personnel should be properly prepared to teach HIV prevention, school systems should offer programs that enable and encourage young people not to engage in sexual

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intercourse, and school systems, in consultation with parents and health officials, should provide AIDS education programs that address preventive behaviors that should be practiced by persons with an increased risk of acquiring HIV, including use of latex condoms. (CDC: 1998)

Most state education agencies responded to the CDC guidelines by adopting an HIV education policy. By 1994, HIV–prevention education was required in over three-quarters of the states (79%) and school districts (83%) nationwide, and the topic was being taught in a required course in 86% of all middle/junior and senior high schools. Similar findings existed in 1996, and appear to have been maintained through 2000. The specificity of the state HIV policy language, however, varied considerably. Some state education agencies simply recommended that HIV prevention education be provided to students and staff, other required it in at least one grade level, while other state education agencies provided more explicit policy guidelines; for example, how many lessons or at what grade levels.

HIV education should be offered, which staff should receive HIV training, and what HIV prevention education curricula or programs might be most effective or considered. The importance of this distinction lies in the fact that state-level policies serve as broad guidelines or recommendations for local districts to consider adopting. District schools boards generally develop or model their local policies after the state policies, or use them as a platform for local public dialogue and possible adoption. The more detailed state policy language is, the greater the guidance offered for school district consideration during local policy development. (CDC: 1988)

The Massachusetts Board of Education (MBOE) issued its Policy on HIV/AIDS Prevention Education in 1990 and amended this policy in 1991. The policy paralleled, and several areas exceeded, the CDC's national guidelines. MBOE strongly recommended that local school districts involve parents and develop HIV prevention education policies consistent with eight state-recommended policy provisions. One of the state's groundbreaking policy provisions that exceeded the CDC guidelines was the recommendation that school districts initiate a public dialogue among the local school

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board, parents, administrators, and community representatives to consider whether to make condoms available in local schools.

To support its policy adoption efforts, Massachusetts Department of Education (MDOE) offered statewide, regional, and local trainings and technical assistance to health coordinators and HIV teachers between 1991 and 1995. In addition, MDOE provided trainings in and promoted use of three research-based, skills oriented HIV prevention education curricula proven effective in reducing sexual risk behaviors among adolescents. The MA Board of Education policy remains in effect today. HIV education staff send out copies of the HIV policy to all superintendents in the fall of each year, and HIV policy and program related trainings continue to be scheduled for local school districts annually. To our knowledge, Massachusetts continues to be the only state education agency in the United States with an HIV education policy that specifically encourages district consideration and dialogue regarding whether to adopt condom availability programs for secondary schools. (MBOE: 1990)

Because Massachusetts, like most states in the United States, is a "local control state", school districts had autonomy to decide whether to adopt any HIV prevention education policy and whether to incorporate the state-recommended language I full, partially, or not at all. Moreover, decisions regarding how HIV prevention education was provided, who provided it, and to which students (School and grade, level, special programs, etc.) all were made locally. As a result, the extent to which school districts adopted the Massachusetts HIV education policies was not known. In addition, little research has assessed the influence of heath education policies, such as those of MBOE, on promoting changes in school health programs that can reduce child and adolescent health-risk behaviors. This is the first study, which we are aware of, that has assessed the impact of local adoption of state-recommended HIV education policies. (MBOE: 1990)

MDOE evaluated the four core components of its HIV prevention education program (policy, staff development, curriculum, and student status) to determine: (1) the extent to which local school districts adopted policies consistent with state policy

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recommendations; (2) whether the adoption of state-recommended policies was associated with staff development and HIV prevention education program characteristics, and (3) whether staff training and use of research-based curricula were associated with the instructional practices of classroom teachers. Through this study, MDOE hoped to gain insight into the statewide diffusion of HIV prevention education policies, staff development, and prevention programs following adoption of its comprehensive and explicit HIV preventions education policy. (CDC: 1988)

2.16.4 Mauritius

In Mauritius, since October 1987, when the first HIV/AIDS case was reported, the total number of HIV/AIDS cases, up to the end of December 2007, amounted to 3133. There is also an increasing tendency in the prevalence of HIV/AIDS cases with 1 out of every 5 cases being a person aged between 15 and 24. Literature reveals that such epidemic has always led to various tragic social and economic consequences including some destructive impacts on health systems in other countries and the international response to HIV/AIDS must embrace prevention, support, treatment and long-term care. Prevention is the only dependable measure and education on AIDS is a priority intervention in the prevention strategy (Bhola & Naugah: 2006).

An increasingly high prevalence of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) cases especially among the young generation has been noted in Mauritius over the last two decades. The HIV/AIDS education is now recognized as an important response to the emerging HIV/AIDS crisis and the Government of Mauritius strongly supports all policies linked with it. The Mauritius Institute of Education (MIE) being a unique tertiary institution in teacher education in the country, has been integrating HIV/AIDS education into various educator training programmes, primary and secondary school curricula, and is also undertaking various research projects in related fields. Under the MIE-School link initiative a project was recently initiated using a blended mode of face-to-face and online interaction of HIV/AIDS course designed for secondary school students. This was aimed at creating

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awareness on HIV/AIDS among students and enabling them to actively participate in the learning process and become independent learners. It also focused on developing a community of practice whereby learners were encouraged to network with their peers and friends from other schools on the above related issues. They were motivated to be instrumental in conveying HIV/AIDS education to their parents and community at large. This project included online interaction in order to provide flexibility in the learning process where the learners can access their pedagogical resources from anywhere and at any time.

Since internet connectivity is a major hindrance to the learning process in many schools of the island, a CD-Rom with all the learning resources on HIV/AIDS was provided to both the students and educators. The Moodle e-learning platform was used as it is an open source and is also based on socio-constructivist approach. The interface was carefully designed to make it more intuitive, user-friendly and navigable and the instructional principles were carefully applied while designing the course material. This approach was pilot tested using questionnaire and semi-structures interviews at one school for a period of one month. The findings were used to amend the online approach and materials prior to its eventual use at two mixed schools in two different educational zones of Mauritius. After 3 months of close monitoring, the effectiveness of the whole HIV programme was evaluated using questionnaire, semi-structured interviews and observations. (Bholah & Naugah: 2006).

Mauritius has a relatively big population of young people and the present data tend to show that there is an on-going HIV-epidemic in the island with more and more youngsters contracting HIV. This has led much concern to the Mauritian Government, which constantly puts more emphasis on education. The latter seems to be the only solution or social vaccine to counteract the trend and prevent the spread of the HIV. However, it is noted that many people have still poor knowledge on the disease despite various campaign and sensitization HIV/AIDS programmes carried out throughout Mauritius. This implies that we need to revisit our approach of dissemination of HIV/AIDS education and also reflect upon the factors influencing the learning of the

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disease including the different teaching aids being used in each sensitization campaign. (Bholah & Naugah: 2006)

Moreover, Mauritius Institute of Education (MIE), the unique National tertiary institution on Teacher Education has been playing a vital role in the prevention of HIV/AIDS as it can easily reach out majority of youngsters (including those in the group 15-20yrs) through its trained educators (multiplier effect) and school curricula. The MIE is already involved in various school outreach projects to help the community and the society at large in the promotion of health education. This project is also an outreach programme, probably first of its kind and aims at networking with students at each school and with others through a blended mode (face-to-face and online interaction) and working together to prevent the spread of the disease. (Bholah & Naugah: 2006).

Under the MIE-school link initiative a project was recently initiated using a blended mode of face-to-face and online interaction of HIV/AIDS course designed for secondary school students. This was aimed at creating awareness on HIV/AIDS among students and enabling them to actively participate in the learning process and become independent learners. At the beginning MIE internationally selected Biology students from form V as they follow the Cambridge International Examination (CIE) Biology (2008) and this hasa section entitled "Sexually Transmitted Diseases (STD)" (addressing the spread of HIV/AIDS and methods by which it may be controlled), which is usually covered at form V level throughout the island. This helped the MIE to convince School Managers and Biology educators at each school and proceed with the study very easily. For instance, they were both briefed about the scope of the project which included a face-to-face session and then online interaction with students on HIV/AIDS in order to provide flexibility in the learning process where the learners can access their pedagogical resources from anywhere and at any time. The main emphasis of the HIV/AIDS education course was on the following areas:

- STD, HIV and AIDS
- modes through which HIV are transmitted
- facts, myths and misconceptions about HIV/AIDS

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- communication skills and assertiveness, negotiation and decision making ways to cope with high risk situations
- human rights (discrimination and stigma)

The Moodle -learning platform was used as it is an open source and is also based on socio-constructivist approach. The interface was carefully designed to make it more intuitive, user-friendly and navigable and the instructional principles were carefully applied while designing the course material. Since Internet connectivity is a major hindrance to the learning process in many schools of the island, a CD-ROM with all the learning resources on HIV/AIDS was provided for both students and educators. Therefore School Managers and Biology teachers readily accepted to participate in the project, as this was not completely a new area to be explored and taught nor disturbed their routine schoolwork. Moreover they were convinced that the online interaction and use of CD-ROM on HIV/AIDS would surely enhance students' understanding of certain concepts on HIV/AIDS and would eventually prevent any spread of the disease among students at the schools and help the society at large. In some cases, the educator of Information and Technology was also briefed about the project in order to help the Biology educators in case they have difficulties to use the Moodle platform. (Bholah & Naugah: 2006).

2.17 CONCLUSION

HIV/AIDS in South Africa and all over the world is real-it touches all our lives. However, the silence and denial that shrouds the disease has accelerated its onslaught. We all bear responsibility- from the president of the country to the educators in the classroom. We cannot afford to be silent anymore. Education and our schools stand at the front-line in this battle against HIV/AIDS much has already been done in the education sector. Here are a few examples:

- Educators unions have helped by publicly breaking the silence: 'AIDS kills educators too';
- The Department of Education has placed priority on HIV/AIDS;
- International agencies support HIV/AIDS education, e.g. EI and WHO among

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several others.

However, our informants on the ground argue that the official initiatives taken, however well meaning, are being undermined by the cultural, socio-economic and gender realities in the classroom and in communities. It follows therefore that any comprehensive strategy to combat the pandemic must start from an understanding of where stakeholders are now, especially educators and learners. The priorities therefore are:

- To enhance the position of women teachers within the education system and teacher union;
- To make male educators and male learners aware about their role in the spread of the pandemic;
- To develop new teaching strategies which address actual beliefs, values and behavior.

As educators at this crucial time in our history we have a responsibility to inform and change behavior. HIV/AIDS is a threat to us all. In Africa we have defeated our colonial masters, in South Africa we have defeated apartheid- schools were the battlegrounds against our oppressors. A new war of liberation has now been called for, but the enemy is far more sinister and lives within us- it stalks our playgrounds, our classrooms and our communities. We have to be ready for it. There is not time to waste. For every minute wasted one of us dies.

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CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter kick-start by defining the meaning of the terms 'research design and methodology followed by an outline of population, sampling method, sample size, data collection method and ethical consideration. The tail-end of the chapter concludes with data management and analysis procedures.

3.2 RESEARCH DESIGN AND METHODOLOGY

3.2.1 Research design

The research design for this study will be quantitative. Quantitative research design follows a deductive research process and involves the collection and analysis of quantitative data to identify statistical relations of variables. Thus it is concerned with numeric information including quantities, percentages and statistics. Quantitative research design emphasise the production of precise and generalisationable statistical findings. When we want to verify whether a cause produces an effect we are likely to use quantitative research design. For the purpose of this study, the quantitative research will give less emphasis on exploring the personal, individual meanings of experiences to the people. This does not mean, though that meaning and feelings have no place in quantitative research. The quantitative research does not deny or ignore personal experiences. (Punch: 2000)

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3.2.2 Methodology

The methodology will comprise the following:

3.2.2.1 Population

Population of this study will comprise of approximately :-

1 520 grade 10 learners (out of 15 schools)

259 teachers

15 Principals

3.2.2.2 Sampling and sample

The researcher will use systematic random sampling. According to Statpac (2009) the advantage of this sampling method is that the degree to which a sample might differ from the population can be calculated unlike with non-probability sampling where sampling error is unknown.

The following formula will be applied to draw a sample:

N/n

Where N is the target population and n is the intended sample size. Thus, every nth learner in the list will qualify for the interviews. Below hereunder are steps to be followed in order to achieve a systematic random sample:

Number the units in the population from 1 to N

Decide on the n (sample size) that is needed

K = N/n = interval size

Randomly select an integer between 1 to K

Then take every K^{th} unit.

Sampling: 60 learners, i.e. 10 learners from 6 schools

30 educators i.e. 5 educators from 6 schools

6 principals from 6 schools

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Sample

The researcher's sample size is composed of:

Learners = 60

Educators = 30

Principals = 6

3.3 DATA COLLECTION STRATEGY.

The researcher will make use of the questionnaire as a tool through which information can be elicited from the respondents. Well-structured questionnaires with closed-ended and open-ended questions designed from the learners, educators and principals will be provided. The reason for designing questionnaires is that the researcher wanted to determine the learners' level of knowledge regarding HIV/AIDS. De Vos (2002: 152) defines a questionnaire "as a set of questions on a form that is completed by the respondent in respect of a research project."

For the purpose of this study, questionnaires will be distributed and administered by the respective class teachers after school, with the assistance of the researcher. The educator will be given an instruction by the researcher to ensure consistency in all the schools and to avoid bias (De Vos, 2002)

The questionnaire will be pre-tested to ensure that any errors can be rectified and any modification can be effected before presenting questionnaires to the full sample. It is anticipated that pre-testing of questionnaires will not results in serious modification of questionnaires as this stage will be preceded by informal discussion on this research topic. Data collected will be kept confidential and the analysis will not reflect individual respondents as it will be reported at an aggregate level. (De Vos, 1998)

Data that has been acquired by other people before, published or unpublished is also considered useful in this study especially to avoid time wasted in repeating studies.

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However, it will be used with care to avoid using information that was done to suit a particular place and achieving some personal objectives. This will include books, journals, magazines, newspapers etc.

3.3.1 Reliability and Validity

Reliability is defined by Golafshani (2003) as the extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability and if the results of a study can be reproduced under a similar methodology. In short, reliability is equivalent to consistency. Validity refers to the degree to which a study accurately reflects or assesses the specific concepts that the researcher is attempting to measure. It is basically concerned with the study's success at measuring what a researcher set out to measure. Sarantakos (1988) argues that researchers should be concerned with both external and internal validity. The former refers to the extent to which results are generalisable while the latter refers to the vigor with which the study was conducted and the extent to which the researcher has taken into account alternative explanations for any causal relationship.

In this study validity will mean truth generated from the research on designing appropriate strategies of teaching HIV/AIDS in schools. It will be through validity that the researcher will be able to determine whether the information collected is in relation with what actually happens or not in schools. This will be enhanced by validating results of the study by presenting them to the learners and educators before they are finalized. It is envisaged that reasons contrary to the general knowledge or researcher's *priori expectation* will be sought during the validation stage. Finally through questionnaires and informal discussions with expert, the researcher will be able to determine whether the information collected is in relation with what actually happens or not in the learning environment.

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3.4. ETHICAL CONSIDERATION

A study of this nature requires a recognition and maintenance of the highest ethical standards especially that HIV/AIDS issues are sensitive and in some cultures discussions of sexual issues are a taboo. There are ethical concerns or guidelines to be considered when conducting survey research (HSRC, 2002). Some of the guidelines are the following:

- Voluntary participation. Researchers need to make sure that participation is completely voluntary. However, voluntary participation can sometimes conflict with the need to have a high response rate. In order to encourage a high response rate, sampling will be done with replacement in this study
- Avoid possible harm to respondents. This includes embarrassment or feeling uncomfortable about questions. The study will avoid inclusion of sensitive questions that could cause embarrassment or uncomfortable feelings and if included will be at the end of the questionnaire. However, it is envisaged that pre-testing of the questionnaire will minimize inclusion of questions of this nature.
- Protect a respondent's identity. This will be accomplished by exercising anonymity and confidentiality. The study promises not to report individual responses in the report nor disclose the individual's identity. Data collected will be reported at an aggregate level.
- Let all prospective respondents know the purpose of the survey. The purpose of the study will be explained in detail before completion of questionnaires by the potential respondents and this will also be in the front page of the questionnaires. More importantly, the front page of the questionnaire will also explain that the results of the study would be used for a dissertation as fulfillment for a Masters degree.

Research on children poses a significant challenge especially taking into account ethical issues mentioned above (e.g age of consent and capacity to give consent) as well as other legal issues. To avoid conflict with any legislative requirements consent of the caregiver or a guardian may be sought before any child under the age of 16 participate in the

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survey. Sixteen years is the cut-off age adopted from the Children's Act, 35 of 2005 which defines a child as any person under the age of 16.

3.5 CONCLUSION

This chapter focused on the research procedures to be followed in this study and these included, sampling, data collection and analysis, among other things. Outlining of the research procedures ensures that the objectives of the study will be attained and the research questions are adequately addressed. Addressing the empirical research will be the basis of the next chapter (Chapter 4).

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CHAPTER 4

4. DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

This chapter focuses on data analysis and interpretation of the results based on questionnaires which were distributed to learners, educators and principals of selected schools. This will mainly be a quantitative analysis based on a sample of 60 learners, 30 educators and 6 principals. The researcher will personally deliver the questionnaires to all selected schools. Results obtained from the principals' questionnaires should be interpreted with caution as the sample size is too small. In the analysis some of the respondents refused to answer.

4.2 ANALYSIS OF RESPONSES FROM LEARNERS

1. Learners were requested to indicate their gender

Table 1

Respondents	Number	Percentage
Males	29	48%
Females	31	52%
Total	**60**	**100%**

Table 1 above indicates that females are slightly the majority in grade 10 of the selected schools and they make 52 per cent of the sample. This is in line with the total population of the sampled schools.

2. Learners were requested to indicate their ages

Table 2

Respondents	Number	Percentage
Below 13	1	1%
13 – 15	7	12%
16 – 18	45	75%
19 – 21	7	12%
Total	**60**	**100%**

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The majority of the respondents (75%) have ages ranging from 16 to 18 years of age compared to 12% whose ages range from 19 to 21 and 13 to 15 years of age. Age distribution of the majority of the respondents is contrary to the expectation as normally grade 10 learners should be 15 years of age and the *priori* expectation was that the majority of respondents would be in the 13 to 15 years of age. This means that the majority of learners have probably lost one year of learning either as a result of dropping out of school or poor performance leading to failure.

3. Learners were requested to indicate their home languages

Table 3

Respondents	**Number**	**Percentage**
Tshivenda	53	88%
Xitsonga	6	10%
No response	1	2%
Total	**60**	**100%**

In terms of the analysis, Tshivenda is the home language for most of the respondents as it is spoken by 88% of the sampled learners. This possibly poses a bit of a challenge for the minority (10%) who speak Xitsonga as their home language while at school they are taught Tshivenda. Two percent did not respond. So one would expect those who speak Tshivenda at home to perform much better than their Tsonga counterparts particularly in Tshivenda as a language.

4. Learners were asked with whom they normally stay at home

Table 4

Respondents	**Number**	**Percentage**
Both parents	29	48%
Mother only	20	34%
Father only	2	3%
Grandmother	7	12%
Grandfather	0	0%
No response	2	3%
Total	**60**	**100%**

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Table 4 above shows that (48%) of learners stay with their parents and 34% of the learners stay with their mothers. This question was applied as a proxy for a guardian. 3% did not respond. Thus there are fertile grounds for learners to be informally taught sexual matters as they stay at least with one adult person at home compared to a situation where learners stay alone without any adult person/guardian.

5. Learners were requested to indicate the type of location

Table 5

Respondents	Number	Percentage
Rural	55	92%
Urban	3	5%
Semi-Urban	2	3%
Other	0	0%
Total	**60**	**100%**

Sampled schools are located in rural areas and it is not surprising that by far the majority of learners (92%) stay in rural compared to 5% and 3% staying in urban and semi urban areas, respectively. Compared to their rural counterparts, urban areas are generally well endowed with resources (e.g libraries), have access to many services and are even exposed to promotional activities such campaigns, billboards on HIV/AIDS. Thus, it is expected that rural dwellers are less informed about so many things including issues on HIV/AIDS.

6. Learners were requested to indicate their religions

Table 6

Respondents	Number	Percentage
Christianity	56	93%
Muslim	1	2%
Other	2	3%
No response	1	2%
Total	**60**	**100%**

Table 6 shows that almost all learners belong to a particular religion with Christianity being the dominant one at 93%. Two percent did not respond. Assuming that learners comply with certain religious beliefs such as the one that advocate for sex before

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marriage, it means that there is a window of opportunity to have low prevalence of HIV/AIDS in the selected regions.

7. Learners were asked where they first heard about HIV/AIDS

Table 7

Respondents	Number	Percentage
School	39	65%
Church	2	3%
Home	8	13%
Community	10	16%
Other	0	0%
No response	1	3%
Total	**60**	**100%**

Table 7 above shows that a greater proportion of learners (65%) first heard about HIV/AIDS at schools followed by 16% who first heard about it in the community where they stay. Three percent did not respond. This means that the majority of learners possibly first heard about the epidemic when they are at least 9 years old. Informal conversation with adults reveals that teaching young people on sexual matters gives an impression that one is indirectly telling them to start getting involved. With the exception of schools, it is for this reason that other potential information sources (e.g churches) are lagging behind in respect of being the first information source.

8 Learners were asked if HIV/AIDS lessons are being taught at school

Table 8

Respondents	Number	Percentage
Yes	28	47%
No	32	53%
Total	**60**	**100%**

The majority of learners (53%) as shown in Table 8 above show that HIV/AIDS lessons are not being taught at schools. Linking this with the result shown in Table 7 above, although 65% of the learners first heard about HIV/AIDS at school they probably first heard about it not as a taught subject but probably informally through interaction with other learners, educators or health workers. If results shown in Table 8 are true, this

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implies that certain schools are in direct conflict with section 2.10 of the National Policy on HIV and AIDS which stated that learners and students must receive education about HIV and AIDS, among other things.

9 Learners were asked if they are satisfied with the way HIV/AIDS is taught

Table 9

Respondents	Number	Percentage
Satisfied	18	30%
Strongly satisfied	7	12%
Dissatisfied	3	5%
Strongly dissatisfied	0	0%
No response	32	53%
Total	**60**	**100%**

Overall learners are satisfied with the way HIV/AIDS is taught at schools as shown in Table 9 above. Satisfaction level is quite high (42%) relative to the dissatisfaction level of 5%. Fifty three did not respond. This means that there is a window of opportunity for those schools whose learners indicated that it is not a taught subject to learn and capitalize on those aspects that makes its satisfaction level so high.

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10 Learners were asked at which grade HIV/AIDS should start to be taught

Table 10

Respondents	Number	Percentage
Grade R - 3	6	10%
Grade 4 - 6	19	32%
Grade 7 - 9	14	23%
Grade 10 - 12	14	23%
Post Matric	7	12%
Total	**60**	**100%**

Table 10 above, the majority of learners (32%) indicated that HIV/AIDS should be taught from as early as Grade 4-6 and this is followed by an equal number of learners (23%) who indicated that it should start to be taught from grade 7 to 9 and grade 10-12. This implies that the teaching of HIV/AIDS should start at an early age

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11 Learners were asked the language which is used to teach HIV/AIDS in their schools

Table 11

Respondents	Number	Percentage
Tshivenda	4	7%
Xitsonga	0	0%
Sepedi	0	0%
English	46	76%
Afrikaans	0	0%
Other	3	5%
No response	7	12%
Total	**60**	**100%**

HIV/AIDS is predominantly taught in English as indicated by 76% of the learners followed by Tshivenda (7%). It should be noted that 'other languages' used to teach HIV/AIDS as indicated by 5% of the learners is a combination of both Tshivenda and English. Twelve percent did not respond. Teaching HIV/AIDS is understandable considering that English is a medium of instruction and it is mostly used to accommodate people from different ethnic groups.

12 Learners were asked if they were satisfied with the language which is used to teach HIV and AIDS in their schools.

Table 12

Respondents	Number	Percentage
Satisfied	10	17%
Strongly satisfied	14	23%
Dissatisfied	3	5%
Strongly dissatisfied	0	0%
No response	33	55%
Total	**60**	**100%**

Overall learners (40%) are satisfied with the language used to teach HIV/AIDS and of these learners a greater proportion of them (23%) are strongly satisfied. 55% did not respond. Of the dissatisfied learners it could be that their language proficiency level is very low. If this statement holds true, then HIV/AIDS should be taught in a simple language whether foreign or vernacular.

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13 Learners were asked if HIV/AIDS is transmitted by infectious virus

Table 13

Respondents	Number	Percentage
True	56	93%
False	4	7%
Total	**60**	**100%**

From Table 13 above, a greater proportion of learners (93%) show that HIV/AIDS is caused by infectious virus. Thus learners understand the causes of HIV/AIDS and their awareness level on this aspect is considerably high.

14 Learners were asked if HIV and AIDS is a punishment from God

Table 14

Respondents	Number	Percentage
True	18	30%
False	42	70%
Total	**60**	**100%**

Table 14 above shows that 70% of the learners do not agree with the statement that HIV and AIDS is a punishment from God. This therefore means that it is widely accepted that it is a disease brought about by other causes such human misbehaviour etc. This is contrary to misinterpretation by some of Luke 21:11 which states that "There would be terrible earthquakes, famines and plaques everywhere, there will be strange and terrifying things coming from the sky".

15. Learners were asked if HIV/AIDS cannot be transmitted by sharing the same classroom with HIV positive learners

Table 15

Respondents	Number	Percentage
True	35	58%
False	25	42%
Total	**60**	**100%**

Table 15 above shows that majority of learners (58%) agree with the statement that HIV/AIDS cannot be transmitted by sharing the same classroom with HIV positive

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learners. However, it is worrying that 42% of the learners agree with that statement. This therefore means that 42% of the learners are likely to discriminate against the infected learners as they believe that mere sharing of classroom with other infected learners put them at risk of contracting HIV/AIDS

16 Learners were asked if only older people can contract AIDS

Table 16

Respondents	Number	Percentage
True	8	13%
False	52	87%
Total	**60**	**100%**

A greater proportion of the learners (87%), as shown in Table 16 do not agree with the statement that only older people can contract AIDS. This therefore means that HIV/AIDS infection has no age limit and anyone can become infected if (s)he has either unprotected sexual intercourse or shares needles/instruments with someone else who is infected.

17 Learners were asked if AIDS is a curable disease

Table 17

Respondents	Number	Percentage
True	34	57%
False	26	43%
Total	**60**	**100%**

Table 17 shows that the majority of learners (57%) regard AIDS as a curable disease while 43% of learners consider it as an incurable disease. A response by the majority of learners is worrying as the plain truth is that AIDS is a killer disease and there is no cure for it. Death in itself normally act as a deterrent and the fact that it is considered a curable disease means that these learners would probably not consider preventing it from spreading and would not practice safe sex.

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18 Learners were asked if AIDS does not exist

Table 18

Respondents	Number	Percentage
Agree	15	25%
Strongly agree	5	8%
Disagree	25	42%
Strongly disagree	15	25%
Total	**60**	**100%**

Forty two per cent of the learners disagree with the statement that AIDS does not exist while 25% equally disagree and agree with that statement. This reflects various beliefs that people have with this epidemic as some people believes that AIDS is not a new disease, but has been present for centuries in Africa and the name AIDS is an evolution of a disease which was called in other names in the past.

19 Learners were asked if it is okay to have unprotected sex with many different boys or girls.

Table 19

Respondents	Number	Percentage
Agree	9	15%
Strongly agree	5	8%
Disagree	15	25%
Strongly disagree	31	52%
Total	**60**	**100%**

The majority of learners (52%) strongly disagree that it is acceptable to have unprotected sex with many different partners. It could be that these learners consider having unprotected sex with too many partners as morally wrong and they are afraid of contracting other infectious disease other than AIDS.

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20 Learners were asked if sex with a virgin can cure AIDS

Table 20

Respondents	Number	Percentage
Agree	11	18%
Strongly agree	7	12%
Disagree	20	33%
Strongly disagree	21	35%
No response	1	2%
Total	**60**	**100%**

The majority of learners (35%) as shown in Table 20 strongly disagree with the myth that having sex with a virgin can cure AIDS. Two percent did not respond. Although the majority of learners (57%) as shown in Table 17 consider HIV/AIDS as a curable disease this disagreement by learners on this question probably indicate that there are other treatments that they think can cure HIV/AIDS such as ARVs.

21 Learners were asked if most teenagers are safe to have sex without using condoms

Table 21

Respondents	Number	Percentage
Agree	18	30%
Strongly agree	4	7%
Disagree	17	28%
Strongly disagree	19	32%
No response	2	3%
Total	**60**	**100%**

The majority of learners (32%) strongly disagree with the statement that teenagers are safe to have sex without condoms and this is followed by 30% of learners who agree with the statement. Three percent did not respond. This probably explains why there is a high prevalence of teenage pregnancy in schools assuming non use of contraceptive by learners.

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22 Learners were asked if teenage pregnancy for learners who are HIV positive give birth to children who are HIV negative

Table 22

Respondents	Number	Percentage
Agree	22	37%
Strongly agree	7	12%
Disagree	19	31%
Strongly disagree	11	18%
No response	1	2%
Total	**60**	**100%**

From Table 22, a slight majority of the learners (37%) agree with the statement that teenage pregnancy for learners who are HIV positive give birth to children who are HIV negative and this is followed by 31% of the learners who agree with the statement. Two percent did not respond. This probably indicates learners' good knowledge about mother to child transmission of HIV as Van Dyk (2005) argues that a mother is more likely to pass the HIV virus to her baby during pregnancy, childbirth or breastfeeding and on the other hand he argues that unless preventative measures are taken 20-40% of children born to HIV positive women are infected.

23 Learners were asked which of the statement listed in the table below is closely associated with HIV

Table 23

Respondents	Number	Percentage
Affecting people and animals	0	0%
A known killer disease	3	5%
Human Immune Virus	57	95%
Healthy individuals	0	0%
Do not know	0	0%
Total	**60**	**100%**

By far the majority of learners (95%) associate HIV with Human Immune Virus. This shows a good knowledge of the epidemic by learners in respect of the causes of HIV/AIDS

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24 From the statement listed in the Table below, learners were asked the statement that suits best in association with HIV

Table 24

Respondents	Number	Percentage
Someone has got serious illness	13	22%
A person does not want to eat food	1	1%
A person is infected with the virus as confirmed by HIV test	38	63%
A person is suffering from stomach ache	4	7%
Do not know	4	7%
Total	**60**	**100%**

A greater proportion of the learners (63%) as shown in the table above indicated that having HIV/AIDS means that a person is infected with the virus as confirmed by HIV test. This implies that through the eyes of the majority of learners HIV testing is the only certain way to tell if a person has been infected with HIV or not.

25 Learners were asked about the disease that is caused by HIV

Table 25

Respondents	Number	Percentage
Asthma	1	2%
Diabetics	1	2%
Heart attack	9	15%
AIDS	48	80%
Do not know	1	1%
Total	**60**	**100%**

The majority of learners (80%) from the table above indicated that HIV causes AIDS. Thus having HIV in the body one is likely to suffer from AIDS and this is a serious disease caused by a virus that destroys the body's natural protection from infection and which usually causes death. In addition, having AIDS gives way to other opportunistic disease and it is not surprising that other learners (19%) have chosen other diseases other than AIDS.

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26 Learners were asked to choose one way through which HIV/AIDS cannot be transmitted

Table 26

Respondents	Number	Percentage
Kissing and hugging	39	65%
Being involved in sexual activities	7	12%
Playing with someone's blood	12	20%
Breast feeding	1	2%
Do not know	1	1%
Total	**60**	**100%**

Kissing and hugging has been chosen by the majority of learners (65%) as one way through which HIV/AIDS cannot be transmitted. This implies that learners understand that HIV infection is not spread by casual and regular contact (e.g handshaking, touching) with an HIV infected person.

27. Learners were asked a possible way of preventing HIV infection in secondary schools

Table 27

Respondents	Number	Percentage
Not allowing anyone to touch their genitals	5	8%
Reporting cases of sexual abuse all the time	16	27%
By not implementing the universal precautions	4	7%
Avoiding sexual intercourse	31	51%
Do not know	3	5%
No response	1	2%
Total	**60**	**100%**

Avoiding sexual intercourse has been identified by 51% of the learners as the main possible way of preventing HIV infection as shown in Table 27. Two percent did not respond. This indicates that the majority of learners in a way do understand that no sex at all is the only real safe method. In addition, they in a way prescribe to the principle of 'prevention is better than cure'.

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28. From the table below, learners were asked to choose one of the universal precautions of preventing HIV

Table 28

Respondents	Number	Percentage
Cleaning blood with bare hands	8	13%
First aid kit with rubber gloves	24	40%
Having direct contact with another person's body fluids	6	10%
Having sexual intercourse with many partners	13	22%
Do not know	6	10%
No response	3	5%
Total	**60**	**100%**

From the table above, 40% of learners chose the use of first aid kit with rubber gloves as one of the universal precautions of preventing HIV and this is followed by 22% of learners who indicated that avoiding having sexual intercourse with many partners is one of the precautions. Five percent did not respond. Thus, the majority of learners (40%) seem to be aware of the universal precautions as stated in the National Policy on HIV and AIDS.

29 Learners were asked about one possible impact of HIV and AIDS

Table 29

Respondents	Number	Percentage
Learners who are infected and affected by HIV/AIDS will attend school on a regular basis	19	31%
Sick learners do well in their studies	10	16%
The illness disrupt teaching and learning	13	22%
Teachers who are infected and affected by HIV/AIDS will always be present at school	13	22%
Do not know	4	7%
No response	1	2%
Total	**60**	**100%**

Possible impact of HIV/AIDS varies widely as shown by sampled learners. The majority of learners (31%) indicated that learners who are infected and affected by HIV/AIDS will attend school on a regular basis followed by an equal percentage (22%) of learners who indicated that the illness disrupts teaching and learning, and that educators who are infected and affected by HIV/AIDS will always be present at school. Two percent did not

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respond. Overall the impact of HIV/AIDS as indicated by learners seem to be minimal and this could be an indication that it is still in its infant stage and as such its impact is somewhat not prevalent at the moment.

30 Learners were asked the way to support a learner living HIV and AIDS

Table 30

Respondents	**Number**	**Percentage**
By visiting him/her at home and buy cards with get well messages	46	76%
By gossiping a negative attitude towards him/her	4	7%
By gossiping about him/her	3	5%
By not listening to her/him when complaining about the sickness	6	10%
Do not know	0	0%
No response	1	2%
Total	**60**	**100%**

By far the majority of learners (76%) believe that the way to support a learner living with HIV/AIDS is by visiting him/her and buying cards with get well messages. Two percent did not respond. This implies the promotion or building of a caring student society need to be encouraged to bring hope and support to the infected learners.

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4.3 ANALYSIS OF RESPONSES FROM EDUCATORS

1. Educators were requested to indicate their gender

Table 1

Respondents	Number	Percentage
Males	16	53%
Females	14	47%
Total	**30**	**100%**

Table 1 above indicates that males are slightly the majority (53%) of the sampled educators in the sampled schools. This is also a reflection of the current general situation in which males dominate the job market

2. Educators were requested to indicate their ages

Table 2

Respondents	Number	Percentage
Below 25	0	0%
26 – 35	3	10%
36 – 45	16	54%
46 – 50	10	33%
51 and over	1	3%
Total	**30**	**100%**

Majority of educators are within the 36 – 45 age bracket followed by those whose ages ranges between 46 – 50 years of age (33%). Overall, teachers' age distribution follows a normal distribution with only a few teachers (10%) within the age bracket of between 26 – 35 and 3% whose age is over 51

3. Educators were requested to indicate their marital status

Table 3

Respondents	Number	Percentage
Single	3	10%
Married	25	83%
Divorced	0	0%
Widowed	2	7%
Other	0	0%
Total	**30**	**100%**

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Considering the age distribution of educators in Table 2 above, it is not surprising that by far the majority of educators (83%) as shown in Table 3 are married. Thus, there are fertile grounds for these educators to speak about sexual matters with learners as they might also be having children not 'immuned' from the scourge of HIV/AIDS.

4. Educators were requested to indicate their academic qualifications

Table 4

Respondents	Number	Percentage
Below Grade 12	0	0%
Grade 12	9	30%
Degree	13	43%
Honours degree	8	27%
Masters degree	0	0%
Doctorate	0	0%
Other	0	0%
Total	**30**	**100%**

Table 4 above shows that the majority of educators (43%) have a degree as an academic qualification. This implies that educators are relatively highly qualified and are capable of performing their educational duties including converting complex issues into simple matters to be understood by learners no matter how difficult or sensitive it is to present a particular topic.

5. Educators were requested to indicate their professional qualifications

Table 5

Respondents	Number	Percentage
STD	19	63%
UED/PGCE	7	23%
SSTC	0	0%
HED	2	7%
Other	2	7%
Total	**30**	**100%**

Table 5 above shows that 63% of educators have acquired the Secondary Teachers' Diploma followed by 23% of educators with a University Education Diploma. An equal

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number of educators (7%) have a Higher Education Diploma and others (e.g BA ED). This means that sampled educators are qualified to teach in secondary schools

6. Educators were requested to indicate their home languages

Table 6

Respondents	Number	Percentage
Tshivenda	28	94%
Xitsonga	1	3%
Sepedi	1	3%
English	0	0%
Afrikaans	0	0%
Other	0	0%
Total	**30**	**100%**

From table 6 above the majority of educators (94%) speak Tshivenda as their home language. Considering their academic qualifications as presented in table 4 it is expected that they are proficient in at least two languages (i.e English and Tshivenda) making it possible for learners to fully understand what is being taught in class.

7. Educators were asked if they agree that HIV/AIDS must be taught at schools

Table 7

Respondents	Number	Percentage
Agree	17	57%
Strongly agree	13	43%
Disagree	0	0%
Strongly disagree	0	0%
Total	**30**	**100%**

Table 7 above indicates that 57% of educators agree that HIV/AIDS must be taught at schools. Overall, all educators agree that it should be taught at schools. This implies that educators fully support prescripts of the National Policy on HIV and AIDS that advocates for the teaching of HIV/AIDS in schools. Assuming that this is not a response in compliance with the requirements of the aforesaid Act, it would appear that educators do teach this subject with passion as they agree with the statement.

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8. Educators were asked if they think that a study of this nature (HIV/AIDS) is important

Table 8

Respondents	Number	Percentage
Yes	30	100%
No	0	0%
Total	**30**	**100%**

Table 8 above shows that all educators agree that a study of this nature (HIV/AIDS) is important. Based on this results and in pursuit of fighting this epidemic it is assumed that educators will support sensible recommendations that will emanate from the study

9. Educators were asked if they personally teach a learning area that entails HIV/AIDS

Table 9

Respondents	Number	Percentage
Yes	24	80%
No	6	20%
Total	**30**	**100%**

The majority of the sampled educators (80%) personally teach a learning area that entails HIV/AIDS. This results therefore confirms that HIV/AIDS is being taught in schools and schools do comply with the prescripts of the National Policy on HIV and AIDS.

10. Educators were asked if they have ever received any formal training courses on HIV/AIDS

Table 10

Respondents	Number	Percentage
Yes	7	23%
No	17	57%
No response	6	20%
Total	**30**	**100%**

Table 10 above reveals that 57% of the educators have never received any formal training courses on HIV/AIDS. Twenty percent did not respond. Section 2.10.3 of the National

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Policy on HIV and AIDS provides that all educators should be trained to give guidance on HIV/AIDS. This implies that only 23% of the sampled educators are in compliance with the section of the aforesaid Act.

11. Educators were asked if they have attended any HIV workshops, seminars or In-Service Trainings

Table 11

Respondents	Number	Percentage
Yes	13	43%
No	17	57%
Total	**30**	**100%**

A greater proportion of educators (57%) as shown in table 11 have never attended any HIV/AIDS workshops, seminars or In-Service Training, compared to 43% of educators who indicated that they have attended. Although HIV/AIDS is taught in schools, it would appear that most educators do not have the necessary skills nor capacity to offer the learning area.

12. Educators were asked if they think that these workshops, seminars or In-Service Trainings are important

Table 12

Respondents	Number	Percentage
Important	5	16%
Unimportant	0	0%
Most important	8	27%
Most unimportant	0	0%
No response	17	57%
Total	**30**	**100%**

Table 12 above shows that 27% of educators indicate that the workshops offered are most important while 16% of them indicate that it is important. Fifty seven percent did not respond. This means that if given the opportunity to attend all educators are willing to attend those workshops given that they are regarded as important. In addition, it could be

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an indication that they are regarded as effective especially by those who have already attended such workshops.

13. Educators were asked sources of information regarding these workshops

Table 13

Respondents	Number	Percentage
Media	12	40%
Letters	0	0%
Circulars	14	47%
Other	1	3%
No response	3	10%
Total	**30**	**100%**

Circulars are the most important source of information on HIV/AIDS workshops as indicated by 47% of the educators and this is followed by 40% of educators who indicated that media is one of the sources of information. Ten percent did not respond. This implies that multiple sources of information should be applied to disseminate information particularly those sources that are directed primarily to the educators.

14 Educators were asked if the government monitors the teaching of HIV/AIDS at schools

Table 14

Respondents	Number	Percentage
Yes	4	13%
No	26	87%
Total	**30**	**100%**

By far the majority of educators (87%) indicate that the government does not monitor the teaching of HIV and AIDS in schools. Section 2.6.3 of the National Policy on HIV and AIDS provides that it is the state's duty to take all reasonable steps to ensure safe schools and institutions environment. Without monitoring the teaching of HIV and AIDS it would be very difficult for government to comply with the prescripts of the Act.

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15 Educators were asked how often the government monitors the teaching of HIV/AIDS

Table 15

Respondents	Number	Percentage
Regularly	1	3%
After every three month	1	3%
No response	28	94%
Total	**30**	**100%**

Table 15 above shows that 3% of the educators who agree with the statement that government monitors the teaching of HIV/AIDS say it is monitored regularly while the other 3% say it is monitored every quarter. Ninety four percent did not respond. It appears that more work still need to be done by government as monitoring happens only in few schools.

16. Educators were asked if they are aware that every child has a right to education

Table 16

Respondents	Number	Percentage
Yes	30	100%
No	0	0%
Total	**30**	**100%**

Table 16 above shows that all educators (100%) agree that education is a right for every child. This implies that learners are entitled to be taught even those aspects of education that enhances their rights to life as entrenched in the Bill of Rights. HIV/AIDS violate the right to life as it leads to death. Thus the teaching of HIV/AIDS should be considered as part of basic education.

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17 Educators were asked if they are satisfied with the teaching of HIV/AIDS at their schools

Table 17

Respondents	Number	Percentage
Satisfied	8	27%
Strongly satisfied	4	13%
Dissatisfied	11	37%
Strongly dissatisfied	3	10%
No response	4	13%
Total	**30**	**100%**

Table 17 shows that 37%, 27%, 13% and 10% of the educators are dissatisfied, satisfied, strongly satisfied and strongly dissatisfied with the teaching of HIV/AIDS in their schools, respectively. Overall 47% of the educators are not satisfied compared to 40% who are satisfied. Thirteen percent did not respond. Thus there is a need for the Department of Basic Education to review the implementation of the National Policy on HIV and AIDS, with an intention of establishing areas for improvement.

18. Educators were asked they have adequate materials of teaching HIV/AIDS

Table 18

Respondents	Number	Percentage
Yes	2	7%
No	27	90%
No response	1	3%
Total	**30**	**100%**

It is indicated that 90% of educators do not have adequate materials of teaching HIV/AIDS as shown in Table 18 above. Three percent did not respond. It is probably for this reason why the majority are not satisfied with the teaching of HIV/AIDS at schools.

19. Educators were asked if they have textbooks on how to teach HIV/AIDS

Table 19

Respondents	Number	Percentage
Yes	9	30%
No	21	70%
Total	**30**	**100%**

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Closely related to the above is an indication by 70% of educators who indicated that they do not have textbooks on how to teach HIV/AIDS. Although majority of sampled educators are teaching this confirms that it is offered without adequate resources that would enable teachers to fully perform on this learning area.

20 Educators were asked if there are any barriers in the teaching of HIV/AIDS

Table 20

Respondents	Number	Percentage
Yes	14	47%
No	16	53%
Total	**30**	**100%**

Table 20 above reveals that 53% of educators indicate that there are no barriers in the teaching of HIV/AIDS compared to 47% who indicated that there are barriers. Low response in respect of those indicating the existence of barriers in the teaching of HIV/AIDS is puzzling considering a high response of educators who indicate that there are neither adequate materials nor textbooks in the teaching of HIV/AIDS. It could be that some educators regard lack of these resources as 'soft' barriers that could be easily dealt with compared to other serious barriers such as culture.

21. Educators were asked to state the main barriers

Table 21

Respondents	Number	Percentage
Lack of teacher-learner support	8	27%
Cultural barriers (taboo/sensitive course to teach)	3	10%
Language	1	3%
Infected people discriminated against	1	3%
No change in behaviour	1	3%
No response	16	54%
Total	**30**	**100%**

Lack of teacher-learner support is one of the main barriers expressed by the majority of educators (27%) (those who responded), followed by cultural barriers (10%). An equal percentage of educators (3%) revealed the following as some of the barriers in the

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teaching of HIV/AIDS, namely language, no change in behaviour and discrimination of people living with the disease. Fifty four percent did not respond. The factors listed above are a good starting point for the Department of Basic Education to focus on when considering improving the teaching of HIV/AIDS however the biggest challenge lies in breaking the cultural barriers.

22. Educators were asked the language they use to teach HIV/AIDS in their schools

Table 22

Respondents	Number	Percentage
Tshivenda	4	14%
English	24	80%
Tsonga	0	0%
Afrikaans	0	0%
Other	1	3%
No response	1	3%
Total	**30**	**100%**

English is the most used language in teaching HIV/AIDS as expressed by 80% of educators followed by Tshivenda (14%). Other languages used as expressed by 3% of educators are a combination of both Tshivenda and English. Three percent did not respond. This result is consistent with learners' responses on this question and therefore this implies that the choice of language to be used for the teaching of HIV/AIDS needs to be accommodative.

23. Educators were asked if they are satisfied with the language which is used to teach HIV/AIDS in their schools

Table 23

Respondents	Number	Percentage
Satisfied	17	57%
Strongly satisfied	6	20%
Dissatisfied	4	13%
Strongly dissatisfied	2	7%
No response	1	3%
Total	**30**	**100%**

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A greater proportion of educators (57%) are satisfied with the language used to teach HIV/AIDS in their schools and this is followed by those who indicated that they are strongly satisfied (20%). Three percent did not respond. Overall, this implies that language used in the teaching of HIV/AIDS is not as such a barrier.

24. Educators (dissatisfied and strongly dissatisfied) were asked the language they think should be used to teach HIV/AIDS

Table 24

Respondents	Number	Percentage
Tshivenda	6	20%
English	0	0%
Tsonga	0	0%
Afrikaans	0	0%
None of the above	0	0%
No response	24	80%
Total	**30**	**100%**

Table 24 above shows that of the dissatisfied educators (20%) all of them prefers that it be taught in vernacular (Tshivenda). Eighty percent did not respond. This means that even government policies in general should be written in all official languages. Currently most of them are available only in Afrikaans and English.

25 Educators were asked if they are some educators who are not yet certain how HIV is contracted and spread

Table 25

Respondents	Number	Percentage
Agree	10	33%
Strongly agree	3	10%
Disagree	10	33%
Strongly disagree	7	24%
Total	**30**	**100%**

An equal number of educators (33%) both agree and disagree with the statement that some educators are not yet certain how HIV is contracted and spread. However, 10% and 24% of educators strongly agree and strongly disagree with the statement, respectively.

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Overall majority of educators (57%) disagree with the statement. It appears that there is need to raise the level of awareness on the part of educators and to capacitate them to be able to perform on their expected duties.

26. Educators were asked whether peoples' names living with HIV/AIDS should be disclosed publicly

Table 26

Respondents	Number	Percentage
Agree	6	20%
Strongly agree	3	10%
Disagree	5	17%
Strongly disagree	16	53%
Total	**30**	**100%**

Table 26 above shows that just above half (53%) of educators strongly disagree that peoples' names living with HIV/AIDS should be disclosed publicly and this is followed by those (20%) who indicated that it should be disclosed in public. It should be noted that confidentiality is a common law right of learners.

27. Educators were asked if there is a perception that girl learners are also prone to HIV infection because of sexual abuse by their educators

Table 27

Respondents	Number	Percentage
Agree	13	43%
Strongly agree	5	17%
Disagree	7	23%
Strongly disagree	5	17%
Total	**30**	**100%**

Table 27 above shows that the majority of educators (43%) agree with the perception that girls are prone to HIV infection because of sexual abuse by their educators as compared with 17% who strongly agree with this. This implies that girls are more vulnerable to contracting the disease compared to their male counterparts as there is a perception that they can even contract it from the very same people who are expected to protect them.

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28. Educators were asked if they agree that even if there is no cure for AIDS the disease can be prevented

Table 28

Respondents	Number	Percentage
Agree	15	50%
Strongly agree	14	47%
Disagree	0	0%
Strongly disagree	1	3%
Total	**30**	**100%**

Fifty per cent of educators agree that although there is no cure for AIDS, it can however be prevented, compared to 47% of educators who strongly agree with the statement. Thus the best defence against infection is prevention considering that it is not curable.

29. Educators were asked if they are also infected and affected by the epidemic

Table 29

Respondents	Number	Percentage
Agree	12	40%
Strongly agree	17	57%
Disagree	0	0%
Strongly disagree	1	3%
Total	**30**	**100%**

Fifty seven per cent of educators strongly agree that educators are either infected or affected by HIV/AIDS, compared to 40% who agree with this. This implies that it is everyone's responsibility to deal with this epidemic as it either infect or affect everyone in the society regardless of peoples' socio-economic background or status.

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30. Educators were asked if AIDS cases and deaths among educators have had various perceived negative impacts in schools

Table 30

Respondents	**Number**	**Percentage**
Agree	14	47%
Strongly agree	13	43%
Disagree	1	3%
Strongly disagree	2	7%
Total	**30**	**100%**

Almost half of educators (47%) agree that AIDS cases and deaths among educators have had various perceived negative impacts while 43% strongly agree. This implies that educators are already directly feeling the negative effects of the epidemic either as a result of losing a colleague or experiencing the suffering of their colleagues.

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4.4 ANALYSIS OF RESPONSES FROM PRINCIPALS

1 Principals were requested to indicate their gender

Table 1

Respondents	Number	Percentage
Males	5	83%
Females	1	17%
Total	**6**	**100%**

Table 1 above indicates that males are by far the majority (83%) of the principals in the sampled schools. This is also a reflection of the current general situation in which males dominate the job market. Thus there is still a need for women empowerment in the education sector for principalship posts.

2. Principals were requested to indicate their ages

Table 2

Respondents	Number	Percentage
Below 25	0	0%
26 – 35	0	0%
36 – 45	3	50%
46 – 50	2	33%
51 and over	1	17%
Total	**6**	**100%**

The majority of principals (50%) have ages ranging from 36 to 45 compared to 33% whose ages range from 46 to 50 and 17% whose age is 51 and above. This means that school principals within the sampled schools are matured people who can guide and assist both learners and educators in the teaching of HIV/AIDS in their schools.

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3. Principals were requested to indicate their marital status

Table 3

Respondents	Number	Percentage
Single	0	0%
Married	6	100%
Divorced	0	0%
Widowed	0	0%
Other	0	0%
Total	**6**	**100%**

All sampled principals are married as shown in table 3 above. There is a great chance that these principals have children at home who they also guide and educate them in life support skills making it simple for them to impart this knowledge to learners who they head.

4. Principals were requested to indicate their academic qualifications

Table 4

Respondents	Number	Percentage
Below Grade 12	0	0%
Grade 12	1	17%
Degree	1	17%
Honours degree	3	49%
Masters degree	1	17%
Doctorate	0	0%
Total	**6**	**100%**

Table 4 above shows that almost half of principals (49%) have an honours degree as an academic qualification, followed by an equal percentage of 17% with grade 12, a degree and a masters degree. This means that principals of the sampled schools are improving their qualifications which further indicate that those schools are under the management of educated principals.

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5. Principals were requested to indicate their professional qualifications

Table 5

Respondents	Number	Percentage
STD	3	50%
UED/PGCE	0	0%
SSTC	0	0%
HED	0	0%
Other (JSTC/BA ED/FDE)	3	50%
Total	**6**	**100%**

Table 5 above shows that half (50%) of principals have acquired the Secondary Teachers' Diploma while the other half has other professional qualifications (e.g BA ED). This means that sampled principals are qualified to teach in secondary schools

6. Principals were requested to indicate their home languages

Table 6

Respondents	Number	Percentage
Tshivenda	6	100%
Xitsonga	0	0%
Sepedi	0	0%
English	0	0%
Afrikaans	0	0%
Other	0	0%
Total	**6**	**100%**

From table 6 above all principals (100%) speak Tshivenda as their home language. Considering their academic qualifications as presented in table 4 it is expected that they are proficient in at least two languages (i.e English and Tshivenda) making it possible to effectively communicate with both learners and teachers.

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7. Principals were asked if HIV/AIDS education and sex education should be enforced in all schools across the country

Table 7

Respondents	Number	Percentage
Agree	0	0%
Strongly agree	6	100%
Disagree	0	0%
Strongly disagree	0	0%
Total	**6**	**100%**

Table 7 above indicates that all principals (100%) strongly agree that HIV/AIDS should be enforced in all schools across the country. This implies that principals fully support prescripts of the National Policy on HIV and AIDS that advocates for the teaching of HIV/AIDS in schools.

8. Principals were asked if the Department of Education must commit its efforts to the provision of training to educators, curriculum development and the provision of adequate teaching aids

Table 8

Respondents	Number	Percentage
Agree	0	0%
Strongly agree	6	100%
Disagree	0	0%
Strongly disagree	0	0%
Total	**6**	**100%**

From table 8 above all principals strongly agree that the Department of Education must commit its efforts to the provision of training to educators, curriculum development and the provision of adequate teaching aids. This shows that principals have a strong desire to see the successful integration of HIV/AIDS teaching in their schools.

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9. Principals were asked if they agree that learners and students with HIV have the right to attend any school or institution in accordance with the National Education Policy Act (No. 27 of 1996)

Table 9

Respondents	Number	Percentage
Agree	2	33%
Strongly agree	4	67%
Disagree	0	0%
Strongly disagree	0	0%
Total	**6**	**100%**

From table 9 above two third of the principals (67%) strongly agree with the statement that HIV infected learners have the rights to attend any school or institution while the remaining number of them (33%) agree with the statement. This means that HIV infected learners would not be discriminated against in respect of admission and registration thereof, for example. It is also clear that principals do comply with section 3 of the National Policy on HIV and AIDS that provides for non-discrimination and equality with regard to learners, students and educators with HIV and AIDS.

10. Principals were asked if schools should develop their own policy on HIV/AIDS

Table 10

Respondents	Number	Percentage
Agree	0	0%
Strongly agree	5	83%
Disagree	1	17%
Strongly disagree	0	0%
Total	**6**	**100%**

Table 10 above indicates that the majority of principals (83%) strongly agree that schools should develop their own policy on HIV/AIDS while only 17% disagree with this statement. The National Policy on HIV and AIDS provides for the development of policy guidelines for each school. This means that the majority of the principals are fully aware that HIV/AIDS policies need to be drawn up for educational institutions that they lead.

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11. Principals were asked whether they have to ensure that universal precautions are applied in their schools

Table 11

Respondents	Number	Percentage
Agree	2	33%
Strongly agree	3	50%
Disagree	1	17%
Strongly disagree	0	0%
Total	**6**	**100%**

Table 11 above indicates that half of the principals (50%) strongly agree, 33% agree and 17% disagree that principals have to ensure that universal precautions are applied in their schools. Thus, the majority of principals (83%) seem to be aware of the universal precautions requirements to effectively eliminate the risk of transmission of all blood-borne pathogens, including HIV in schools as stated in the National Policy on HIV/AIDS.

12. Principals were asked if HIV/AIDS will result in the decline of school enrolment rates and rising drop out rates

Table 12

Respondents	Number	Percentage
Agree	1	17%
Strongly agree	3	49%
Disagree	1	17%
Strongly disagree	1	17%
Total	**6**	**100%**

Table 12 above shows that almost half of the principals (49%) strongly agree that school enrolment will decline and drop out will rise as a result of HIV and AIDS. An equal number of principals (17%) agree, disagree and strongly disagree with the statement. This means that the principals' future expectation is that there will be a reduction in learner population possibly leading to the redeployment of resources (e.g human resource and capital assets)

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13. Principals were asked if educators were also infected and affected by the epidemic

Table 13

Respondents	Number	Percentage
Agree	0	0%
Strongly agree	6	100%
Disagree	0	0%
Strongly disagree	0	0%
Total	**6**	**100%**

All the principals (100%) as shown in table 13 above strongly agree that educators are also infected and affected by the epidemic. This implies that it is everyone's responsibility to deal with this epidemic as it either infect or affect everyone in the society regardless of peoples' socio-economic background or status. This poses a great responsibility on the principals in terms of guiding both learners and educators on HIV/AIDS.

14. Principals were asked if HIV/AIDS is taught in their schools

Table 14

Respondents	Number	Percentage
Yes	6	100%
No	0	0%
Total	**6**	**100%**

Table 14 above indicates that all principals agree that HIV is taught in their schools and this means that all the sampled schools are in compliance with the requirements of the National Policy on HIV/AIDS.

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15. Principals were asked if they are satisfied with the language used to teach HIV/AIDS

Table 15

Respondents	Number	Percentage
Satisfied	4	67%
Strongly satisfied	2	33%
Dissatisfied	0	0%
Strongly dissatisfied	0	0%
Total	**6**	**100%**

Overall all principals (100%) are satisfied with the language used to teach HIV/AIDS as indicated in table 15 above. However, 33% of the principals are strongly satisfied compared to 67% who are satisfied. Through the eyes of the principals, this means that language is not at all a barrier to the teaching of HIV/AIDS.

16. Principals were asked since when it (HIV/AIDS) has been offered at their schools

Table 16

Respondents	Number	Percentage
1994	3	49%
2000	1	17%
2001	1	17%
2002	1	17%
Total	**6**	**100%**

Almost half of the principals (49%) indicated that HIV/AIDS teaching has been offered since 1994 followed by an equal percentage of 17% who indicated that it has been offered since 2000, 2001 and 2002. This means that on average the teaching of HIV/AIDS has been in existence for almost 10 years with years of offering ranging from 7 to 15 years.

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17. Principals were asked if they view HIV/AIDS lessons that need to be offered in their schools

Table 17

Respondents	Number	Percentage
Yes	6	100%
No	0	0%
Total	**6**	**100%**

All principals (100%) agree that HIV/AIDS lessons should be offered in their schools as shown in table 17 above. Thus, all principals are in compliance with the National Policy on HIV/AIDS that provides for teaching of HIV/AIDS in all schools.

18. Principals were asked at which grade HIV/AIDS should be taught

Table 18

Respondents	Number	Percentage
Grade 7 – 12	1	17%
Grade 8 – 12	4	66%
All Grades	1	17%
Total	**6**	**100%**

Responses on grades at which HIV/AIDS lessons should be taught varies with two third of principals (66%) indicating that it should be offered from Grade 8 to 12, followed by an equal percentage (17%) who indicated that it should be offered from Grade 7 to 12 and all grades. Responses by the majority of principals (66%) implicitly suggest an amendment to section 2.10.2 of the National Policy on HIV/AIDS that stipulates that both in the primary and secondary grades educators should provide education about HIV/AIDS.

19. Principals were asked if the Department of Education offer training courses on HIV/AIDS

Table 19

Respondents	Number	Percentage
Yes	5	83%
No	1	17%
Total	**6**	**100%**

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Table 19 above reveals that the majority of principals (83%) agree that the Department of Education offer training courses on HIV/AIDS while 17% disagree. This implies that while training courses are offered in most schools it appears that those training courses are still yet to be offered or communicated to fewer schools in the sampled regions

20 Principals were asked how often the department offer training courses on HIV/AIDS

Table 20

Respondents	**Number**	**Percentage**
Rarely/once per year	5	83%
No response	1	17%
Total	**6**	**100%**

Table 20 above indicates that it is rare for the government to offer training courses on HIV/AIDS as shown by 83% of the principals who indicated that the department offers training courses. Seventeen percent did not respond. This means that training courses offered by the department are inadequate and there seem to be a need for it to be offered regularly.

21 Principals were asked if they have ever attended HIV/AIDS workshops

Table 21

Respondents	**Number**	**Percentage**
Yes	5	83%
No	1	17%
Total	**6**	**100%**

The majority of principals (83%) as shown in table 21 above have ever attended HIV/AIDS workshops while 17% have never attended. This confirms that training courses are offered in most schools but are still yet to be offered or communicated to other schools in the sampled regions.

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22. Principals were asked if they think that HIV/AIDS workshops are important

Table 22

Respondents	Number	Percentage
Yes	6	100%
No	0	0%
Total	**6**	**100%**

From table 22 above all principals (100%) agree that HIV/AIDS workshops are important. It means that these workshops are effective and given the opportunity principals are prepared to attend them including those who have not been exposed to them

23. Principals were asked if the National Policy on HIV and AIDS is adequate in addressing the challenges of HIV/AIDS in schools

Table 23

Respondents	Number	Percentage
Yes	4	67%
No	2	33%
Total	**6**	**100%**

Sixty seven per cent of principals in table 23 above agree that the National Policy on HIV/AIDS is adequate in addressing the challenges of HIV/AIDS in schools, while 33% disagree. This poses a challenge on the side of the Department of Education and other stakeholders to focus on the full implementation of the Act (e.g training) to realize its intended benefits.

24. Principals were asked if there are any gaps in the National Policy on HIV and AIDS

Table 24

Respondents	Number	Percentage
It is not practical and offer no help in schools	2	33%
No response	4	67%
Total	**6**	**100%**

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Of the sampled principals (33%) who indicated that the National Policy on HIV/AIDS is not adequate in addressing the challenges of HIV/AIDS in schools, all of them revealed that the policy is not practical and offer no help in schools. Sixty seven percent did not respond. Thus without focusing on this identified flaw the policy will simply remain an academic policy document.

25. Principals were asked if they agree with the criticism leveled against the government that it is not monitoring the teaching of HIV/AIDS at schools

Table 25

Respondents	**Number**	**Percentage**
Yes	5	83%
No	1	17%
Total	**6**	**100%**

By far the majority of principals (83%) agree with the criticism leveled against the government that it does not monitor the teaching of HIV/AIDS in schools. However, at least 17% of principals do not agree. Thus there is a window of opportunity for government and other partners to focus on this flaw as identified by the majority of principals.

26. Principals were asked how the government should improve on its monitoring of HIV/AIDS

Table 26

Respondents	**Number**	**percentage**
Should employ one person per circuit dedicated to HIV/AIDS	1	17%
Regular school visit	3	49%
Teaching of HIV/AIDS at least once per week (30 minutes)	1	17%
No response	1	17%
Total	**6**	**100%**

The majority of the principals (49%) suggest that in order to improve on monitoring of HIV/AIDS there should be regular school visit to immediately detect any challenges experienced. Other suggestions proposed by principals as shown in table 26 include appointing a dedicated person per circuit to focus specifically on HIV/AIDS (17%) as

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well as teaching it at least once per week (17%). This means that the teaching of HIV/AIDS should be offered as a distinct learning area with resources fully dedicated to it.

27. Principals were asked if they have ever noticed or experienced any negative impact as a result of HIV/AIDS

Table 27

Respondents	Number	Percentage
Yes	4	67%
No	2	33%
Total	**6**	**100%**

Two third of the principals (67%) agree that they have ever noticed or experienced negative impacts as a result of HIV/AIDS while 33% have not yet experienced nor noticed anything. Thus it is imperative that each school must have its own policy guidelines on HIV/AIDS including those that have not experienced any negative impact or affected by the scourge of the epidemic.

28. Principals were asked to state the negative impacts that HIV/AIDS has on learners

Table 28

Respondents	Number	Percentage
Poor performance and absenteeism	3	50%
Learners without parents	1	17%
No response	2	33%
Total	**6**	**100%**

Table 28 above indicates that the majority of principals (50%) express learners' poor performance and absenteeism as a negative impact caused by HIV/AIDS whereas 17% is for learners without parents. Thirty three percent did not respond. Poor performance and absenteeism would results in high failure rate and this will be exacerbated by high population of orphans and all these combined breeds poverty. Thus the Department of Education should in future expect an increase in demand for social assistance (e.g feeding scheme) to be extended to secondary schools, for example.

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29 Principals were asked to state the negative impacts that HIV/AIDS has on educators

Table 29

Respondents	Number	Percentage
Poor performance and time consumed on consultation	2	33%
Teachers frustration on how to comfort the learners affected	1	17%
Redeployment of educators as a result of the death of learners	1	17%
No response	2	33%
Total	**6**	**100%**

Table 29 indicates that half of principals (33%) express educators' poor performance and time consumed on consultation as a negative impact of HIV/AIDS while 17% of them express educators' frustration on how to comfort the learners affected and another 17% express educators redeployment as a result of the death of learners. Thirty three percent did not respond. This implies that the impacts of HIV/AIDS are significant and will affect all sectors of the economy (e.g health, education and transport).

30 Principals were asked the main barriers they experience in teaching HIV/AIDS

Table 30

Respondents	Number	Percentage
Lack of well informed teachers and sensitivity on HIV/AIDS	1	17%
Infected children feel embarrassed and discriminated against	3	49%
Talking to learners about sexual issues	1	17%
Lack of resources	1	17%
Total	**6**	**100%**

From table 30 above almost half of the principals (49%) express embarrassment and discrimination felt by infected learners as the main barriers experienced in teaching HIV/AIDS. This barrier is equally followed by lack of well informed teachers and sensitivity on HIV/AIDS, lack of resources and talking to learners about sexual issues as equally expressed by 17% of the principals. This means that problems experienced varies widely and some of them are beyond the departments control e.g breaking cultural barriers and therefore calls for a multidisciplinary or multi-stakeholder approach in dealing with the epidemic.

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4.5 CONCLUSION

In this chapter data from questionnaires was analyzed and interpreted. The questionnaires were based on basic knowledge regarding HIV/AIDS, teaching of HIV/AIDS and also general knowledge regarding HIV/AIDS.

This chapter leads to the next chapter on summary, findings, conclusions and recommendations.

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CHAPTER 5

SUMMARY, FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 SUMMARY

This research focuses on the teaching of HIV/AIDS in secondary schools since HIV/AIDS is not taught and assessed as other subjects in the school curriculum. HIV/AIDS is an important subject and it is not taken seriously in terms of how it is taught.

The research was limited to Vhembe District in the Vuwani area within Vhuronga 1 (one) circuit. The study was limited to six secondary schools and it focused on learners, educators and principals. The methodology applied in this research is quantitative.

Questionnaires were used as a suitable data collection instrument and in this case respondents in a group completed questionnaires on their own. Data collected were kept confidential and the analysis did not reflect individual respondents as it was reported at an aggregate level. Data collection was analysed using either Excel or Statistical Programme for Social Scientists (SPSS). This research also presented the definitions of terms.

The study also dealt with literature review whereby researcher reviewed what other scholars observed as in the teaching of HIV/AIDS in secondary schools nationally and internationally.

The study also focused on the research design and methodology through which data was collected with regard to the teaching of HIV/ AIDS in secondary schools.

The study also dealt with the analysis and interpretation of data that has been collected.

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5.2 FINDINGS

Respondents were requested to answer questions that were relevant to the questions of research in chapter 1 as follows:

5.2.1 Is HIV/AIDS being taught at schools? If so, at which grade should it start?

In addressing this question different views exist between learners, educators and principals regarding the teaching of HIV/AIDS in schools. Majority of learners indicated that HIV/AIDS is not taught at schools while the majority of educators and principals agree that HIV/AIDS is taught in their schools.

Majority of learners indicated that teaching of HIV/AIDS should start being taught as from grade 4 to 6 and that is contrary to Section 2.10 of the National Policy on HIV/AIDS which states that learners should be taught from grade zero to further education and training institutions and to educators. (Department of Education (DoE): 1996, National Education Policy Act 1996, Act No. 27 of 1996)

5.2.2. How is the level of awareness amongst learners and which area of the epidemic has a high or low level of awareness?

In answering this question, the learners seem to have a high level of awareness on the causes of the epidemic, but the level of awareness in terms of infection and consequences is very low. According to Section 9.2.5 of the National Policy on HIV/AIDS state that education on HIV/AIDS should be taught to both learners and students on how to behave towards persons with HIV/AIDS, raising awareness on prejudice and stereotypes around HIV/AIDS. (DoE: 1996, National Education Policy Act 1996, Act No. 27 of 1996)

The most important thing that the majority of learners seem not to know is that it is not curable. And the National Policy on HIV/AIDS stated that there is no cure for HIV infection available at present. As they are aware that this is a killer disease, they are

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always scared to contract the disease. (DoE: 1996, National Education Policy Act 1996, Act No. 27 of 1996)

5.2.3 What kind of support services is offered to educators to enhance the teaching of HIV/AIDS?

In responding to the question, the majority of educators reflected that they did not go for training. Majority of principals have gone to training through workshops, but training is inadequate. Even though principals have attended shoddy training is not cascaded to educators and learners.

5.2.4 What role does the government plays in ensuring the effective implementation of the National Policy on HIV/AIDS with special reference to monitoring of schools?

In addressing this question researcher discovered that the government is not doing enough in terms of monitoring the teaching of HIV/AIDS in schools. Without monitoring is difficult to detect challenges emanating from the implementation of National Policy on HIV/AIDS. And that is contrary to Section 14.1 of the National Policy on HIV/AIDS as it states that every education department must designate an HIV/AIDS Programme Manager and a working group to communicate the policy to all staff, to implement, monitor and evaluate the Department's HIV/AIDS programme, to advise management regarding programme implementation and process, and to create a supportive and non-discriminatory environment. Teaching of HIV/AIDS is rarely monitored albeit it appears that the National Policy on HIV/AIDS is clearly defined. Principals seem not to have problems with it whereas the problem is the implementation of the National Policy on HIV/AIDS. In terms of the above, one would deduce that schools are complying with the National Policy on HIV/AIDS whereas is not. (DoE: 1996, National Education Policy Act 1996, Act No. 27 of 1996)

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5.2.5 What critical role do schools play in relation to other institutions or structures that exist in communities?

In dealing with this question researcher found out that schools are playing an important role as a main source of information. Low level of responses in respect of churches, homes and communities is disappointing.

With regard to educators, they attend their HIV/AIDS workshops through circulars.

5.2.6 Are there any barriers in the teaching of HIV/AIDS?

In responding to this question researcher found out that majority of learners, educators and principals suggest that English should be the medium of instruction for teaching HIV/AIDS, whereas few people prefer that it should be taught in home language. Other barriers identified by principals are: Lack of well informed educators and lack of sensitivity on HIV/AIDS. Infected children feel embarrassed and discriminated against when HIV/AIDS is taught in class, whereas Section 3.1 of the National Policy on HIV/AIDS state that no learner, student or educator with HIV/AIDS may be unfairly discriminated against directly or indirectly. (DoE: 1996, National Education Policy Act 1996, Act No. 27 of 1996)

Talking to learners about sex and lack of teaching resources.

Other barriers identified by educators are:
Lack of teacher- learner support materials, cultural barriers (taboo), language, infected people are discriminated against and no change in behaviour.

5.2.7 Has there been any impact experienced or noticed as a result of HIV/ AIDS?

In answering this question researcher also found out that learners have not neither experience nor notice the impact of HIV/AIDS. Amongst educators and principals the

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negative impact has already been experienced or noticed. Negative impact experienced by principals on learners is as follows: Poor performance, absenteeism, deterioration of performance and learners without parents.

Negative impact identified by principals on educators as a results of HIV/AIDS are as follows: poor performance and time consumed on consultation; deterioration in interpersonal skills; frustration on how to comfort the learners infected and affected and redeployment of educators as a results of the death of learners.

5.3 CONCLUSIONS

Most people today are aware about HIV/AIDS as a subject and that can bring awareness and knowledge which is the most valuable resource to our learners and the most valuable resource to our learners and the nation. HIV/AIDS is being ignored or neglected by educators in schools because it is not being taught and assessed as other learning areas. That is because the majority of educators have received meager training. Information gathered by educators is not well filtered down to grassroots and this result as a backlog in promoting good health in the community, since the knowledge on combating the spread of HIV/AIDS epidemic would be inadequate. Educators need quality capacity building in order to integrate HIV/AIDS issues into their daily teaching and learning activities.

5.4 RECOMMENDATIONS

Researcher recommends the following as a result of the findings:

RECOMMENDATION 1: TEACHING OF HIV/AIDS

Researcher recommends that learners should be taught about the basic knowledge of HIV/AIDS as early as in their lives as possible, i.e. from primary grades and should be an ongoing process. Educators should comply with Section 16.1 of the National Policy on

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HIV/AIDS in schools which state that this policy applies to public schools which enroll learners in one or more grade zero and grade twelve, to further education and training institutions and to educators. This implies that all schools should have an HIV/AIDS policy. The school policy should be in line with the national policy on HIV/AIDS for learners, students and educators, which are stipulated in Government Gazette No. 20372 (August 1999). (DoE: 1996, National Education Policy Act 1996, Act No. 27 of 1996)

After HIV/AIDS lesson presentations, educators should give learners assignments, written work, projects or homeworks based on the learning content. HIV/AIDS posters should be displayed in the classrooms from time to time. Researcher recommends the following teaching and learning aids that among others, can be used successfully in teaching HIV/AIDS:

Tape records
Overhead projectors
Film strips
DVD's
Illustrations
Flip boards
Flannel boards
Learner support materials
Teacher support materials
National policy on HIV/AIDS

This will provide educators with information regarding their teaching effectiveness. Learners should be taught about the Bill of Rights so that they can protect their own human dignity and that of those whom they live and interact within their communities. Educators should make sure that all learners are practicing universal precautions that will protect them from HIV infection. All educators should say something about HIV/AIDS in their different learning areas. Therefore, offering of the HIV/AIDS in schools needs to be elevated.

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RECOMMENDATION 2: LEVEL OF AWARENESS

Researcher recommends that once the Department of Education elevate the status of HIV/AIDS teaching and learning within Life Orientation and other learning areas, it is expected that the level of awareness will also rise. Educators should always take into consideration the learners level of understanding and development. All children should be taught about the basic awareness of HIV/AIDS, as early in their lives as possible.

Kelly (2000:100) also writes that the school has a responsibility to be a centre of information and support on HIV/AIDS in the community members it serves. Community members should be trained on survival skills that will help our children to adopt behaviours that will protect them from HIV infection.

Parents also have a role to play in the promotion of HIV/AIDS awareness. According to Van Zyl (2002: 98) the parents are primary educators of learners. The school is the secondary educator. Learners can only be cared for effectively if the school, parents and other major role-players in the community form a partnership, establish a network, take hands and join forces. Schools should also organize workshops for parents on HIV/AIDS.

Churches also have a role to play in the promotion of HIV/AIDS awareness. The Department of Education should also evaluate and thoroughly support teaching and learning and the promotion of HIV/AIDS awareness. The Department of Health should also render excellent service to schools, e.g HIV/AIDS awareness campaigns. All stakeholders and other departments should join hands in the HIV/AIDS awareness programs. This idea is supported by President Thabo Mbeki (9 October 1998), who stated that. "The power to defeat the spread of HIV/AIDS lies in our partnership: as youth, as women and men, as business people, as workers, as religious people, as parents and educators, as farmers and farm workers, as the unemployed and the professionals, as the rich and the poor-in fact all of us. Today we join hands in this partnership against HIV/AIDS; together we pledge to spread the message."

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RECOMMENDATION 3: TRAININGS AND WORKSHOPS

Researcher recommends that there is a great need for the Department of Education to develop a training strategy on HIV/AIDS. Such strategy will encapsulate how often training will be offered, who qualifies how often and what are the resources available to implement the strategy.

Further training should be provided by the Department of Education for all educators as stipulated in the National Policy on HIV/AIDS on appropriate teaching skills that can be used in presenting HIV/AIDS lessons. In order for schools to play a role in HIV/AIDS so that they can sustain the interventions and provide ongoing support for their learners both educators and principals should attend workshops so that they can be up to date with HIV/AIDS knowledge. Principals should organize school-based workshops where educators can discuss relevant issues around HIV/AIDS.

Section 10 of the National Policy on HIV/AIDS state that: appropriate course content should be available for the pre-service and in-service training of educators to cope with HIV/AIDS in schools.

Section 2.10.3 of the National Policy on HIV/AIDS state that: all educators should be trained to give guidance on HIV/AIDS. Educators should respect their position of trust and the constitutional rights of all learners and students in the context of HIV/AIDS. (DoE: 1996, National Education Policy Act 1996, Act No. 27 of 1996)

RECOMMENDATION 4: MONITORING OF SCHOOLS

Researcher recommends that the Department of Education should dedicate or earmark resources for monitoring teaching of HIV/AIDS in schools. The department should make sure that HIV/AIDS is taught and examinable and inspection should be done on a regular basis. There should be a dedicated person or Education Specialist of HIV/AIDS who will

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among other things focus on the implementation of National Education Policy on HIV/AIDS and challenges experienced thereof. And therefore, all departments and different stakeholders should join hands in the battle against HIV/AIDS.

RECOMMENDATION 5: INFORMATION SOURCES

Researcher recommends that this is not to be seen primarily as a responsibility of the schools and Department of Education. There should be partnership and solidarity between schools, homes, churches and other stakeholders in the community.

RECOMMENDATION 6: BARRIERS TO TEACHING

Researcher recommends that this calls for the translation of the National Education Policy on HIV/AIDS into all 11 official languages for it to be fully understood by all parties.

RECOMMENDATION 7: IMPACT OF HIV/AIDS

Researcher recommends that given the lack of evidence underpinning the abstinence strategy in the first place, it is crucial that condom use and education be emphasized to both learners and educators.

Researchers need to ensure that the messages that he is sending to youth are not contradictory and that counseling to sexually active learners. Urgent steps are required to provide factual and empowering information about each of the ABC components in order to counter misinformation, fear and stigma. According to Section 5.4 of the National Policy on HIV/AIDS "If and when learners and students with HIV/AIDS become incapacitated through illness, the school or institution should make work available to them for study at home and should, where practically possible, be allowed to educate their children at home in accordance with the policy for home education in terms of

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Section 51 of the South African Schools Act, 1996 or provide older learners with distance education.

Finally, researcher also ensure free and widespread testing so that individuals can be empowered to protect themselves as well as their loved ones by being informed of their own and their partner's infection status.

RECOMMENDATION FOR FURTHER STUDY

The research study of teaching of HIV/AIDS in secondary schools can be explored by prospective researchers in these areas:

1. Combating the spread of HIV/AIDS in schools
2. A comparative study on the impact of HIV/AIDS between African and European countries.

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APPENDICES

SCHEDULE A

QUESTIONNAIRES

QUESTIONNAIRES FOR LEARNERS

The purpose of this questionnaire is to gain information about the teaching of HIV/AIDS in secondary schools within Vhuronga One (1) Circuit.

All information will be treated as confidential and it will only be used for research purposes only. It is only the researcher who will use it and no person other than the researcher will have access to it. The results of the study would be used for a dissertation as fulfillment for a Masters degree.

Do not either write your name or the name of the school.

INSTRUCTIONS FOR QUESTIONNAIRE

Use an ink pen. Do not use a pencil.

Please try and answer all questions.

SECTION A

PERSONAL INFORMATION

Kindly answer the following questions by crossing X on the appropriate block.

1. Gender

Male	Female

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2. Your age

Below 13	13-15	16-18	19-21	22 and over

3. What is your home language?

Tshivenda	Xitsonga	Sepedi	English	Afrikaans	Other (specify)

4. With whom do you normally stay at home (i.e. parents/guardians)

Both parents	Mother only	Father only	Grandmother	Grandfather	Other (specify)

5. Type of location

Rural	Urban	Semi-urban	Other (specify)

6. Religion

Christianity	Muslim	Other (specify)

SECTION B : CONTEXTUAL

Answer the following questions: 1

Mark with an X in the appropriate blocks where possible:

7. Where did you first hear about HIV/AIDS?

School	Church	Home	Community	Other (Specify)

8. At school, are HIV/AIDS lessons being taught?

Yes	No

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9. If yes, are you satisfied with the way HIV/AIDS is taught?

Satisfied	Strongly satisfied	Dissatisfied	Strongly dissatisfied

10. At which grade should learners start to be taught about HIV/AIDS?

Grade R-3	Grade 4-6	Grade 7-9	Grade 10-12	Post Matric

11. Which language is being used to teach HIV/AIDS in your school?

Tshivenda	Xitsonga	Sepedi	English	Afrikaans	Tshivenda and English	Other (specify)

12. Are you satisfied with the language which is used to teach HIV/AIDS in your school?

Satisfied	Strongly satisfied	Dissatisfied	Strongly dissatisfied

State whether the following statements are True or False.

13. HIV/AIDS is transmitted by infectious virus.
14. HIV/AIDS is punishment from God.
15. HIV cannot be transmitted by sharing the same classrooms with HIV positive learners.
16. Only older people can contract AIDS.
17. AIDS is a curable disease.

Mark with an X at an appropriate block

	Agree	Strongly agree	Disagree	Strongly disagree
18. AIDS does not exist				
19. It is OK to have unprotected sex with many different girls/boys				
20. Sex with a virgin can cure AIDS				

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21. Most teenagers are safe to have sex without using condoms.				
22. Teenage pregnancy for learners who are HIV Positive give birth to children who are HIV Negative				

Choose the answer which you think is the most appropriate by underlining the correct statement:

23. Which of the following is closely associated with HIV?

a) Affecting people and animals
b) A known killer disease
c) Human Immune Virus
d) Healthy individuals
e) Do not know

24. Having HIV in the body means that:

a) Someone has got serious illness
b) A person does not want to eat food
c) A person is infected with the virus as confirmed by HIV test.
d) A person is suffering from stomach ache
e) Do not know

25. People with HIV in their bodies eventually become sick with:

a) Asthma
b) Diabetics
c) Heart attack
d) AIDS
e) Do not know

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26. HIV/AIDS cannot be transmitted through the following ways:

a) Kissing and hugging
b) Being involved in sexual activities
c) Playing with someone's blood
d) Breastfeeding
e) Do not know

27. HIV infection in secondary schools can be prevented by:

a) Not allowing anyone to touch their genitals
b) Reporting cases of sexual abuse all the time
c) By not implementing the universal precautions
d) Avoiding sexual intercourse
e) Do not know

28. Which one of the following is part of the universal precautions?

a) Cleaning blood with bare hands
b) First aid kit with rubber gloves
c) Having direct contact with another person's body fluids
d) Having sexual intercourse with many partners
e) Do not know

29. HIV/AIDS will have impact on learners because of one of the following:

a) Learners who are infected and affected by HIV/AIDS will attend school on a regular basis.
b) Sick learners do well in their studies
c) The illness disrupts teaching and learning

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d) Teachers who are infected and affected by HIV/AIDS will always be present at school.

e) Do not know

30. You support a learner living with HIV and AIDS by doing one of the following:

a) By visiting him/her at home and buy cards with get well messages

b) By gossiping a negative attitude towards him/her

c) By gossiping about him/her

d) By not listening to her/him when complaining about the sickness.

e) Do not know

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

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QUESTIONNAIRES FOR EDUCATORS

The purpose of this questionnaire is to gain information about the teaching of HIV/AIDS in secondary schools within Vhuronga One (1) Circuit.

All information will be treated as confidential and it will only be used for research purposes only. It is only the researcher who will use it and no person other than the researcher will have access to it. The results of the study would be used for a dissertation as fulfillment for a Masters degree.

Do not either write your name or the name of the school.

INSTRUCTIONS FOR QUESTIONNAIRE

Use an ink pen. Do not use a pencil.

Please try and answer all questions.

SECTION A

PERSONAL INFORMATION

Answer the following questions by crossing the relevant answer:

1. Gender

Male	Female

2. Your age

Below 25	26-35	36-45	46-50	51 and over

3. Marital status

Single	Married	Divorced	Widowed	Other (Specify)

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4. What is your highest academic qualification?

Below Grade 12	Grade 12	Degree	Honours Degree	Masters Degree	Doctorate	Other (Specify)

5. What is your professional qualification?

STD	UED/PGCE	SSTC	HED	Other (Specify)

6. What is your home language?

Tshivenda	Xitsonga	Sepedi	English	Afrikaans	Other (Specify)

SECTION B: CONTEXTUAL

Mark with an x at an appropriate block.

7. Do you agree that HIV/AIDS must be taught in school?

Agree	Strongly agree	Disagree	Strongly disagree

8. Do you think a study of this nature (HIV/AIDS) is important?

Yes	No

9. Do you personally teach a learning area that entails HIV/AIDS?

Yes	No

10. If yes have you ever received any formal training course on HIV/AIDS?

Yes	No

11. Have you attended any HIV/AIDS workshops, seminars or In Service Trainings?

Yes	No

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12. Do you think these workshops, seminars or In Service Trainings are important?

Important	Unimportant	Most important	Most unimportant

13. How do you get information regarding these workshops?

Media	Letters	Circulars	Others (specify)

14. In your observation, does the government monitor the teaching of HIV/AIDS at schools?

Yes	No

15. If yes, how often does the government monitor the teaching of HIV/AIDS?

_____

16. Are you aware that every child has a right to education?

Yes	No

17. In overall are you satisfied with the teaching of HIV/AIDS at this school?

Satisfied	Strongly satisfied	Dissatisfied	Strongly dissatisfied

18. Do you have adequate materials of teaching HIV/AIDS?

Yes	No

19. Do you have text books on how to teach HIV/AIDS?

Yes	No

20. In your views are there any barriers in the teaching of HIV/AIDS?

Yes	No

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21. If yes, please state the main barriers.

_____

_____

_____

Choose the answer that you think is the most appropriate by underlying the correct statement.

22. Which language is used to teach HIV/AIDS in your school?

a) Tshivenda

b) English

c) Xitsonga

d) Afrikaans

e) Other (Specify)

23. Are you satisfied with the language which is used to teach HIV/AIDS in your school?

a) Satisfied

b) Strongly satisfied

c) Dissatisfied

d) Strongly dissatisfied

24. If dissatisfied or strongly dissatisfied which language do you think should be used to teach HIV/AIDS?

a) Venda

b) English

c) Tsonga

d) Afrikaans

e) None of the above

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25. Some educators are not yet certain how HIV is contracted and spread.

Agree	Strongly agree	Disagree	Strongly disagree

26. People's names living with HIV/AIDS should be disclosed publicly.

Agree	Strongly agree	Disagree	Strongly disagree

27. There is a perception that girl learners are also prone to HIV Infection because of sexual abuse by their educators.

Agree	Strongly agree	Disagree	Strongly disagree

28. Although there is no cure for AIDS, the disease can be prevented.

Agree	Strongly agree	Disagree	Strongly disagree

29. Educators are also infected and affected by the epidemic

Agree	Strongly agree	Disagree	Strongly disagree

30. AIDS cases and deaths among educators have had various perceived negative impacts in schools.

Agree	Strongly agree	Disagree	Strongly disagree

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

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QUESTIONNAIRES FOR PRINCIPALS

The purpose of this questionnaire is to gain information about the teaching of HIV/AIDS in secondary schools within Vhuronga One (1) Circuit.

All information will be treated as confidential and it will only be used for research purposes only. It is only the researcher who will use it and no person other than the researcher will have access to it. The results of the study would be used for a dissertation as fulfillment for a Masters degree.

Do not either write your name or the name of the school.

INSTRUCTIONS FOR QUESTIONNAIRE

Use an ink pen. Do not use a pencil.
Please try and answer all questions.

SECTION A

PERSONAL INFORMATION

Answer the following questions by crossing the relevant answer:

1. Gender

Male	Female

2. Your age

Below 25	26-35	36-45	46-50	51 and over

3. Marital status

Single	Married	Divorced	Widowed	Other (Specify)

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4. What is your highest academic qualification?

Below Grade 12	Grade 12	Degree	Honours Degree	Masters Degree	Doctorate	Other (Specify)

5. What is your professional qualification?

STD	UED/PGCE	SSTC	HED	Other (Specify)

6. What is your home language?

Tshivenda	Xitsonga	Sepedi	English	Afrikaans	Other (Specify)

SECTION B: CONTEXTUAL

Mark with an x at an appropriate block.

	Agree	Strongly agree	Disagree	Strongly disagree
7. HIV/AIDS education and sex education should be enforced in all schools across country				
8. Department of Education must commit its efforts to the provision of training to eduucators, curriculum development and the provision of adequate teaching aids				
9. According to National Policy on HIV/AIDS learners and students with HIV have the right to attend any school or institution				
10. Schools should develop their own policy on HIV/AIDS.				
11. Principals have to ensure that universal precautions are applied in their schools				

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12. As a result of HIV/AIDS school enrolment rates will decline and dropout rates will rise				
13. Educators are also infected and affected by the epidemic				

14. Is HIV/AIDS taught in your school?

Yes	No

15. Are you satisfied with the language which is used to teach HIV/AIDS

Satisfied	Strongly satisfied	Dissatisfied	Strongly dissatisfied

16. Since when has it been offered at your school?

_____

_____

17. In your view is it a lesson (HIV& AIDS) that needs to be offered in your school?

Yes	No

18. At which grade should HIV/AIDS be taught?

_____

_____

19. Does the Department of Education offer training courses on HIV/AIDS?

Yes	No

20. If yes, how often?

_____

_____

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21. Have you ever attended HIV/AIDS workshops?

Yes	No

22. Do you think HIV/AIDS workshops are important?

Yes	No

23. In your views, is the National Policy on HIV/AIDS adequate in addressing the challenges of HIV/AIDS in schools?

Yes	No

24. If no, what are the gaps?

_____

_____

_____

25. Government is usually criticized for not monitoring the teaching of HIV/AIDS at schools, do you share the same sentiments?

Yes	No

26. If Yes, how should the government improve on its monitoring of HIV/AIDS?

_____

_____

_____

_____

27. As a principal, have you ever noticed or experienced any negative impact as a result of HIV/AIDS?

Yes	No

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28. If yes what are the impacts, please if applicable state how does it impact:

Learners: _____

_____

_____

29. Educators: _____

_____

_____

30. In your view, what are the main barriers experienced in teaching HIV/AIDS.

_____

_____

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

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SCHEDULE B

LETTERS

Enquiries: Mr. Randela R.J
Cell no: 0828413689

P.O.BOX 3227
SIBASA
0970
26 JUNE 2007

The District Senior manager
Vhembe District
Department of Education
Private Bag X2250
Sibasa
0970

Dear Sir

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH IN SECONDARY SCHOOLS IN VUWANI AREA-VHURONGA ONE (1) CIRCUIT.

I RANDELA RUDZANI JUSTICE hereby apply for permission to visit secondary schools in Vhuronga One(1) Circuit.

I have persuaded the Masters Degree of Education with the University of Venda for Science and Technology for a period of 3 years as from this year, i.e.2007-2009. I intend conducting research with secondary schools grade 10 learners, educators, and principals by means of questionnaires.

My research topic is:

Teaching of HIV and AIDS in secondary schools with specific reference to grade 10 learners in Vhuronga One (1) Circuit under the Vhembe District in the Limpopo Province.

Hoping to receive your positive response.

Thanking you in advance.

Yours Faithfully

RANDELA RUDZANI JUSTICE (Mr.)

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PROVINCIAL GOVERNMENT

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Fax: (015) 962 6039
(015) 962 3076

26/6/2007

Ref: 2/5/5/1

Enq: Muthambi M.J.

DEPARTMENT OF EDUCATION
REGIONAL OFFICE
REGION 3
2007 -06- 27
PRIVATE BAG X2250
SIBASA 0970
LIMPOPO PROVINCE

To: Randela R.J.
P.O.Box 3227
SIBASA
0970

PERMISSION TO CONDUCT RESEARCH

1. The above matter has reference
2. Your application to conduct research in schools at Vhuronga 1 circuit has been granted.
3. Please note that permission is granted on condition that your research is done outside contact time to avoid class disruptions.
3. You are therefore required to contact the circuit Manager of Vhuronga 1 before you visit any school. Please take this letter along with you when you meet the Circuit Manager.
4. Wishing you a successful academic year.

LIMPOPO DEPARTMENT OF EDUCATION
VHURONGA ONE CIRCUIT
PRIVATE BAG X 1248
05 AUG 2009
05/08/2009

1.....
District Senior Manager : Vhembe

DEPARTMENT OF EDUCATION
VHEMBE DISTRICT

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