

STRATEGIES FOR BRINGING HIV/AIDS AWARENESS IN PRIMARY SCHOOLS

by

SPHIWE MAGDELINE VILAKAZI
BA; BEd (UNISA)

Submitted in partial fulfilment of the requirements for the degree

MASTER OF EDUCATION WITH SPECIALISATION IN
LEARNERS SUPPORT, GUIDANCE AND COUNSELLING

in the

FACULTY OF EDUCATION

at the

UNIVERSITY OF PRETORIA

SUPERVISOR: PROF L.J. JACOBS

OCTOBER 2005

ACKNOWLEDGEMENTS

I would like to express my indebtedness and aptitude to the following people who have played a significant role in making this study a success. In particular I sincerely wish to thank:

- The Almighty God for the power, courage and mental strength He gave me to undertake this arduous task.
- My supervisor, Prof L.J. Jacobs for his untiring guidance, patience and tolerance that encouraged me to forge my way ahead. Without him, I would not have made it.
- My colleague, Mr Vikizitha Wycliffe Mtshali for his valuable guidance and constructive comments which helped me to accomplish this study, which has been a most enriching and rewarding learning experience.
- Doctor Zayizayi Mkhabela, for his valuable contributions and positive comments I received while I was busy with this project.
- My beloved sisters Zodwa and Noma for their keen interest in this project.
- Mr. Christopher Ngcane, Thuli Gouws, Priscilla Malele, Sindile Samantha Mayisela and Mr. Sifiso Andrew Mathebula for their meticulous typing of this research.
- My husband Hendry who tolerated my travelling to Pretoria throughout the research, my son and my daughter, as well as my brothers and sisters for their love and appreciation of all my educational endeavours.
- The principal of Lekazi Primary School, Mrs E. Mabuza and her staff for co-operation and support in this research.
- The Mpumalanga Reference Library staff for permitting me to use their library facilities.
- Finally to my parents, the late Mr Elliot Nkosi and Mrs Maria Nkosi who brought me to this earth and gave me an experience of being parented under hardship and poverty, which has contributed to bringing me where I am today, and which I will always value and appreciate.

DECLARATION

I, SPHIWE MAGDELINE VILAKAZI, declare that:

“STRATEGIES FOR BRINGING HIV/AIDS AWARENESS IN PRIMARY SCHOOLS”

is my own work and that all the sources I have quoted have been acknowledged by means of references.

Mrs. S.M. Vilakazi

Date: October 2005

DEDICATION

I dedicate this study to:

- All primary school learners who daily face difficult challenges of HIV/AIDS in their life journey.

- All primary school educators who are in the struggle against HIV/AIDS.

TABLE OF CONTENTS

TITLE	PAGE NO.
Title page	i
Acknowledgements	ii
Declaration	iii
Dedication	iv

CHAPTER 1

1.1 INTRODUCTION	1
1.2 AWARENESS OF THE PROBLEM	1
1.3 ANALYSIS OF THE PROBLEM	3
1.3.1 THE IMPACT OF HIV/AIDS ON EDUCATION	3
1.3.2 DEMOGRAPHIC IMPACT	4
1.3.3 ECONOMIC IMPACT	4
1.4 STATEMENT OF THE PROBLEM	5
1.4.1 GENERAL STATEMENT	5
1.4.2 SPECIFIC STATEMENT OF THE PROBLEM	5
1.5 MOTIVATION FOR THE RESEARCH	5
1.5.1 ASSUMPTIONS	6
1.6 AIMS OF THE RESEARCH	6
1.6.1 SPECIFIC AIM	6
1.6.2 GENERAL AIMS	6
1.7. CLARIFICATION OF CONCEPTS	7
1.7.1. THE CONCEPT AIDS	7
1.7.2 THE CONCEPT HIV	8
1.7.3 THE CONCEPT AWARENESS	8
1.7.4 THE CONCEPT SEXUALITY EDUCATION	9

1.7.5	THE CONCEPT SEX INFORMATION	9
1.7.6	THE CONCEPT STRATEGY	9
1.8.	OUTLINE OF THE RESEARCH	10
1.9.	CONCLUSION	10
CHAPTER 2		
2.1.	INTRODUCTION	12
2.2	BASIC AWARENESS OF HIV/AIDS	12
2.2.1	CHILDREN WHO ARE HIV POSITIVE	12
2.2.2	CHILDREN WHO HAVE AIDS	13
2.2.3	WHAT CHILDREN SHOULD KNOW ABOUT THE WAY THE VIRUS WORKS	13
2.2.4	THE DIFFERENT STAGES OF HIV/AIDS THAT CHILDREN SHOULD KNOW	14
2.3	KNOWLEDGE THAT CHILDREN SHOULD HAVE ABOUT THE TRANSMISSION OF HIV/AIDS	15
2.4	WHAT CHILDREN SHOULD KNOW ABOUT FACTORS PROMOTING THE SPREAD OF HIV INFECTION	17
2.4.1	ILLITERACY AND LACK OF KNOWLEDGE ABOUT HIV/AIDS	17
2.4.2	THE PRESENCE OF SEXUALLY TRANSMITTED INFECTIONS (STI'S)	18
2.4.3	GENDER INEQUALITY AND FEMALE SUBORDINATION	20
2.4.4	POVERTY	21
2.4.5	SOCIAL NORMS AND CULTURAL PRACTICES	22
2.4.6	SEXUAL VIOLENCE, CHILD ABUSE AND EXPLOITATION OF WOMEN	23
2.4.7	RAPE	24
	TABLE 1: NUMBER OF RAPE CASES REPORTED FROM THE YEAR 2000-2004 OF CHILDREN RAPED AT EHLANZENI REGION.	24
2.4.8	TEENAGE PREGNANCY	25
2.5	IMPORTANT INFORMATION THAT CHILDREN SHOULD KNOW ABOUT THE PREVENTION OF HIV/AIDS	25

2.5.1	ABSTAINING FROM SEX	25
2.5.2	PRACTICING SAFE SEX	26
2.5.3	STAYING IN A MONOGAMOUS RELATIONSHIP	26
2.5.4	ALTERING SEXUAL BEHAVIOUR	27
2.5.5	PRACTISING UNIVERSAL PRECAUTIONS	27
2.6	OTHER IMPORTANT INFORMATION THAT CHILDREN SHOULD KNOW ABOUT HIV/AIDS	28
2.6.1.	FACTORS THAT MAY NOT CAUSE HIV/AIDS	28
2.6.2.	CONFIDENTIALITY AND HIV/AIDS COUNSELING	28
2.6.3.	TESTING FOR HIV	29
2.6.3.1	ELISA TEST	30
2.6.3.2	POLYMERASE CHAIN REACTION (PCR) TEST	30
2.6.3.3	WESTERN BLOT TEST	30
2.6.4	PARTNER NOTIFICATIONS AND DISCLOSURE	31
2.7	FEELINGS AND ATTITUDES OF CHILDREN LIVING WITH HIV/AIDS	31
2.8	HOW CAN CHILDREN LIVE POSITIVELY WHEN INFECTED AND AFFECTED BY HIV/AIDS?	33
2.9	COMMUNITY RESPONSES TO CHILDREN LIVING WITH HIV/AIDS	35
2.10	KNOWLEDGE THAT CHILDREN SHOULD HAVE REGARDING ASSISTANCE AVAILABLE FOR PEOPLE LIVING WITH HIV/AIDS.	37
2.10.1	HOME BASED CARE SERVICES	37
2.10.2	PALLIATIVE CARE	38
2.10.3	MEDICATION FOR HIV/AIDS	39
2.11	INFORMATION THAT CHILDREN SHOULD HAVE ABOUT THE EFFECTS OF HIV/AIDS	40
2.11.1	ORPHANHOOD	40
2.11.2	MOTALITY RATE	41
2.11.3	OVERCROWDING IN HOSPITALS	42
2.11.4	HIGH RATE OF CRIME	42

2.12	IMPORTANT ASPECTS THAT CHILDREN SHOULD KNOW ABOUT THE FUNDAMENTAL RIGHTS FOR PEOPLE LIVING WITH HIV/AIDS	43
2.13	CONCLUSION	44

CHAPTER 3

3.1	INTRODUCTION	46
3.2	THE SIGNIFICANCE OF LIFE SKILLS PROGRAMS TO PRIMARY SCHOOL LEARNERS.	46
3.3	WHY DO WE NEED TO INCLUDE LIFE SKILLS IN HIV/AIDS PROGRAMMES?	48
3.4	HOW PRIMARY SCHOOL LEARNERS GET INFECTED WITH HIV?	49
3.4.1	MOTHER-TO-CHILD TRANSMISSION	49
3.4.2	INFECTION DUE TO SEXUAL ACTIVITY AND SEXUAL EXPLOITATION	50
3.4.3	UNSAFE PRACTICES	50
3.5	HOW CAN HIV INFECTION BE PREVENTED IN PRIMARY SCHOOLS?	51
3.5.1	THE ROLE OF EDUCATIONS IN DECREASING THE SPREAD OF HIV IN PRIMARY SCHOOLS	51
3.5.2	IMPLEMENTATION OF UNIVERSAKL PRECAUTIONS AS A WAY OF PREVENTING HIV IN PRIMARY SCHOOLS	52
3.6	PRIMARY SCHOOL LEARNERS WHO ARE INFECTED AND AFFECTED BY HIV/AIDS	54
3.6.1	LEARNERS LIVING WITH HIV/AIDS	55
3.6.2	CARING FOR AND SUPPORTING LEARNERS INFECTED AND AFFECTED BY HIV/AIDS	55
3.6.3	CARING FOR THE HEALTH OF HIV POSITIVE LEARNERS IN PRIMARY SCHOOLS	56
3.6.4	HOW CAN THE SCHOOL ASSIST PARENTS LIVING WITH SICK LEARNERS?	58
3.7	PRIMARY SCHOOL LEARNERS ORPHANED AS A RESULT OF HIV/AIDS	59
3.8	THE IMPACT OF HIV/AIDS ON THE EDUCATION SECTOR	61

3.9	THE IMPACT OF HIV/AIDS ON PRIMARY SCHOOL LEARNERS	62
3.10	THE IMPACT OF HIV/AIDS ON ORPHANS	63
3.11	THE IMPACT OF HIV/AIDS ON EDUCATORS	64
3.12	MANAGING THE SPREAD OF HIV INFECTION IN PRIMARY SCHOOLS	65
3.12.1	HEALTH ADVISORY COMMITTEE	65
3.12.2	PRIMARY SCHOOL LEARNERS' RIGHTS AND HIV/AIDS	66
3.12.3	SCHOOL POLICY ON HIV/AIDS	67
3.13	STAKEHOLDERS THAT CAN ASSIST PRIMARY SCHOOL LEARNERS IN THE BATTLE AGAINST HIV/AIDS	68
3.13.1	THE PRIMARY SCHOOL AS A CENTER OF HOPE AND CARE IN THE COMMUNITY	69
3.13.2	PARENTS AS SCHOOL PARTNERS	69
3.13.3	THE DEPARTMENT OF EDUCATION: REGIONAL OFFICE	70
3.13.4	THE DEPARTMENT OF SOCIAL WELFARE AND CHILD WELFARE ORGANIZATIONS	71
3.13.5	THE DEPARTMENT OF HEALTH	71
3.13.6	THE DEPARTMENT OF JUSTICE	71
3.13.7	NON-GOVERNMENTAL AND COMMUNITY-BASED ORGANIZATIONS, WHICH COULD ASSIST THE SCHOOL	71
3.13.8	PRIVATE MEDICAL DOCTORS, PSYCHOLOGISTS AND COUNSELORS	72
3.13.9	VOLUNTEERS IN THE COMMUNITY	72
3.14	STRATEGIES FOR BRINGING ABOUT HIV/AIDS AWARENESS IN PRIMARY SCHOOLS	72
3.15	CONCLUSION	74

CHAPTER 4

4.1	INTRODUCTION	75
4.2	RESEARCH PROBLEM	75

4.3	AIMS OF THE RESEARCH	75
4.4	METHOD OF RESEARCH	76
4.5	QUANTITATIVE RESEARCH METHODOLOGY	76
4.6	QUALITATIVE VERSUS QUANTITATIVE RESEARCH	77
4.7	QUALITATIVE RESEARCH METHODOLOGY	77
4.8	RESEARCH DESIGN	78
4.9	GAINING ENTRY INTO THE FIELD	79
4.10	DATA COLLECTION METHODS RELEVANT TO QUALITATIVE APPROACH	79
4.10.1	OBSERVATIONS	79
4.10.2	METHOD OF OBSERVATION	80
4.11	FOCUS GROUP INTERVIEWS	82
4.11.1	EXPLAINING THE TERM “FOCUS GROUP INTERVIEW”	82
4.11.2	THE FOCUS GROUP PROCESS	83
4.11.3	PHYSICAL ARRANGEMENT OF THE GROUP	84
4.12	DATA COLLECTION METHODS RELEVANT TO QUANTITATIVE APPROACH	87
4.12.1	QUESTIONNAIRES	87
	TABLE 2: DISTRIBUTION OF QUESTIONNAIRES AMONGST LEKAZI PRIMARY SCHOOL LEARNERS	88
	TABLE 3: THE CONTENT OF FOUNDATION PHASE QUESTIONNAIRES	90
	TABLE 4: THE CONTENT OF INTER MEDIATE PHASE QUESTIONNAIRES	90
	TABLE 5: THE CONTENT OF THE SENIOR PHASE QUESTIONNAIRES	90
4.13	TARGET POPULATION AND SAMPLING	91
4.13.1	TARGET POPULATION	91
4.13.2	SAMPLING STRATEGIES	91
4.14	HYPHOTHESIS	92
4.15	RELIABILITY AND VALIDITY	93
4.15.1	RELIABILITY OF OBSERVATIONAL DATA	93

4.16	ETHICAL REQUIREMENTS	94
4.17	DATA ANALYSIS	95
4.17.1	DATA ANALYSIS TECHNIQUES	95
4.18	CONCLUSION	96

CHAPTER 5

5.1	INTRODUCTION	97
5.2	ANALYSIS AND INTERPRETATION OF DATA FROM THE OBSERVATIONS	97
5.2.1	OBSERVATIONS THAT WERE OBSERVED BY THE RESEARCHER	97
5.2.2.1	THE FOUNDATION PHASE OBSERVATIONS	97
	TABLE 6: SUMMARIES OF LESSON EVALUATION AND MARKS OBTAINED BY PARTICIPANTS IN THE FIRST OBSERVATIONS	101
5.2.1.2	THE INTERMEDIATE PHASE OBSERVATIONS	102
	TABLE 7: SUMMARIES OF LESSON EVALUATION AND MARKS OBTAINED BY PARTICIPANTS IN THE FIRST OBSERVATIONS	104
5.2.1.3	THE SENIOR PHASE OBSERVATIONS	105
	TABLE 8: SUMMARIES OF LESSON EVALUATION AND MARKS OBTAINED BY PARTICIPANTS IN THE FIRST OBSERVATIONS	108
	TABLE 9: TOTAL MARKS THAT WERE OBTAINED BY THE THREE PARTICIPANTS THAT WERE OBSERVED BY THE RESEARCHER	108
5.3	OBSERVATIONS THAT WERE OBSERVED BY THE COLLEAGUES OF THE RESEACHER	108
5.3.1	OBSERVATIONS BY THE FIRST COLLEAGUE OF THE RESEARCHER	108
5.3.1.1	THE FOUNDATION PHASE OBSERVATIONS	108
	TABLE 10: SUMMARIES OF LESSON EVALUATION, AND THE MARKS OBTAINED BY PARTICIPANTS IN THE SECOND OBSERVATIONS	111
5.3.1.2	THE INTERMEDIATE PHASE OBSERVATIONS	111

TABLE 11: SUMMARIES OF LESSON EVALUATION, AND THE MARKS OBTAINED BY PARTICIPANTS IN THE SECOND OBSERVATIONS	113
5.3.1.3 THE SENIOR PHASE OBSERVATIONS	113
TABLE 12: SUMMARIES OF LESSON EVALUATION, AND THE MARKS OBTAINED BY PARTICIPANTS IN THE SECOND OBSERVATIONS	115
TABLE 13: TOTAL MARKS THAT WERE OBTAINED BY PARTICIPANTS IN THE SECOND OBSERVATIONS	116
5.3.2 THE OBSERVATIONS OF THE SECOND COLLEAGUE OF THE RESEACHER	116
5.3.2.1 THE FOUNDATION PHASE OBSERVATIONS	116
TABLE 14: SUMMARIES OF LESSON EVALUATION, AND THE MARKS OBTAINED BY PARTICIPANTS IN THE SECOND OBSERVATIONS	118
5.3.2.2 THE INTERMEDIATE PHASE OBSERVATIONS	118
TABLE 15: SUMMARIES OF LESSON EVALUATION, AND THE MARKS OBTAINED BY PARTICIPANTS IN THE SECOND OBSERVATIONS	121
5.3.2.3 THE SENIOR PHASE OBSERVATIONS	122
TABLE 16: SUMMARIES OF LESSON EVALUATION, AND THE MARKS OBTAINED BY PARTICIPANTS IN THE SECOND OBSERVATIONS	123
TABLE 17: TOTAL MARKS THAT WERE OBTAINED BY PARTICIPANTS IN THE THIRD OBSERVATIONS	124
TABLE 18: A SUMMARY OF LESSONS OBSERVED BY THE THREE OBSERVERS AND MARKS OBTAINED BY PARTICIPANTS	124
5.4 THE AVERAGE PERCENTAGE FOR THE NINE OBSERVATIONS	125
TABLE 19: THE AVERAGE PERCENTAGES OBTAINED BY PARTICIPANTS IN THE THREE DIFFERENT OBSERVATIONS	125
5.5 THE FOCUS GROUP INTERVIEWS	125
5.5.1 THE FOUNDATION PHASE FOCUS GROUP INTERVIEW	125
5.5.2 THE INTERMEDIATE PHASE FOCUS GROUP INTERVIEW	129
5.5.3 THE SENIOR PHASE FOCUS GROUP INTERVIEW	133
5.5.4 PARENTS FOCUS GROUP INTERVIEW	137

5.5.5	LEARNERS FOCUS GROUP INTERVIEW	139
5.6	ANALYSIS AND INTERPRETATION OF DATA FROM THE QUESTIONNAIRES	142
5.6.1	INTRODUCTION	142
5.6.2	THE FIRST SET OF QUESTIONNAIRES	142
5.6.2.1	RESPONSES OF THE FOUNDATION PHASE	142
	TABLE 20: MARKS OBTAINED BY FOUNDATION PHASE RESPONDENTS	142
5.6.2.2	THE AVERAGE PERCENTAGE FOR THE FOUNDATION PHASE	143
5.6.2.3	RESPONSES OF THE INTERMEDIATE PHASE	143
	TABLE 21: MARKS OBTAINED BY INTERMEDIATE PHASE RESPONDENTS	143
5.6.2.4	THE AVERAGE PERCENTAGE FOR THE INTERMEDIATE PHASE RESPONDENTS	144
5.6.2.5	RESPONSES OF THE SENIOR PHASE	144
	TABLE 22: MARKS OBTAINED BY THE SENIOR PHASE RESPONDENTS IN NTHE SECOND SET OF QUESTIONNAIRES	144
5.6.2.6	THE AVERAGE PERCENTAGE FOR THE SENIOR PHASE	144
5.6.2.7	RESPONSES OF THE THREE PHASES OF LEKAZI PRIMARY SCHOOL	145
	TABLE 23: MARKS THAT WERE OBTAINED BY RESPONDENTS IN THE THREE PHASES FOUND IN THE FIRST SET OF QUESTIONNAIRES	145
5.6.2.8	THE AVERAGE PERCENTAGE FOR THE PHASES OF LEKAZI PRIMARY	145
5.6.3	THE SECOND SET OF QUESTIONNAIRES	145
5.6.3.1	RESPONSES OF THE FOUNDATION PHASE	145
	TABLE 24: MARKS OBTAINED BY THE FOUNDATION PHASE RESPONDENTS IN THE SECOND SET OF QUESTIONNAIRES	146
5.6.3.2	THE AVERAGE PERCENTAGE FOR THE FOUNDATION PHASE RESPONDENTS	146
5.6.3.3	RESPONSES OF THE INTERMEDIATE PHASE	146
	TABLE 25: RESPONSES OF THE INTERMEDIATE PHASE	146

5.6.3.4	THE AVERAGE PERCENTAGE FOR THE INTERMEDIATE PHASE RESPONDENTS	147
5.6.3.5	RESPONSES OF THE SENIOR PHASE	147
	TABLE 26: RESPONSES OF THE SENIOR PHASE	147
5.6.3.6	THE AVERAGE PERCENTAGE FOR THE SENIOR PHASE RESPONDENTS	147
	TABLE 27: TOTAL MARKS THAT WERE OBTAINED BY RESPONDENTS IN THE THREE PHASES.	148
5.6.4	THE AVERAGE PERCENTAGE FOR THE THREE PHASES OF LEKAZI PRIMARY SCHOOL RESPONDENTS	148
5.6.5	COMPARISON OF THE TWO SETS OF QUESTIONNAIRES	148
	TABLE 28: THE AVERAGE PERCENTAGES OBTAINED BY EACH PHASE AND THE AVERAGE PERCENTAGE FOR THE SCHOOL	148
5.7	CONCLUSION	149
CHAPTER 6		
6.1.	INTRODUCTION	150
6.2.	LITERATURE FINDINGS	150
6.2.1	KNOWLEDGE THAT CHILDREN SHOULD HAVE REGARDING HIV/AIDS	150
6.2.2	PRIMARY SCHOOL LEARNERS AND HIV/AIDS	150
6.3	FINDINGS FROM THE OBSERVATIONS OF EDUCATORS	151
6.4	FINDINGS FROM FOCUS GROUPS INTERVIEWS	151
6.5	FINDINGS FROM THE QUESTIONNAIRES OF THE LEARNERS	152
6.5.1	FINDINGS FROM THE FIRST SET OF QUESTIONNAIRES OF THE LEARNERS	152
6.5.2	FINDINGS FROM THE SECOND SET OF QUESTIONNAIRES OF THE LEARNERS	152
6.6	TESTING THE HYPOTHESIS	152
6.7	LIMITATIONS OF THE STUDY	153
6.7.1	OBSERVATIONS	153
6.7.2	FOCUS GROUP INTERVIEWS	153

6.8	RECOMMENDATIONS	153
6.8.1	RECOMMENDATIONS BASED ON LITERATURE	153
6.8.2	RECOMMENDATIONS BASED ON OBSERVATIONS	154
6.8.3	RECOMMENDATIONS BASED ON FOCUS GROUP INTERVIEWS	155
6.8.4	RECOMMENDATIONS BASED ON THE QUESTIONNAIRES OF THE LEARNERS	155
6.9	RECOMMENDATIONS BASED ON TEACHING SKILL THAT CAN BE USED BY EDUCATORS IN PRESENTING HIV/AIDS LESSONS	155
6.9.1	HIV/AIDS PLANNING OF LESSONS	157
6.9.2	STRATEGIES FOR BRINING HIV/AIDS AWARENESS TO PRIMARY SCHOOL LEARNERS	158
6.9.2.1	FOUNDATION PHASE STRATEGIES	158
6.9.2.2	INTERMEDIATE PHASE STRATEGIES	159
6.9.2.3	STRATEGIES RECOMMENDED FOR THE SENIOR PHASE LEARNERS	160
6.10	STRATEGIES FOR BRINGING ABOUT HIV/AIDS AWARENESS THAT CAN BE USED OM THE THREE PHASES FOUND IN PRIMARY SCHOOLS	161
6.11	RECOMMENDATIONS BASED ON REPONSIBILITIES OF EDUCATORS REGARDING THE IMPLEMENTATION OF HIV/AIDS PROGRAMS IN PRIMARY SCHOOLS	164
6.12	CONCLUSION	164
 ANNEXTURES		
	ANNEXTURE A: LETTER FOR PERMISSION TO CONDUCT RESEARCH IN LEKAZI PRIMARY SCHOOL	166
	ANNEXTURE B: QUESTIONNAIRE FOR THE FOUNDATION PHASE	168
	ANNEXTURE C: QUESTIONNAIRE FOR THE INTERMMEDIATE PHASE	174
	ANNEXTURE D: QUESTIONNAIRE FOR THE SENIOR PHASE	177
	ANNEXTURE E: OBSERVATION GUIDE	180
	BIBLIOGRAPHY	181

SUMMARY

This study examined strategies that can be used for bringing about HIV/AIDS awareness in primary schools. The strategies are effective teaching skills that can be employed by educators for bringing HIV/AIDS awareness to primary school learners.

The responsibilities of educators in the implementation of HIV/AIDS programs in primary schools were discussed. 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. Another one was that educators should also make sure that effective teaching and learning of HIV/AIDS does take place in the schools.

The study has also examined knowledge that children should have regarding the HIV/AIDS epidemic. The basic awareness of HIV/AIDS by children was found to be essential. Some of the factors that promote the spread of HIV infection were also discussed. Different types of STIs were discussed. From the discussions, it is evident that there is a link between STIs and HIV/AIDS. Although STIs can be treated by medication, they are sometimes hard to cure. In this study, it was discovered that the early and correct treatment of STIs is an important weapon in the armoury against HIV transmission.

The significance of life skills programs in primary schools was also examined. It was discovered that the subject of HIV/AIDS could not be taught in isolation; life skills programs should always be included. The issue of primary school learners who are infected and affected by HIV/AIDS was also discussed. It was discovered that in the context of HIV/AIDS, learners fall into two main groups, namely the infected and affected. Infected learners are those learners who are living with the virus in their bodies, while affected learners are those who have infected family members or friends. Various ways by which HIV can be transmitted and prevented in primary schools were also examined.

Strategies that can be used for bringing about HIV/AIDS awareness in primary schools were dealt with in chapter six. Recommendations based on teaching skills that can be used by educators in presenting HIV/AIDS lessons were made.

KEYWORDS

AIDS, Affected learners, CD4 cells, Effective teaching, Herpes, HIV, Infected learners, Orphanhood, Palliative care, Strategies.

CHAPTER 1

INTRODUCTION, AWARENESS OF THE PROBLEM, STATEMENT OF THE PROBLEM AND AIMS OF THE RESEARCH

1.1 INTRODUCTION

HIV (Human Immunodeficiency Virus) infection continues to spread around the world. In a number of countries like Europe, America, Australia, India, Thailand and South Africa, AIDS is the leading cause of death in adults in the age group 15-49 years (World Health Organization (WHO) 2003). Estimates by the Joint United Nations Program on HIV/AIDS (UNAIDS) indicate that 58 million people worldwide have been infected with HIV and almost 22 million people have died as a result of AIDS. Unless a cure is found, or life-prolonging therapy can be made more widely available, the majority of those now living with HIV will die within a decade (WHO Report 2003). The virus continues to spread, causing nearly 16,000 new infections a day. Indeed, HIV/AIDS is among the top ten killers worldwide, and given current levels of HIV infection, it may soon move into the top five (WHO Report 2003).

1.2 AWARENESS OF THE PROBLEM

The first cases of AIDS were identified in 1980 in Los Angeles in the United States. Initially, most cases of AIDS in the United States were diagnosed in homosexual men, who contracted the virus primarily through sexual contact and intravenous drug use. Drug users became infected mainly by sharing contaminated hyperdemic needles (Evian 2000). The first two cases of AIDS were identified in South Africa in 1985 in KwaZulu Natal. For the first eight years since the discovery in South Africa, the epidemic was primarily located among homosexuals. Nonetheless, as the number of cases rose, the disease began spreading among groups (Evian 2000). At present, there is evidence that about 5.6 million South Africans are already infected with HIV and about 1800 get infected each day (WHO 2004). According to a survey commissioned by the Nelson Mandela Foundation and conducted by the South African Human Sciences Research Council (5 August 2003), the Free State has the highest infection rate, which is 14,9%, followed by Gauteng's 14,7% , Mpumalanga's 14,1%, KwaZulu-Natal's 11,7%, Western Cape's 10,7% and the Eastern Cape, which has the lowest at 6,6%. The study is said to be more reliable, since it deals with the entire population instead of an antenatal survey of pregnant women, which surveys only a small segment of the population. HIV/AIDS is undoubtedly the most formidable public health problem facing South Africa today. Never in a modern history has a single incurable virus affected as many people as HIV/AIDS (Manaka 2002).

The former National Minister of Education, Professor Kader Asmal, mentioned that: "Many schools are beginning to experience the consequences of HIV/AIDS. The epidemic hits the education sector by reducing

the supply of experienced educators. Both educators and learners are dying in large numbers due to HIV/AIDS related illnesses” (Department of Education 2000: 3). This is supported by Maree (2002: 30), when he states that: “The quality of teaching and learning is affected by HIV/AIDS. In the absence of sick educators, those who are at school have to take an extra load. Learners who are infected and affected by HIV/AIDS become ill and fall behind with their studies. Some of these learners cannot return to school because of sickness”. This implies that HIV/AIDS disrupts teaching and learning.

The researcher became aware of HIV/AIDS in South Africa while she was a high school educator in 1992. Nurses from the Department of Health were invited to come and address learners on the topic of HIV and AIDS. This awareness became earnest around 1995, when the National Department of Health started releasing HIV/AIDS information to the public through mass media. Around 1996, the Department of Education entered the fray by organizing workshops for senior management. It was during this time that an attempt was made to formulate policy on HIV/AIDS. It is also during this time that the Department of Education appeared to be taking the HIV/AIDS problem very seriously. Around 1997, workshops were organized by the Department of Education in conjunction with the Department of Health. This was done in all nine provinces.

The researcher, as a high school educator, also attended one of the HIV/AIDS workshops and thereafter became involved in the implementation of HIV/AIDS programs. At these HIV/AIDS workshops, shocking HIV/AIDS statistics were released. All along, the HIV/AIDS programs were limited to secondary schools, the assumption being that primary school learners were not actively involved in sexual matters. In 1999, the decision was taken by the National Department of Education that life skill programs should be implemented as early as possible, starting from grade R up to tertiary level. In 1999, the researcher was redeployed from Thembeke High School to Kamagugu Primary School. At this primary school, the researcher was made responsible for life skills and life orientation learning areas. It is during this period that the researcher discovered the following:

- Most of the primary school learners had inaccurate information regarding HIV/AIDS;
- Strategies used by some educators in bringing about HIV/AIDS awareness were inadequate and sometimes age inappropriate;
- There were no proper guidelines for educators to implement the HIV/AIDS programs, even though they were aware of their limitations.

From the above experience, the researcher became interested in designing strategies for bringing about HIV/AIDS awareness in primary schools. At the present moment, the researcher is employed by the Department of Education as a first education specialist responsible for psychological services. Therefore, the researcher cannot turn a blind eye to what is happening around her in the primary schools in the Mgwenya

circuit in Mpumalanga Province. The researcher has observed that primary school learners engage in sexual activities at an increasingly younger age. Most of these learners have several partners. The results are that they become pregnant, have abortions and contract sexually transmitted infections, of which HIV is the most dangerous. The researcher has also observed that some of the educators find it difficult to talk about sexual matters to learners. This is supported by Louw (2002: 45), when she states that: "It is not all the schools that have started teaching about HIV/AIDS programs". This implies that educators need quality capacity building in order to integrate HIV/AIDS issues into their daily teaching and learning activities. Evian (2000: 10) indicates that "some of the educators do not have the ability to present HIV/AIDS lessons in their classrooms. This has resulted in many educators sending ambiguous messages to their learners about HIV/AIDS. Some of the educators in schools still feel ashamed to teach about sexuality education". It seems to the researcher that, if some of the educators are afraid to talk about HIV/AIDS in schools, then in some of the schools there is silence about the disease. This silence might lead to a low level of knowledge about HIV/AIDS in primary schools.

The research therefore is an exercise to find possible strategies for bringing about HIV/AIDS awareness in primary schools in the Mgwenya Circuit in Mpumalanga Province. The researcher believes that, if primary school learners are not armed with proper life skills, they will become innocent victims of sexual abuse, harassment and HIV/AIDS. This causes problems for the Department of Education in many ways, e.g. school dropouts, teenage pregnancy and other related problems like declining numbers of enrolment in schools, which might also result in jobless educators.

1.3 ANALYSIS OF THE PROBLEM

The HIV/AIDS epidemic has become a thorny issue in Mpumalanga Province. People are dying in large numbers due to HIV/AIDS related illnesses (Manaka 2002). HIV/AIDS seems to have the greatest impact on three main areas, which are discussed below.

1.3.1 THE IMPACT OF HIV/AIDS ON EDUCATION

In Mpumalanga Province, there are 50 000 learners and 19 000 educators infected with HIV (Manaka 2002). Due to the consequences of HIV/AIDS, orphans and other learners are withdrawn from schools, as their families cannot afford to spend on education. Some of the primary schools in the province have enrolments below 300 learners, which is the minimum, and may therefore be closed and the remaining learners moved to other schools (Manaka 2002). This shows that the quality of learning outcomes and education is affected by several confounding factors, which will emerge as the pandemic takes a deeper hold on the education sector. Already, the Department of Education have begun to experience increased problems of educator and learner

absenteeism, and the loss of educators and learners, inspecting officers and planning and management personnel (Manaka 2002).

1.3.2 DEMOGRAPHIC IMPACT

According to Caesar (2003: 10), the demographic impact of the HIV/AIDS epidemic on the population in Mpumalanga Province from modelled trends include:

- Lower population growth rates due to increased child and adult mortality;
- A lower fertility rate due to the death of potential mothers in the 15-45-age range;
- Life expectancy that will drop by twenty years (from 68 to 48 years) by the year 2010 and the increase of dependency rates;
- Orphanhood that will also increase by the year 2010.

1.3.3 ECONOMIC IMPACT

In Mpumalanga Province, productivity has declined in all sectors due to sickness, absenteeism and funeral attendance. Public sector services, in common with private sectors, are affected since conditions of services allow public servants generous absenteeism due to sickness (Manaka 2002). Manaka points out that HIV/AIDS has the greatest impact on the economy because of the following factors:

- Economic growth is slow due to a smaller economically active population;
- Economic participation declines, as the younger members of the labour force are the most affected;
- The representation of women in the labour market worsens, since more women than men leave to care for sick family members, although in percentage terms, this may have been set off by declining male participation in the labour market due to death and illness.
- Poverty levels in the population have risen sharply as parents who are sick no longer bring in an income from employment and the number of child-headed households increases.
- Declining participation in education and training of young female learners, as they are withdrawn from school to care for the sick.

From what has been said above, it is quite apparent that the culture of teaching and learning is affected by HIV/AIDS. The disease is a serious public health, social and economic problem affecting the whole province, which requires to be addressed as a major priority through appropriate individual and collective actions (Manaka 2002). It seems there will be a less qualified teaching force, as trained and experienced educators are replaced with younger and inexperienced educators. Furthermore, it is quite clear that as

HIV/AIDS continue to take its toll, there will be schools without competent educators. This has a negative impact on the education system's ability to plan, manage and implement policies and programs.

1.4 STATEMENT OF THE PROBLEM

The problem can be stated by asking the following two questions:

1.4.1 GENERAL STATEMENT

Question 1: Which strategies can be used in order to bring HIV/AIDS awareness to Mgwenya Circuit, with specific reference to Lekazi Primary School, Mpumalanga Province?

Question 2: What are the responsibilities of educators regarding the implementation of HIV/AIDS programs in primary schools?

1.4.2 SPECIFIC STATEMENT

In order to answer the above questions, the following specific questions will be addressed:

- What are HIV and AIDS?
- What does it mean to be HIV positive?
- What does it mean to have AIDS?
- How is HIV transmitted, and how can the disease be prevented?
- Which effective teaching methods can educators use in the implementation of HIV/AIDS programs?
- How can parents become involved in the implementation of HIV/AIDS programs?
- What should educators do to make sure that learners have mastered the learning content in HIV/AIDS programs?
- What are the opinions of educators with regard to the management of HIV/AIDS programs in primary schools?

1.5 MOTIVATION FOR THE RESEARCH

The research has been motivated by the staggering and frightening statistics of HIV/AIDS in Mpumalanga Province. The alarming statistics shows the severity of the disease. According to a Department of Health Report (January 2002), "Mpumalanga Province is the second highest with the infection rate of 27.9%". The current HIV/AIDS pandemic is a problem that dwarfs all other problems in the province (Department of Health, June 2002). The research will be conducted because schools are already experiencing the effects of

the HIV/AIDS epidemic (Department of Education 2002: 2). Educators should help the young ones to protect themselves from becoming infected with HIV, getting sick and dying (Department of Education Report 2002: 2). The researcher believes that by providing accurate information to learners, the spread of HIV/AIDS can be reduced. This study attempts to achieve this noble goal.

1.5.1 ASSUMPTIONS

The researcher has the following assumptions:

- The researcher believes that bringing about HIV/AIDS awareness should be of great help in decreasing HIV infection in primary schools;
- The researcher believes that primary school learners should have more knowledge about HIV/AIDS;
- The research might change educators' perceptions and attitudes of how to deal with learners living with HIV/AIDS;
- The research should encourage primary school learners to play their role in the struggle against HIV/AIDS;
- With knowledge and understanding of the disease, learners suffering from HIV/AIDS should be able to speak out and disclose their status;
- The research should make a contribution to the improvement of teaching about life skills and HIV/AIDS in primary schools.

1.6 AIMS OF THE RESEARCH

1.6.1 SPECIFIC AIM

Devising strategies for bringing about HIV/AIDS awareness.

1.6.2 GENERAL AIMS

In order to achieve the specific aim, it is the general aim of this research to:

- Differentiate between HIV and AIDS;
- Explain the meaning of being HIV positive and of having AIDS;
- Provide accurate information on the transmission and prevention of HIV/AIDS;
- Design guidelines that will assist educators in the implementation of HIV/AIDS programs in primary schools;
- Identify the role of educators regarding learners living with HIV/AIDS in primary schools;

- Probe the perception of educators with reference to their presentation of HIV/AIDS lessons in primary schools;
- Identify responsibilities of educators regarding the implementation of HIV/AIDS programs in primary schools; and
- Design questionnaires for primary school learners in order to check the level of HIV/AIDS awareness.

1.7 CLARIFICATION OF CONCEPTS

1.7.1 THE CONCEPT AIDS

AIDS is an abbreviation for *Acquired Immune Deficiency Syndrome*. This is a serious disease caused by a virus that destroys the body's natural protection from infection, and which usually causes death (International Dictionary of English 2003: 28).

The Oxford Advanced Dictionary (2003: 25) defines AIDS as an often-fatal disease marked by severe loss of resistance of infection.

The Longman Dictionary of Contemporary English (2003: 28) defines AIDS as a very serious disease caused by a virus that stops your body from defending itself against infections.

AIDS (Acquired Immune Deficiency Syndrome) is the name that has been given to an illness.

Acquired means that it is an illness that you get from someone else. HIV is not spread through casual inadvertent contact like flue or chicken pox. In order to be infected, a person has to do something that will expose him/her to the virus (Whiteside and Sunter 2000).

Immune system is the way we describe our body's defence system. This is our body's way of protecting itself against illness. HIV affects the immune system.

Deficiency means "not enough". With AIDS, our bodies do not have enough immune system, and so cannot fight infections well. The immune system is weakened.

Syndrome means it is not just one disease, but it presents itself as a number of diseases that come as the immune system fails (Whiteside and Sunter 2000).

1.7.2 THE CONCEPT HIV

HIV is an abbreviation for *human immunodeficiency virus*. It is a retrovirus that causes AIDS (Concise Oxford Dictionary 2003: 644).

According to the Longman Dictionary of Contemporary English (2003: 679), HIV is a kind of virus that enters the body through blood or sexual activity, and can cause AIDS.

The International Dictionary of English (2003: 673) states that HIV is the virus believed to cause AIDS.

Human Immunodeficiency Virus (HIV). The virus attacks the body's immune system, which protects the body against illness. It is the virus that causes AIDS. HIV slowly attacks and destroys the immune system, leaving the infected individual vulnerable to malignancies and infections that eventually cause death (Mather 2002: 45).

According to Caesar (2003: 9), HIV is a tiny living organism that can be seen only under a special high-powered microscope. In fact, the virus is so tiny that 100,000 of them could fit on the head of a pin. The virus grows best in the living cell.

For the purpose of this research, the definitions of HIV/AIDS disease suit the topic. HIV/AIDS is a known killer disease and one of the major threats to human existence worldwide. It is the most dangerous disease because it is incurable. Anyone can become infected with HIV - men, woman and children, all race groups, heterosexuals and homosexuals, the rich and the poor. HIV/AIDS has no age restriction. The researcher believes that education remains the most immediate way to stem the growing number of AIDS cases. This means that learners from primary schools need to be educated about sexually transmitted infections, pregnancy and HIV/AIDS. The HIV/AIDS pandemic in our schools compels all educators to become involved. In order to prevent the spread of the disease, it is crucial for the educators to teach learners about sexual education before they become sexually active. The increasing incidence of sexual abuse also stresses the urgency to work with children from a very young age.

1.7.3 THE CONCEPT AWARENESS

Awareness means knowing that something exists, or having knowledge or experience of a particular thing (International Dictionary of English 2003: 86).

According to the Oxford Advanced Dictionary (2003: 70), awareness means to be interested in knowing about current events.

According to the Longman Dictionary of Contemporary English (2003: 75), awareness means knowledge or understanding of a particular situation or subject.

Awareness means conscious, not ignorant, having knowledge. It also means to be well informed (Concise Oxford Dictionary 2003: 87).

It is true that HIV/AIDS has been a subject of neglect in schools for so many years. This implies that learners need to be taught about HIV/AIDS. If they are not taught about the disease, they will never be aware that HIV/AIDS exists and they will remain ignorant about the disease.

1.7.4 THE CONCEPT SEXUALITY EDUCATION

According to Van der Merwe (2002: 69), sexuality education is mainly a matter of education, which is about guiding the child to responsible adulthood, and is always accompanied by values and norms. Education and moulding are the primary aims of sexuality education.

Van Dyk (2001: 69) defines sexuality education as a lifelong process of acquiring information and forming attitudes, beliefs, values about identity, relationships and intimacy, body image and gender roles.

For the purpose of the study, sexuality education will mean equipping primary school learners with survival skills that will protect them from HIV infection.

1.7.5 THE CONCEPT SEX INFORMATION

Sex information is defined by Van der Merwe (2002: 69) as knowledge about sex learned from the streets, neighbours, relatives, friends, peers, parents, guardians and from the media. This knowledge is transmitted for the sake of imparting information that without having education and moulding as an aim, values and norms are absent. Sex information can be dangerous and can lead to permissiveness and promiscuity.

1.7.6 THE CONCEPT STRATEGY

Strategy (singular) means the skill of planning in advance the movements of armies in a war. It also means a well-planned series of actions for achieving an aim, especially success against an opponent (Longman Dictionary of Contemporary English 2003: 1426).

According to the Oxford Advanced Dictionary (2003: 1179), a strategy is a plan designed for a particular purpose. It is the process of planning or carrying out a plan in a skilful way.

The International Dictionary of English (2003: 1435) defines strategy as a detailed plan for achieving success in situations such as war, politics, business, industry or sport; the skill of planning for such situations. Hope (2003: 989) proposes that “strategy” be defined as: “The determination of the basic long-term goals and objectives of an enterprise and the adoption of course of action and the allocation of resources necessary for carrying out these goals”.

According to Fowler and Fowler (2002: 1052), the concept strategy refers to generalship, the art of war, management of an army or armies in a campaign, art of so moving or disposing troops or ships or aircraft so as to improve upon an enemy the place and time conditions for fighting preferred by oneself.

For this study, strategy (plural - strategies), means ways and means, art and plans, tactics of doing something to circumvent a prevalent anomaly.

1.8 OUTLINE OF THE RESEARCH

This research comprises of the following chapters:

Chapter One: Introduction to the research, the research problem and the aims of the research.

Chapter Two: The knowledge that children should have regarding HIV/AIDS.

Chapter Three: The primary school learner and HIV/AIDS.

Chapter Four: The research methodology.

Chapter Five: Empirical research.

Chapter Six: Findings and recommendations.

1.9 CONCLUSION

“With the spread of HIV/AIDS reaching greater proportions, the call is not for individual actions, but for a group effort, even a multi-disciplinary approach” (Manaka 2002: 7). This implies that everybody should be involved in the fight against HIV/AIDS. Even schools should be involved in this team action and need to join hands with other agencies that seek to bring about healing and equilibrium in the community. The researcher believes that it is also imperative that all role-players, i.e. parents, educators, learners and the community at large be totally committed in fighting HIV/AIDS. Parents should not see education as something that belongs to a school, but should work together with the schools in protecting the children from sexual abuse, which might result in HIV infection. One of the most urgent responses to HIV/AIDS is to build

the capacity of children to support themselves by enabling children to stay in schools, and acquire not only vocational skills, but also life skills. Although the primary and most traditional role of the schools is to equip children with literacy and numeric skills, schools are now expected to take on a new and perhaps daunting role of equipping children with survival skills.

Having discussed the awareness of the problem, statement of the problem and aims of the research, the literature review will be dealt with in the next chapter.

CHAPTER 2

KNOWLEDGE THAT CHILDREN SHOULD HAVE REGARDING THE EPIDEMIC OF HIV AND AIDS

2.1 INTRODUCTION

In the previous chapter, the problem under investigation was introduced. In this chapter, various sources of information on the HIV/AIDS epidemic will be examined. The relevant research literature will be reviewed with the aim of providing the context for the research and to justify the need for such a project. This chapter will discuss the basic and essential information about HIV/AIDS. This includes the basic factual information on what it means to be HIV positive, what it means to have AIDS, how the disease is spread, and how to prevent getting the disease. The chapter will also stress how the disease is not spread in order to avoid unnecessary discrimination and fear. The chapter will furthermore discuss the common feelings and attitudes of children living with HIV/AIDS that are portrayed in real life situations.

2.2 BASIC AWARENESS OF HIV/AIDS

It is the opinion of the researcher that 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. The researcher believes that 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.

2.2.1 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 7-10 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 defence would not normally become ill from these infections. This explains why children with HIV are susceptible to unusual infection and clinical conditions.

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.

2.2.2 CHILDREN WHO HAVE AIDS

Having AIDS as described by Nourse (2000: 7), “indicate that a child has some kind of illness, sometimes a series of illnesses because the body no longer has what it needs to fight off diseases or infections”. Nourse (2000: 7) further states that: “Often, children with AIDS who develop serious illnesses 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”.

2.2.3 WHAT CHILDREN SHOULD KNOW ABOUT THE WAY THE VIRUS WORKS

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

- “In order for the 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 defence 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 viremia 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.

- 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 litre 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. The 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".

2.2.4 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 mouth infection (thrush), fatigue and tiredness, swelling of lymph glands in the neck and armpits, mild weight loss and occasional fevers. This phase does not yet signify the onset of AIDS.
- The AIDS phase. In this phase Mather (2002: 5) emphasizes that: "As the body's defences 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 illnesses and resultant weakening of the body, a person with AIDS almost invariably deteriorates and dies from infection, profound weight loss and weakness”.

The researcher believes that 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 and 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.

2.3 KNOWLEDGE THAT CHILDREN SHOULD HAVE REGARDING THE TRANSMISSION OF HIV/AIDS

According to the researcher, 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;
- 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 (man 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 presence 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 prenatally, at the time of delivery, or postnatal through breast-feeding. Nourse (2000: 34) also indicates that infection at delivery is the most common mode of transmission. A number of factors influence the risk of infection, particularly the viral load of the mother at birth - the higher the load, the higher the risk. A low CD4 count is also associated with increased risk.

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 an infected person. These needles are likely to carry the HIV and when used by another person, they may transmit this virus into 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, since this route introduces the virus directly into the bloodstream. Blood banks seek 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 into the body. This 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.

The researcher believes that there can be no prevention of HIV transmission without the maintenance of behaviour 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.

2.4 WHAT CHILDREN SHOULD KNOW ABOUT FACTORS PROMOTING THE SPREAD OF HIV INFECTION

2.4.1 ILLITERACY AND LACK OF KNOWLEDGE ABOUT HIV/AIDS

The researcher believes that 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 judgement 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 practising 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. The researcher believes that health professionals, HIV/AIDS counsellors and educators are well positioned to educate children about HIV/AIDS. It seems to the researcher 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 to adopt behaviours 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”.

The researcher is of the opinion that a substantial number of cases of HIV/AIDS infection are due to illiteracy. The researcher believes that children with more knowledge about HIV/AIDS are expected to live healthier and more productive 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”.

2.4.2 THE PRESENCE OF SEXUALLY TRANSMITTED INFECTIONS (STIS)

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, sterilisation and even death in the case of HIV/AIDS. Michele (2000: 50) writes that: “The presence of STI’s, particularly uteers or 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 in 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 newborn 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 when they are grown-ups. Symptoms of the disease are discharge or bleeding from the vagina between periods and a burning pain when urinating. Sometimes fever, nausea and severe stomach pains occur. Boys usually have a watery white drip from the penis. Chlamydia can also make a man sterile (i.e. unable to have children).

- Genital warts. This STI is a virus. Boys usually have small bumps all over the 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).
- Gonorrhoea. This is a bacterial disease, treatable with penicillin. The disease produces 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 the lower pelvic area. Sexual organs may become red and itchy. If not treated, this disease can cause heart trouble, infertility, skin disease, arthritis and blindness.
- Syphilis is caused by a bacteria and is treatable with large doses of antibiotics. The disease has three stages namely:
 - Stage 1: During this stage, painless, reddish brown sores appears on the mouth, genitals or rectum.
 - Stage 2: A rash appears anywhere on the body, with a fever and sore throat. During this stage flu symptoms, weight or hair 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 birth. The disease can also cause heart disease, brain damage, blindness and death.
- Vaginitis. This is a yeast infection. Symptoms of the disease are yellow, creamy discharge in the underwear, bad odour coming from the vagina, itching genitals, burns when urinating, and a discharge running on the clothes.
- Pelvic Inflammatory Disease (PID). Symptoms of the disease are severe pelvic pains, bad odour from the vagina, vomiting, and a tight and painful abdomen. The disease usually spreads to the ovaries, causing the inflammation.
- Hepatitis B. This is the disease that causes cirrhosis and it scars the liver permanently. The disease is a hundred times more contagious than HIV. The disease is 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 a blood test can show that the disease is present. Symptoms of the disease are jaundice, nausea, tiredness and darkened urine.

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. The researcher also believes that 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 armoury against HIV transmission. In the researcher's opinion, STIs can cause HIV/AIDS to spread faster.

2.4.3 GENDER INEQUALITY AND FEMALE SUBORDINATION

Throughout the world, gender inequalities are a major driving force behind the 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.

The researcher has observed that black women living in rural areas in particular are the most adversely affected by HIV/AIDS. This does not always translate into safe sexual behaviour that will reduce the risk of HIV infection. Conditions of poverty, patriarchy and violence seemingly seal their vulnerability to and powerlessness against HIV/AIDS (Mpumalanga Newspaper, 22 May 2003). Many women, not only in Mpumalanga 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 than women to be admitted to health care facilities. Family resources are also more 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 some customary legal arrangements, which may increase their vulnerability to HIV (McGeary 2001).

In the opinion of the researcher, 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.

2.4.4 POVERTY

The researcher has observed that poverty is increasing in Mpumalanga Province. 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 Mpumalanga Province, it is especially the poor that suffer the negative health effects of a subsistence lifestyle, whether in rural or urban areas (Provincial Population Unit Report 2003: 30).

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 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 favours 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 the 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 increase, 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 neighbours. 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 characterised by neglect and poor socialisation".

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 researcher is of the opinion that the implementation of a provincial poverty eradication strategy to address the impact of HIV/AIDS should be of the highest priority in Mpumalanga Province, not only to address the impact of the epidemic, but also to curb the spread of HIV infection.

2.4.5 SOCIAL NORMS AND CULTURAL PRACTICES

The researcher contends that 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 to have sex. In some of the rural areas in Mpumalanga Province, the researcher has observed that 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 that 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 fathers to repay the dowry.

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 summarised as follows :

- The practice of the levirate (inheritance of a wife by the deceased husband’s brother), where the woman 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 an 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 of HIV infection.

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.

The researcher believes that in combatting these negative cultural norms, it is imperative to educate children to refrain from high risk behaviour such as multiple partners and unprotected sex.

2.4.6 SEXUAL VIOLENCE, CHILD ABUSE AND EXPLOITATION OF WOMEN.

In Mpumalanga 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 % (Mpumalanga 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. Subservience in marriage, often reinforced by violence, can compromise women’s ability to protect themselves 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.

The researcher has observed that a growing number of sexually exploited children has contributed to the spread of HIV infection among this population. According to a Mpumalanga Department of Health Report (2003: 10), 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 Mpumalanga Child Protection Unit’s (SAPS) publication (2004: 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.

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.

2.4.7 RAPE

Rape and gang rape have become extremely potent methods of spreading HIV in Mpumalanga Province. Considering the high prevalence of HIV in Mpumalanga Province, the high risk sexual behaviour of rapists, the high levels of violence against rape victims, and the risk of acquiring HIV infection after rape, is significant. Rape is associated with an increased likelihood of 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 their rapists have a higher risk of being infected”.

The above implies that rape and HIV go hand in hand. If a woman is raped, she is already at risk of HIV infection because a 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 that the 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).

According to the Nelspruit Child Protection Unit of the South African Police Service (January 2005: 4), Table 1 indicates the number of cases reported for the period 2000 - 2004 of children raped in the Ehlanzeni region.

YEAR	NUMBER OF CASES REPORTED
2000	664
2001	720
2002	790
2003	800
2004	890

The above figures indicate that rape cases increases every year, and this might result in the spread of HIV infection in Mpumalanga Province.

2.4.8 TEENAGE PREGNANCY

Teenage pregnancy and birth rates are unacceptably high in Mpumalanga Province, and they show a steady increase in black communities (Department of Health 2001: 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 Health 2003).

It seems to the researcher 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 emphasise condom 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 womanhood (Van Rensburg 2002). The researcher is also of the opinion that teenage pregnancies need to be addressed in a constructive manner, especially in view of the HIV/ AIDS epidemic, and the fact that the human rights of many teenage girls are infringed through acts of sexual violence and exploitation.

2.5 IMPORTANT INFORMATION THAT CHILDREN SHOULD KNOW ABOUT THE PREVENTION OF HIV/AIDS

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

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

2.5.1 ABSTAINING FROM SEX

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

2.5.2 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: 63) mentions the following points:

- 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.

2.5.3 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: 20) 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 interest, 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.

2.5.4 ALTERING SEXUAL BEHAVIOUR

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

2.5.5 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”. The researcher believes that practicing universal precautions will always protect children from being infected with HIV. Information provided by the South African Medical and Dental Council (2003: 3) 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);
 - 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, the researcher’s opinion is that 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 behaviours that will protect them from HIV infections. Children need to be well informed about the necessity and advantages of using a condom.

2.6 OTHER IMPORTANT INFORMATION THAT CHILDREN SHOULD KNOW ABOUT HIV/AIDS

2.6.1 FACTORS THAT DO NOT CAUSE HIV/AIDS

The researcher has observed that 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 (2004: 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.

2.6.2 CONFIDENTIALITY AND HIV/AIDS COUNSELING

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 a basic human right and a fundamental principle of ethics of medical practice. However, even without consent, information can be disclosed to a third party in the case of specified notifiable diseases under the Public Health Act, where appropriate public health interventions can be applied”. The researcher believes that excessive emphasis on confidentiality may lead to increased stigma, discrimination and perpetuate denial of the epidemic. On the issue of confidentiality, all the potential advantages and disadvantages of disclosing HIV must be discussed. ‘Shared confidentiality’, where 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) asserts: “Counselling is a vital component of HIV/AIDS prevention, control and care. It is an interpersonal interaction between the counsellor and the client that enables the client to deal with and make informed decisions about his/her situation”. Williams (2000: 20) also mentions that: “HIV counselling has two main functions that are 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, 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 can assess and understand risky lifestyles and define their potential for behaviour change. Darylmply (2000: 16) states that “in order to overcome some of the problems associated with HIV testing and the traumas of receiving a positive HIV test result, it is necessary to counsel an individual adequately before the test. Counselling should determine, first, whether there is indeed any need for the HIV test, to whom 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”. Darylmply (2000: 17) also emphasizes that “pre-test counselling and post-test counselling is very important in helping the client to understand and cope with the HIV test results”. It is the researcher’s opinion that people should be encouraged to go for HIV counselling before and after testing for HIV.

2.6.3 TESTING FOR HIV

The researcher believes that 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 in the blood. Antibodies are produced by the 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) mentions the following three different tests used in South Africa and they are summarized as follows:

2.6.3.1 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 1000 results is wrong.

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

2.6.3.2 POLYMERASE CHAIN REACTION (PCR) TEST

The PCR test is used to check other test 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 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.

2.6.3.3 WESTERN BLOT TEST

This is an expensive and time-consuming test, which involves filtering the patient's blood for specific viral proteins. The Western blot test is re-evaluated for a number of reasons. 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 Elisa and other enzyme immunoassays are at least as sensitive as the Western blot, much cheaper, and not as subject to observer bias, and would therefore be more economical and more beneficial for HIV diagnostical purposes in developing countries.

The researcher is of the opinion that 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. First:

the earlier an infection is spotted, the earlier it may be slowed down by new treatment. Second, the earlier it is spotted, the better chance there is to prevent its spread, and keep blood banks free of infected blood.

2.6.4 PARTNER NOTIFICATIONS AND DISCLOSURE

According to Check (2000: 24), “partner notification means sharing information about one’s HIV status with his/her sexual partner. Check (2000: 24) further states that men and women should be informed that engaging in sex with a new partner of unknown HIV status or with different partners poses a risk of HIV transmission. In many cases, information regarding a partner’s HIV status may not be shared and the other partner may continue to be put at risk. For Check (2000: 26), partner notification of HIV status is an important issue for both men and women”.

It is the researcher’s opinion that we cannot ignore the fact that many millions of South Africans are infected with HIV, and most of these are unaware of their infection. For many of those who know their HIV status, public openness is difficult, since it requires a safe environment and support for being open about the disease. In many instances, such support does not exist. However, the more we are open about HIV/AIDS, the better equipped we are to tackle the epidemic head-on.

In supporting what has been said above, Radebe, who was interviewed by S. Fox in a publication commissioned by the Department of Health (2000: 31), pointed out that: “When people think of HIV/AIDS, they think about careless individuals who get infected, so they think it’s a disgrace and try to hide it”.

This research project reasons that children living with HIV/AIDS need to be regarded as part of the rich fabric of the society. Children must not be defined by their illness or HIV status. There is no justification for discriminating against and blaming children for the AIDS epidemic. HIV/AIDS should be regarded as any other illness and people living with AIDS need empathy, warmth and caring.

From the previous discussion of HIV tests and partner notification/disclosure, it is essential to discuss the feelings and attitudes of children living with HIV/AIDS, i.e. how they can live positively when infected and affected by HIV/AIDS. Community responses to children living with HIV/AIDS and practical ways to assist them will also be discussed.

2.7 FEELINGS AND ATTITUDES OF CHILDREN LIVING WITH HIV/AIDS

The researcher has observed that children living with HIV/AIDS have their own traumatic experiences and fears, which include fear of loneliness, fear of pain and the fomenting feelings of uselessness. When children are first diagnosed with HIV, it seems the world has stopped. Children normally have strong

feelings and attitudes about HIV/AIDS as a result of both the seriousness of the disease and the main means of transmission. Van Zyl (2002: 61) identified some common feelings and attitudes of children living with HIV/AIDS, which are discussed below:

- Denial: when a child discovers that she/ he has HIV/AIDS, one of the most common reactions is that of denial. Children living with HIV/AIDS find it very difficult to believe they have the disease. According to Van Zyl (2002: 61), a child denies because at that stage he/she may be looking very healthy and strong. Denials are often characterized by blame shifting, irresponsibility and inaction;
- Shock is another common initial reaction to learning that one has HIV/AIDS and it is associated with the feeling of confusion;
- Anger: some children get very angry when they discover that they have HIV/AIDS. Sometimes the anger is often directed against God, other people, or oneself;
- Fear is mentioned as an almost universal reaction to HIV/AIDS. Children living with HIV/AIDS fear death, pain and loss of social standing, stigmatization and shame. Some fear leaving their parents behind;
- Loneliness: Van Zyl (2002: 61) points out that most children living with HIV/AIDS fear loneliness. This stems from the following:
 - A feeling that others do not understand their predicament;
 - Other people shunning them in their illness;
 - Self-consciousness. Many children living with HIV/AIDS believe that others are looking at them or talking about them. This makes them want to hide
- Guilt: Van Zyl (2002: 62) also mentions that feelings of guilt are often experienced by children living with HIV/AIDS. This guilt can be experienced on several levels:
 - A child living with HIV/AIDS whose behaviour has caused him/her to be infected with the virus may feel guilty about it;
 - A child living with HIV/AIDS may feel guilty about the shame they have brought on their family, church and/or community. They may feel guilty for the expenses their families incur as a result of their illness.

- Depression can be characterized by hopelessness, self-centeredness and wishes for death. Under depression, Van Zyl (2002: 62) points out that some children living with HIV/AIDS might see no reason for living. They may feel useless and loose hope.
- Acceptance. Lastly, Van Zyl (2002: 62) mentions that some of the children living with HIV/AIDS come to the place of acceptance of their disease. Usually acceptance brings both hope and peace of mind. With acceptance usually comes a willingness to discuss problems and take action on one's own behalf.

The researcher argues that children living with HIV/AIDS cannot cope very well in life, if they are not supported and cared for by their families and community members. Caring for children living with HIV/AIDS in this research should be understood to mean the positive way, which is more concerned with the understanding of their pains and needs. It is important for children who are not infected and affected by HIV/AIDS to show acceptance and reassurance, both verbally and non-verbally. The researcher believes that children should be taught to care for people living with HIV/AIDS, and not to discriminate against them.

2.8 HOW CAN CHILDREN LIVE POSITIVELY WHEN INFECTED AND AFFECTED BY HIV/AIDS?

The researcher argues that although there is no cure for HIV/AIDS, there are certain things that can be done to help children living with HIV/AIDS avoid re-infections and live longer. One of the advices is that if a child has HIV infection, although he may feel good, he needs to take good care of himself as soon as he finds out he has HIV. This is the key to delaying the onset of more serious problems. Above all, children infected and affected by HIV/AIDS should visit their doctors regularly, and should not wait until they get sick.

The Agency for Health Care Policy and Research (AHCPR 2000: 10) has developed a series of pamphlets with the help of health care experts and consumers designed to help children cope with certain medical conditions such as HIV. The following hints are stipulated, which may help children living with HIV/AIDS to stay well longer:

- Get immunizations to prevent other infections;
- Avoid exposure to infection, e.g. children with colds or other illnesses and human or pet waste;
- Eat healthy food. This will help keep the body strong, keep energy and weight up, and help strengthen the immune system;
- Exercise regularly so that they stay strong and fit;

- Get enough sleep and rest;
- Finish the medicines, even though the child may feel better;
- Do not worry, because worrying can lead to stress, and stress can weaken the immune system, so they have to take steps to reduce stress. Activities that may relieve stress include breathing exercises, leisure walks, reading and community activities.

Mather (2002: 22) emphasizes that: “Hope is very important, so children living with HIV/AIDS should try to keep a positive outlook. Each time they visit the doctor, they must be sure to ask about new treatment and clinical trials in which they might take part”. This implies that children living with HIV/AIDS should not give up on life. In addition, Van Dyk (2001: 89), mentions the following factors that can help children living with HIV/AIDS to live positively:

Lifestyle

- A healthy lifestyle and sensible diet can help delay the progression to full-blown AIDS among HIV positive children;
- They should seek immediate medical attention if they fall ill to prevent the onset of complications such as pneumonia and other diseases;
- They should drink less caffeine (in coffee and colas);
- They should avoid alcohol - too much alcohol makes HIV infection worse;
- They should also avoid smoking;
- They should abstain from sexual activities.

Social support

- Children living with HIV/AIDS should build their own support; they should not rely on the nurse or counsellor for everything;
- They must learn to do things on their own, like:
 - Sharing their problems with someone close to them and someone they trust;
 - See a counsellor to help them adjust better. If they are feeling really bad, they will find it difficult to get closer to other people. They may push them away when they really need their love and care;
 - They must look at whom they can rely on for support in future and make sure that they build a good relationship with family and friends.

Healthy eating

It is very important for children living with HIV/AIDS to eat healthy foods. Nutrients are the good things in food that the body uses to build itself, get energy, and heal itself by improving eating habits and getting all the nutrients needed. Children who are living with HIV/AIDS can greatly improve their quality of life. Food that will give children living with HIV/AIDS energy (foods that boost the immune system) is tabulated as follows:

- Fresh fruits and vegetables;
- Immune boosting food contains vitamins and minerals, which help and protect the body;
- Green leafy vegetables like spinach or cabbage;
- Yellow vegetables like pumpkin and carrots;
- Fruits that have vitamin C, like oranges, lemon, naartjies, guava and mangoes.

Edwards (2002: 92) indicates that children living with HIV/AIDS should avoid frying foods and should rather grill, steam or boil their food. He stresses that: “A positive attitude towards life can be developed by:

- Setting goals in life;
- Believing in oneself;
- Looking at the positive side of life;
- Knowing one’s strengths and weaknesses”.

The researcher supports the inclusion of nutrition as a core part of any HIV package. Nutrition is also linked to treatment. Clean water supplies and adequate food must be made available as part of an overall treatment, care and support package. The above information will assist children in knowing that they need to develop a positive attitude towards life and accept their sickness.

2.9 COMMUNITY RESPONSES TO CHILDREN LIVING WITH HIV/AIDS

“Society sometimes has no understanding about the facts of HIV/AIDS, and this has resulted in negative attitudes towards those infected and affected by HIV/AIDS. Stigmatization is mostly manifested in the desire to see children living with HIV/ AIDS isolated both socially and geographically, removed from the confines of the community” (Manaka 2002: 10). The researcher has observed that people who do not know better about the disease, stigmatize children living with HIV/AIDS. Some people think negative things about children who are infected with the virus, without having any valid reason to do so. Some people are judgmental. These people are concerned about how someone acquired the virus, and they judge the person’s behaviour. Society label people living with HIV/AIDS as guilty or bad, for example children are often

regarded as innocent victims, where-as adults are regarded as having “done something bad to bring HIV on themselves” (Manaka 2002: 20). In supporting this idea, Van Dyk (2001: 20) mentions that: “It is not the HIV which is killing me or making my life not worth living, but the bad attitudes of people towards me and their rejection of me.”

The problem cited above provides a true reflection of what is happening in our communities. This implies that some members in communities have a negative attitude towards children living with HIV/AIDS. In supporting what has been mentioned above, Van Dyk (2001: 90-91) indicates that: “Society has got some common feelings towards children living with HIV/AIDS”. They are summarized as follows:

- Worry about social interactions with children living with HIV/AIDS. Van Dyk (2001: 90-91) indicates that children in societies are worried about associating with children living with HIV/AIDS socially, i.e. that they are vulnerable to being infected with HIV. Some are even worried that children of people living with HIV/AIDS can pass it on to other children while playing. This has led some people to keep their children away from children living with HIV/AIDS. People in the society do not know that it is not possible for children to become infected with HIV by interacting socially with children living with HIV/AIDS.
- Indifference: Van Dyk (2001: 90-91) also states that: “Most children do not even bother to have more information about HIV/AIDS. Some children are ignorant about the disease. They think they can tell who are infected with HIV by looking at them. So, they continue living a careless life without taking any precautions. This is partly why the disease is spreading at such a high rate”.

The researcher believes that the eradication of these problems is essential, and society needs to understand the facts of HIV/AIDS in order to have the right attitudes towards those who are infected and affected by HIV/AIDS. It is imperative for societies to move from an attitude of discrimination to acceptance of children living with HIV/AIDS. The society should dispel rejection and encourage and facilitate reconciliation between children living with HIV/AIDS. The researcher also believes that children living with HIV/AIDS should be supported, loved and accepted by the community at large as human beings, even though they are sick. Acceptance is linked to respect and it involves being non-judgmental. Acceptance is shown by:

- Avoiding telling children what to do, but rather helping them to decide for themselves;
- Involving “putting yourself in the child’s shoes and understand his/her feelings” (Jackson 2002).

The researcher has observed HIV/AIDS occurring within communities, and has realized that HIV/AIDS is not a personal problem only, but also a community problem. If a person living with HIV/AIDS does not

have hope, that person would go back to re-infect the community. This means that although people may not be infected, they are affected. It also shows that communities have a lot of people who may not be infected with HIV/AIDS, but are infected with 'AFRAIDS', i.e. Acute Fearing Regarding HIV/AIDS. This seems to be a more serious and prevalent condition with communities than with the actual people that are living with HIV/AIDS in their bodies (Kelly 2000). What has been discussed above will assist children in understanding that some people in their communities stigmatize children living with HIV/AIDS.

2.10 KNOWLEDGE THAT CHILDREN SHOULD HAVE REGARDING ASSISTANCE AVAILABLE FOR PEOPLE LIVING WITH HIV /AIDS

2.10.1 HOME-BASED CARE SERVICES

According to the Mpumalanga Department of Health (June 2003), the following important facts were mentioned regarding home-based care services:

- At the late stage of the illness when full recovery is not possible, people with HIV/AIDS are referred for home care;
- The family are taught how to look after the ill person, i.e. washing, feeding, and basic nursing care;
- The home-care service with the help of the clinic needs to make sure that problems like pain, vomiting and diarrhoea are controlled with medicines. The family may also need help with food, childcare, washing and cleaning;
- The family caregivers also need emotional support from those close to them. A counsellor will provide some help. At this stage, the family has already been informed that the person has AIDS, and that they will at some stage need to care for him/her at home;
- Hospice beds also provide care, but this is for people dying of AIDS who are without families, the homeless or when the family cannot cope.

Louw (2002: 29) also points out that: "One of the militating factors against the home based care services model, is that the home based caregivers need to be aware of the complications of the home based care services like the emotional, financial, and medical stress, which in most cases must be carried by the person living with HIV/AIDS, his family, friends or children".

The researcher argues that home-based care services are good, because they bring people living with HIV/AIDS closer to their families and communities. Therefore, people living with HIV/AIDS will be receiving care and treatment from home as an integral part of the community. When people living with HIV/AIDS come closer to their families and communities, it means that families and communities should fully carry out the task of caring, loving and supporting people living with HIV/AIDS, and extend a hand of

friendship. To achieve this, families need to acquire or change certain attitudes, and manifest those attitudes through actions that are friendly to people living with HIV/AIDS. Manaka (2002: 138) indicates that: “Dealing with AIDS patients compels a home based caregiver to be a person of compassion, love, integrity and wholesomeness. Persons suffering from HIV/AIDS need attention and profound understanding. Only such persons can help the sufferers along the latter’s lonely gruesome, and often times, hopeless journey through the valley of the shadow of death. Such a condition requires preliminary preparations on the part of the caregiver”. This means that the caregiver have to posses a willing heart to be able to execute their mission to people living with HIV/AIDS. Another important thing is that the caregiver should be prepared to answer most questions. People living with HIV/AIDS usually ask questions that reflect self-pity and punitive guilt. Some of them want to know how they are going to die, what will happen to them when they die and if they are still acceptable to God. This is where the caregiver needs to be very careful not to inflict more pain through a lack of sound information and stereotype views.

The caregiver must show the patients that they are of value before God and before people, even in their dying.

2.10.2 PALLIATIVE CARE

Maree (2002: 52) indicates that: “In palliative care, there is a combination of active and compassionate therapies, which comfort and support individuals and families living with a life-threatening illness. During periods of illness and bereavement, palliative care strives to meet physical, psychological, social and spiritual needs while remaining sensitive to personal, cultural and religious values, beliefs and practices. Palliative care should start at the time of diagnosis and can be combined with therapies for treating opportunistic illness, or it may be the total focus of care”.

Edwards (2002: 66) indicates that palliative care requires the following:

- A team approach including people living with HIV/AIDS, caregivers, health and social service providers, and considers the needs of the whole person;
- Medical and nursing care, social, emotional support, counselling and spiritual care;
- A caregiver who will treat people living with HIV/AIDS with respect and acceptance, acknowledges their right to privacy and confidentiality, and respond caringly to their individual needs.

Edwards (2002: 66) also indicates that palliative care aims at:

- Encouraging hope; and
- Improving the quantity of life at the end of life, by relieving symptoms and enabling a person to die in comfort, with dignity.

An article in the Department of Health Directorate for HIV/AIDS and STI's (2003: 42) indicates that: "One of the most difficult aspects of caring for people living with HIV/AIDS, is deciding when to stop active treatment and to begin to prepare the person and his/her family for dying". This indicates that caring for people living with HIV/AIDS in the terminal stages of AIDS puts a great strain on everyone involved. The decision to stop treatment requires considerable skill and sensitivity. Whenever possible, the decisions should be taken by the palliative caregivers, family members and loved ones.

2.10.3 MEDICATION FOR HIV/AIDS

The researcher believes that children should be made aware that presently, there is no cure for HIV/AIDS. Nourse (2000: 54-59) mentions that there are possible ways used by doctors to fight HIV infections, namely:

- By finding drugs to attack the virus itself;
- By finding better ways to fight down the opportunistic infections or cancers that cause AIDS patients to die;
- By finding better tests for finding HIV infection early (so that maybe someday, it might be treated earlier);
- By finding a vaccine against HIV, so that people can be protected against infection in the first place.

Nourse (2000: 66-68) also indicates that anti-retrovirals (ARVS) control the HIV and slow down its growth. He mentions the following concerning ARVS:

- They protect the white cells, which protect the body;
- These drugs do not get rid of the virus. They have however been found to double the lifespan of people infected with HIV;
- The drugs have side effects. People who are using these drugs will need to see their doctors regularly;
- People using these drugs must report any unusual side effects to their doctors;
- People must make sure that they take the medication properly.

According to Whiteside & Sunter (2000: 21), there are three stages in the treatment of HIV positive people. The first stage is when people are infected, but CD4 counts are high. At this point, the emphasis is on positive living, staying healthy, eating the correct food and exercising. The second stage is when the CD4 cell count begins to drop. At this stage, prophylactic treatment to prevent TB and other common diseases is

normally started. The third stage is the use of antiretroviral drugs to fight HIV directly. This can start when the CD4 cells count drops below 350.

2.11 INFORMATION THAT CHILDREN SHOULD HAVE ABOUT THE EFFECTS OF HIV/AIDS

The researcher contends that there are effects of the disease, i.e. factors resulting from HIV/AIDS. Some of these factors are:

- Orphanhood;
- Mortality rate;
- Overcrowding in hospitals; and
- High rate of crime.

2.11.1 ORPHANHOOD

The researcher has observed that one of the most visible and tragic outcomes of HIV/AIDS are the growth in the number of orphans. According to an Mpumalanga HIV/AIDS Unit Desk Report (20 June 2004), “there are 50 000 orphans below the age of 15 who have lost both parents in Mpumalanga Province. In about 50 % of the cases, these children have been orphaned by AIDS”. It seems to the researcher that the growth in the number of orphans is taxing the coping strategies of families and the society at large. Extended families that have been coping economically are now being overwhelmed. The importance of parents is demonstrated by Louw (2002: 32), who postulates that: “Parents are important primary care workers. If a young child has no parents, the child’s health is often worse, and has got no bright future.” The researcher has observed that as a result of AIDS, an increasing number of children are being looked after by grandparents. Often the grandparents are unable to care for the children adequately. They may be poor, elderly and expected to care for large numbers of grandchildren. Jackson (2002: 60) points out: “Orphans are often moved from one household to another, sometimes with relatives who neglect, maltreat or abuse them. Increasingly in AIDS affected communities, relatives are unwilling to foster children, so they are left living alone in child headed households”. This idea is supported by Manaka (2002: 81), who indicates that: “Emotionally, orphans are found to be suffering as a result of the deprivation of loss and the problems of having to cope with adult responsibilities prematurely”. This is true, because the increase in the number of orphans with no extended family is already being felt in rural areas with inadequate facilities to accommodate their needs. This has resulted in increased homelessness, including street kids, and increased risk of child exploitation as well as child sex work. This idea is supported by Nourse (2000: 39), when he mentions that: “Depending on the age of the child, the death of a parent due to HIV/AIDS can be the most catastrophic event in his or her life. The younger the child, the more he or she is dependent on his or her

parent. Loss of a parent in early childhood means loss of a central figure in the child's emotional life. Some children may have witnessed their parents dying of AIDS, and are psychologically traumatized by the manner in which their parents died".

This is true, especially in cases where both parents have died and the parental role is assumed by grandparents, uncles, aunts or close family friends. Change of homes and guardians, especially in early childhood, creates chaos and disorganization in the lives of children and their psychological and intellectual development. From what has been mentioned above, the researcher also predicts that if nothing is done to stem the HIV/AIDS tide in the province, by the end of this decade, there will be a two-fold increase in deaths among children aged between one and five.

2.11.2 MORTALITY RATE

The most direct demographic consequences of AIDS are an increase in mortality. Without effective treatment of HIV infection, people develop AIDS and die. The direct effect on mortality arises from the deaths of adults and children (Lowveld/Laeveld Newspaper, 14 December 2004). As a result of the growth in HIV prevalence and the failure to control the spread of HIV, Mpumalanga Province faces a major AIDS epidemic. Instead of being able to focus purely, or even largely, on prevention activities, the province is about to deal with the consequences of large-scale conversion from HIV to AIDS (Mpumalanga Newspaper, 26 June 2003).

According to the Department of Health Report (December 2003), "the scale of the epidemic in the province is considerable. The year 2003 data shows that 30% of antenatal clinic attendees are infected". According to the researcher, this indicates that as the epidemic progresses, the sheer number of illnesses, deaths and orphans will be greater in Mpumalanga Province. The expectations of assistance health care will be greater as the epidemic develops. Concurrently, the human resources that are expected to provide these services will, in turn, be depleted by the epidemic. The ages at which the majority of people are infected means AIDS increases mortality among those that typically have the lowest mortality rate. In Mpumalanga Province, AIDS has been identified as the major cause of deaths of adults aged 15 to 44 (Department of Health Report, 13 December 2002). The report further demonstrates that 29% of all deaths in the 15-29 age group are now AIDS related and predicts that, if left unchecked, the total number of AIDS related deaths in Mpumalanga Province will rise by 2010.

It is a well known fact that HIV positive woman may pass the infection to the foetus during pregnancy or through breast-feeding. "In Mpumalanga Province, 15 % of children born to infected mothers are infected. Most HIV positive children develop AIDS and die within a few years of birth, increasing infant and child mortality. The highest rates of mortality are observed in rural areas where socio-economic conditions are

poorer” (Department of Social Services Report, 13 June 2003). The researcher has observed the high mortality rate that has reached such crisis proportions, that the families and communities are beginning to feel the strain. In some of the rural areas, residents are expected to bury their loved ones in other areas, because there is no more land in the area. As the HIV/AIDS pandemic take its toll on the population, Mpumalanga Province is confronted with fast-dwindling space in graveyards (Mpumalanga Newspaper, 3 July 2003).

2.11.3 OVERCROWDING IN HOSPITALS

Overcrowding in hospitals is acknowledged as a problem by the Department of Health in Mpumalanga Province. The increase in HIV infection rates has resulted in an increased burden on primary health care services due to increased numbers of patients with HIV related complaints (Mpumalanga Department of Health Report, December 2003). In addition, the health section has already experienced an increase in HIV related hospital admissions and length of stay, resulting in a rise in bed occupancy rates. According to the Themba Hospital Report of 26 May 2003, “AIDS patients spend 60 days more in hospital beds than patients of other diseases”. This indicates that state hospitals recognize that they are neither the appropriate location nor can they provide care for all people with AIDS. That is why patients who have been hospitalized for a long time are discharged to be cared for at home, and this places an extra financial burden on the households. According to Embhuleni Hospital Report, it was indicated that: “AIDS patients occupied more than 30 percent of hospital beds by the year 2004. It is estimated that by 2006, about 40 % of all hospital beds would be required for AIDS patients”.

From what has been said above, it seems as if the health sectors will clearly be hard hit with massive increased demands for health care. Rose Smart, director of HIV/AIDS and STIs in the Department of Health (June 2003), states: “Realistically, our health services are not going to cope. I mean they are barely coping at the moment and the burden is going to increase phenomenally, to the extent where I think we can anticipate where most of the beds in any hospital medical ward will be occupied by people with HIV and AIDS or the related disease”. This implies that the health services need to consider creative alternatives to provide hospital care, e.g. home-based care.

2.11.4 HIGH RATE OF CRIME

The researcher believes that HIV/AIDS has contributed to the high rate of crime in Mpumalanga Province, because of a large orphan population as the epidemic takes its toll. “Growing up without parents, and badly supervised by relatives and welfare organizations, this growing pool of orphans is at greater than average risk to engage in criminal activities” (Jackson 2002). According to Edwards (2002: 69), “it is within the age of 15 and 24 where people’s propensity to commit crime is at its highest”. Thus, an increasing number of

AIDS orphans who have grown up without parental support and supervision, have turned to crime. The researcher believes that crime is made worse by lack of guidance, care and support for HIV positive people, including children. Especially children orphaned by AIDS have no role-models, and most of them have resorted to crime in order to survive. It seems to the researcher that the province in future will experience a rapid increase in the number of children growing up with no parents because of the effects of AIDS. The fact that most of the orphans grow up without adequate parental supervision and under impoverished conditions, increase their temptation to engage in criminal activities at an early age.

In supporting what has been said above, the Mpumalanga Department of Correctional Service publication (March 2004) mentions that: "Interviews were undertaken with young South African men serving jail sentences, or involved in crime. Most of the interviewees were orphans due to HIV/AIDS related deaths and they were abandoned, kicked out of their relatives' homes and had to live in streets. Many of them expressed feelings of being unloved by their relatives".

From what has been said above, the researcher predicts that during the next ten to twenty years, the number of orphan juveniles and young adults as a proportion of the general population will peak. This will exert an upward pressure on the crime rate, as juveniles and young adults are proportionately more likely to commit crime than adults.

2.12 IMPORTANT ASPECTS THAT CHILDREN SHOULD KNOW ABOUT THE FUNDAMENTAL RIGHTS FOR PEOPLE LIVING WITH HIV/AIDS

The researcher believes that children should be taught about the Bill of Rights, i.e. that it has a list of all the fundamental rights of people living in South Africa. In addition to the right to equality under the Equality Clause (Section 9 of the Bill of Rights), these rights are also very important for people living with HIV or AIDS. Subject to Section 9 of the Bill of Rights, people living with HIV or AIDS have a right to:

- Have their dignity respected and protected;
- Make decisions concerning reproduction, security and control over their bodies, and not to be subjected to medical or scientific experiments without informed consent;
- Privacy, to keep HIV/AIDS information to themselves;
- Freedom of expression, which includes freedom to receive or impart information or ideas;
- Freedom of association;
- Freedom of movement and residence, and to leave the country and to enter, to remain in and to reside anywhere in the country;
- Choose their trade, occupation or profession freely;
- Fair labour practice;

- An environment that is not harmful to their health or well-being;
- Access adequate housing. No-one may be evicted from their homes, or have their homes demolished, without an order of court made after considering all the relevant circumstances;
- Health care services, including reproductive care and social security. No-one may be refused emergency medical treatment;
- A basic education, including adult basic education;
- Access any information that is held by another person, and that is required for the exercise or protection of any rights;
- Conditions of detention that are consistent with dignity;
- Just administrative action.

Everyone whose rights have been negatively affected by administrative action has the right to be given written reasons.

From the provisions of the Bill of Rights cited above, it is clear that human rights is a tool by which people are empowered to protect their own human dignity and that of those with whom they live and interact in the community. The researcher believes that in the context of HIV/AIDS, human rights and ethics are essential to protect human dignity and to reduce human suffering. They are essential to empower people to avoid infection, and if living with HIV/AIDS, to live healthy, productive and happy lives as long as possible. It is high time that communities realize that people living with HIV/AIDS should not be discriminated against, but they should be accepted, loved and respected like any other human being. Safeguarding the human rights will enable people to avoid infection or, if already infected, to cope more successfully with the effects of HIV/AIDS. It is the researcher's opinion that children should be taught about their parent's rights, including those who are living with HIV/AIDS.

Children should be made aware of the following pertaining to their parent's rights in the workplace:

- No parent should be dismissed at work because of his/her HIV status;
- Parents should not be forced to go for HIV testing. Even employers are not allowed to force their employees to go for HIV testing; and
- Parents should know that their HIV status is confidential.

2.13 CONCLUSION

This chapter gave an exposition of the relevant research literature about the knowledge that children should have regarding the HIV/AIDS epidemic. From the literature review, it is clear that not one sector can make a significant inroad in the fight against the epidemic. A true partnership involving the government, the

private sector and the community is essential to face the problem. The researcher believes that an important first step in the fight against HIV/AIDS is to create a non-discriminatory environment. It needs to be repeated that discrimination against those known or believed to be HIV positive is not only an assault on the rights of those concerned, and the community at large, but also encourages the spread of HIV/AIDS and worsen its impact. "Children living with or affected by HIV need support in confronting the multiple challenges of chronic, incurable and generally fatal condition that can result in social ostracism and economic disaster" (United Nations Report on HIV/AIDS 2003: 93). This indicates that it is high time that family members, representatives of religious communities, health care providers and HIV/AIDS counsellors become important sources of psychological and spiritual support for coping with HIV infection in oneself or the family. Associations of children living with HIV are a good example of community mechanisms that provide both psychological and social support. An important goal of social support is inclusion, enabling the affected children to live without fear, and to continue functioning as normal members of the society. The researcher believes that psychological and social support can help reduce stigma and other negative consequences of being HIV Positive. It is the opinion of the researcher that children should be taught survival skills that will protect them from HIV infection. It is very important to teach children not to make decisions that will affect their lives. This research intends to assist in informing and creating awareness in children about HIV and AIDS.

Chapter Three will deal with the primary school learner and HIV/AIDS.

CHAPTER 3

THE PRIMARY SCHOOL LEARNER AND HIV/AIDS

3.1 INTRODUCTION

This chapter focuses on the impact of the epidemic HIV/AIDS on primary school learners. It also describes the urgency and need for primary schools in Mpumalanga Province, with specific reference to Mgwenya Circuit, to respond to the challenges of the negative impacts of HIV/AIDS. "Primary schools have an essential role to play in reversing the very pandemic that threatens it. Young people, especially the primary school learners, offer a window of hope in stopping the spread of HIV/AIDS, if they have been reached by life skills programs" (Kelly 2000: 68). The researcher believes that in the absence of a cure, the best way to deal with HIV/AIDS is through prevention by developing and/or changing behaviour and values. This idea is supported by Williams (2000: 7), when she states: "It is the primary schools that are the principal channel through which messages about HIV/AIDS can reach South Africa's window of hope, the 7 -14 year olds". This means that primary school learners must be empowered to internalize age appropriate information about HIV/AIDS and demonstrate that they have learned this. Primary school learners must be supported in forming personally held values and attitudes that will enable them to behave in ways that will protect them from risky behaviour and HIV infection. The primary schools will have to take on a more explicit role in behaviour formation, and educators will have to play a more active role in facilitating (Louw 2002: 69).

3.2 THE SIGNIFICANCE OF LIFE SKILLS PROGRAMS TO PRIMARY SCHOOL LEARNERS

The researcher has observed that there are life skills programmes that are being implemented in primary schools. Some primary school learners, as they mature and become sexually active, face serious health risks with too little factual information, too little guidance about sexual responsibility, few skills about how to protect themselves from adult coercion, and too little access to health services. This is supported by Jackson (2002: 69) when he states: "Some primary school learners are not yet sexually active. These learners need support and skills to postpone sexual activities. Some suffer from sexual abuse and they need protection and care. Some start sex before marriage and change sexual partners several times before they marry. They need help to either abstain from sex or use condoms to prevent pregnancy and STI's, particularly at this critical time when there is a threat of death from AIDS". The researcher believes that life skills programs is one way to offer the information and skills that primary school learners need to deal with these issues.

Sikiti in Louw (2002: 18) indicates that: “There are five key psycho-social aspects that are included in life skills programs which aim to influence health and social behaviour”. These areas are:

- Self-awareness (self-esteem) and empathy;
- Private communication and interpersonal relationships;
- Decision-making and problem-solving;
- Creative thinking and critical thinking;
- Coping with emotions and coping with stress.

Furthermore, Caesar (2003: 14) emphasizes that: “Life skills programs aim to foster positive behaviours across this range of psycho-social skills, and to change unacceptable behaviours learned early which may translate into appropriate and risky behavior at a later stage of life”. This indicates that life skills programs are one way of helping learners to respond to situations requiring decisions that may affect their lives. Such skills are best learned through experiential activities, which are learner centered and designed to help young people gain information, examine attitudes and practice skills.

Therefore, life skills education programs promote positive health choices, taking informed decisions, practicing healthy behaviours, and recognizing and avoiding risky situations and behaviours. Louw (2002: 89) emphasizes that: “Life skills programs provide a variety of exercises and activities in which learners do something and then process the experience together, generalizing about what they learned and ideally, after much practice in the program, attempt to apply it to future real situations. This implies that life skills help young people to deal effectively with the demands and challenges of everyday life and to respond to the difficulties encountered in everyday life. In fact, the life skills programs help children to become socially and psychologically competent and to function confidently and competently with themselves, with other people and with the community. McGeary (2001: 13) emphasizes that: “Life skills programs are more effective when educators:

- Explore their own attitudes and values, and establish a positive personal value system;
- Establish an open and positive classroom climate;
- Place education about STIs/AIDS within the context of a general program on personal development, health and living skills;
- Use a positive approach, which emphasizes awareness of values, assertiveness, relationship skills, decision-making and self-esteem”.

From what has been said above, it seems as if life skills programs do not lead to more frequent sex or to earlier onset of sexual activities. They do not lead young people to promiscuity, but help young people to delay the initiation of sexual activity (Kelly 2000).

3.3 WHY DO WE NEED TO INCLUDE LIFE SKILLS IN HIV /AIDS PROGRAMS?

“The subject of HIV/AIDS cannot be taught in isolation; life skills should always be included. Any program about HIV/AIDS prevention should always be presented in the context of life skills” (Edwards 2002: 3). This implies that the teaching programmes go by a variety of names, such as HIV/AIDS education and life skills. Although there is a difference between these, the essential concern of them all is to communicate relevant knowledge, engender appropriate values and attitudes and build up personal capacity to maintain or adopt behaviour that will minimize the risk of becoming infected with HIV (Maree 2000). According to Manaka (2002: 92), “HIV/AIDS programs need to be taught in schools. The school is the right place where learners can learn more about sexual matters rather than getting this information from the streets, friends and neighbours”. This is true. If children are not taught about sexual matters in schools, they will get the wrong information and this might lead to sex information that are dangerous. In supporting this idea, Louw (2002: 69) mentions that: “Sexuality education involves more than teaching sex, and is always accompanied by norms and values. Sex information on the other hand is transmitted for the sake of imparting information without having education and moulding as an aim. Values and norms are absent. Sex information can lead to permissiveness and promiscuity”. This implies that educators need to understand and know the difference between sex information and sexuality education so that they can provide accurate information to the learners regarding HIV/AIDS programs.

Louw (2002: 10) indicates that: “The function of sexuality education is to encourage the development of pride in every adolescent and his/her chosen lifestyle. This includes:

- P - preparing the individual for the physical changes of adolescence; protecting him/her against guilt and exploitation by providing the necessary information and skills;
- R - removing fears and misconceptions regarding sexuality;
- I - informing and providing insight into one’s sexuality attitudes, beliefs and values;
- D - developing positive self-esteem;
- E - education about responsible sexual relationships, sexual decisions and the choices available.

In the Vergani & Palmer source in Louw (2002: 11), it is emphasized that sexuality education should aim to:

- Make young people to like and respect themselves;
- Help learners see sexuality as a natural and positive part of life;
- Teach the skills needed to make informed and responsible decisions regarding sexual relationships;

- Teach learners how to protect themselves from exploitation and how not to exploit others;
- Explore different values and attitudes in order to help each learner develop his/her own moral framework;
- Teach understanding, tolerance and respect for different sexual needs, orientation and values;
- Teach learners how to communicate and express their needs and feelings;
- Teach learners how to use health services, and how to find the information they need.

The researcher has observed that some parents are against the teaching of sexuality education in schools. They argue that there is no need to teach their children about sexual matters. Some parents feel that if their children are taught sexuality education, the educators will be giving them information on sex and permission to engage in sexual activities. Some parents even fear that their children may then become pregnant or suffer sexual exploitation. Most of the parents believe that sex is something which should not be discussed across ages, between adults and the young, but only between the young themselves as equals (Edwards 2002). This is not true. As parents they need to talk to their own children about sexual matters. The researcher believes that through sexuality education, learners will receive accurate information about sexual matters. Sexuality education pertains to educators teaching about life skills that will help learners to cope with life and especially with difficult situations. Sexuality education is a sensible approach that will not harm the learners. Rather, it will guide learners to become responsible young men and women and will help them in the prevention of HIV infection (Jackson 2002).

3.4 HOW PRIMARY SCHOOL LEARNERS GET INFECTED WITH HIV?

According to UNAIDS (June 2003 Report: 10), learners could be infected in three ways, namely:

- Mother-to-child transmission;
- Infection due to sexual activity and sexual exploitation;
- From unsafe practices.

3.4.1 MOTHER-TO-CHILD TRANSMISSION

In a Department of Health Report (June 2003: 10), it was indicated that: “In most cases, all infection in learners below the age of 13 are the result of transmission from an infected mother to her child during pregnancy or from breastfeeding”

3.4.2 INFECTION DUE TO SEXUAL ACTIVITY AND SEXUAL EXPLOITATION

Louw (2002: 4) indicates that: “The highest rates of HIV infections are found amongst young people. Girls and young women may be susceptible to HIV infection because they are less able to control the situations in which they have intercourse, and also because their reproductive tract is easily damaged and provide less of a barrier to the virus”. This idea is supported by Van Zyl (2002: 89), when he states that: “Sexual harassment and exploitation of learners by older men is considered one reason for the high vulnerability of school girls to HIV”. McGeary (2001: 10) indicates that: “Teachers in Southern Africa have one of the highest group HIV infection rates, a problem embedded in the exploitative nature of teacher-student sexual relationships in many schools”. This is true, because some of the young girls, especially in rural areas, need extra cash often to pay school fees and female learners know they can benefit from a teacher’s favour. Apart from profiting directly by trading sex for high marks, some learners also consider it an honour to sleep with their male educators, and even boast about it to their peers. Partly, as a result of these practices, some learners are infected with HIV at a higher rate than their male counterparts. The researcher has observed that the other crucial factor pushing up HIV rates in young girls is age mixing. If the girls’ sole sex partners were boys of their own age, they would run little risk of becoming infected with HIV. The girls may be infected with HIV because they sleep with older men who may have had an infected partner. While there are many cultural and economic reasons for this kind of cross-generational sex, the fear of HIV seems to be prompting some men to seek out partners they believe are less likely to be infected, e.g. young girls (UNAIDS Report, June 2000: 66). Another deeply entrenched form of exploitation of young girls is their trafficking into prostitution and sexual slavery. In some cases, primary school learners, especially girls, contract HIV after being raped (Kelly 2000).

3.4.3 UNSAFE PRACTICES

Edwards (2002: 55) indicates that: “Learners can be infected with HIV from unsafe practices. These practices include:

- Traditional health practices (such as scarification);
- Cultural practices such as circumcision;
- Unscreened blood products;
- The use of contaminated medical instruments, e.g. used needles.

From what has been said above, it is clear that educators have a special responsibility to guide learners and encourage them to stay away from unsafe practices.

3.5 HOW CAN HIV INFECTION BE PREVENTED IN PRIMARY SCHOOLS?

The researcher has observed that HIV/AIDS is spreading like a veld fire, and that prevention is the only way to defeat the disease. Edwards (2002: 10) writes 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 AIDS, the disease can be prevented.

3.5.1 THE ROLE OF EDUCATORS IN DECREASING THE SPREAD OF HIV IN PRIMARY SCHOOLS

There are several things that educators need to do in decreasing the spread of HIV in primary schools. The HIV/AIDS Emergency Guidelines for 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 behaviours;
- 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
- 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 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 a disciplinary offence”. This implies that educators have to be role-models to their learners. 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 infection. These are:

- Making sure that all learner’s immunizations are up to date;
- Making sure that water is safe for drinking and food preparation;

- Making sure that universal precautions (means and ways of preventing HIV infection) are implemented in the school;
- Keeping the school environment in clean and hygienic conditions; and
- Maintaining optimal health and hygiene.

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

- To stay away from situations where they feel uncomfortable;
- Never to go to the 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
- To avoid dangerous places that might lead to rape.

In the light of the 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 primary 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. The researcher suggests that all primary 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

3.5.2 IMPLEMENTATION OF UNIVERSAL PRECAUTIONS AS A WAY OF PREVENTING HIV IN PRIMARY SCHOOLS

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

3.5.2.1 No-one should have direct contact with another person's blood or body fluids

- Every first 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;
- If there are no gloves available, plastic shopping bags can be put 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.

3.5.2.2 Stop the bleeding as quickly as possible

- If a learner is bleeding, the first action must be to 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.

3.5.2.3 Cleaning wounds

- Once the bleeding has been stopped, the injured learner should be helped to wash their grazes or wounds in clean water with antiseptic;
- Wounds must then 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.

3.5.2.4 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 running water; and
- The area should be cleaned with antiseptic.

3.5.2.5 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
- Educators must ensure that toilets are clean, hygienic and free from blood spills.

3.5.2.6 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.

3.5.2.7 Prevention of HIV during sport

- First-aid kits with rubber gloves should be available during every sport session;
- No-one should play a sport with uncovered wounds or flesh 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.

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

3.6 PRIMARY SCHOOL LEARNERS WHO ARE INFECTED AND AFFECTED BY HIV/AIDS

Edwards (2002: 99) indicates that: "In the context of HIV/AIDS, learners fall into two main groups, infected learners and affected learners". According to UNAIDS (2003: 13), infected learners are those learners who have the virus in their bodies. Affected learners include one or more of the following:

- Learners from households with infected family members; or
- Learners orphaned as a result of HIV/AIDS.

3.6.1 LEARNERS LIVING WITH HIV/AIDS

Mather (2002: 15) points out that: “Care and support within the school environment would entail a holistic approach to the disaster caused by the HIV/AIDS epidemic and the impact it will have on learners who are infected with HIV/AIDS”. This implies that principals, educators and parents should join hands and ensure that all children are protected against infection with HIV and understand the illness.

The researcher suggests that plans will have to be made so that the infected learners are kept as healthy as possible in a clean, safe environment and that they are not discriminated against. It is also important that the infected learners are looked after with love and understanding and are assisted with the barriers of learning that they may experience. In supporting this idea, Kelly (2000: 61) points out that: “HIV/AIDS being a major threat to the good health well being of school children, infected learners should be encouraged and helped to carry the weight of their circumstances. They have to be emotionally “picked up” so that they will not fall or sink back and give up on life”. This is supported by Mather (2002: 30) when he states: “Learners living with HIV/AIDS in any way will have to cope with repercussions. If such learners are still further traumatized by e.g. discrimination or neglect of any kind in the school situation, the problem will be exacerbated considerably”.

3.6.2 CARING FOR AND SUPPORTING LEARNERS INFECTED AND AFFECTED BY HIV/AIDS

Louw (2002: 36) states that: “Never, never, give up on a learner ... she or he may be the next president”. This means that all learners, even those who are infected and affected by HIV/AIDS, should be encouraged and motivated to participate in school activities and with school tasks. This could enhance their self-esteem and give meaning to their lives, especially in situations or circumstances that are very difficult/negative and appear to be hopeless. Even learners who have the virus in their bodies are expected to reach adulthood and to study further or start a career. The researcher is aware of the conversation between learners when they talk to their peers about their dreams, desires and aspirations. For example, some used to say that:

- “When I am grown up I want to become a pilot”;
- “When I am big, I want to work on computers”;
- ”My dad works on computers, that is what I want to do one day”;
- “I want to travel”;
- “I want to go to America”.

Learners infected and affected by HIV/AIDS have the same dreams; desires and aspirations as any other learners. Edwards (2002: 77) writes that: “HIV positive children, as long as the child is attending school, he

or she is part of the world of his or her peers. Sometimes, these learners must expend great energy and courage to get to school and then more to get through the day. To have their teachers regard their presence as meaningless is insulting". This opinion is supported by Louw (2002: 9), when he writes that: "Educators should constantly keep in mind that children infected with HIV/AIDS have unexpected ability, reserved power, untapped strength, unused success, dormant gifts, hidden talents, latent power, latent excellence, etc. and should make a concerted effort to ensure that this is developed. This will certainly contribute to enhance their self-esteem and ultimately provide quality and meaning to their lives." The researcher suggests that educators must be able to recognize and identify aspects that could act as barriers in learners with regard to learning and development. Educators should bear in mind that every learner is unique and will learn and develop at his/her own pace. It is also the educator's responsibility to provide learners living with HIV/AIDS with the necessary academic support that they will need in their daily lives.

Van Zyl (2002: 16) writes that: "It is in the classroom that most support can be given to learners who are in distress. Care and support lives within the power of each educator. By displaying a willingness to assist, even if it is only by giving emotional support, the educator can alleviate a lot of stress". Van Zyl (2002: 16) suggests the following guidelines for educators:

- Assure the learners that they are available if they want to talk to them;
- Communicate with learners in a sensitive way (establish a relationship of trust);
- Build positive self-esteem by giving honest feedback;
- Make time to talk to learners having problems;
- Never tell a learner's secret(s) to the class;
- Call the parent/caregiver and social worker to support and establish the learner's well-being;
- Don't make infected and affected learners conspicuous by giving them too much attention; and
- Be willing to give learners medicine according to prescription, if they are too young to take the responsibility.

From what has been highlighted above, it can be argued that the needs of learners infected with HIV/AIDS extend far beyond drugs and health care. Those who suspect or learn that they are infected, need psychological support to cope with the implications of having a life threatening disease. At the same time, those learners affected by the epidemic need social support to alleviate the many consequences of HIV diagnosis, repeated bouts of illness and ultimately, death.

3.6.3 CARING FOR THE HEALTH OF HIV POSITIVE LEARNERS IN PRIMARY SCHOOLS

The researcher believes that good health for any learner is a combination of preventing unnecessary risk and illness, as well as promoting the general emotional well-being and holistic development of the learners. To do

this in the school situation, the educator needs to create a caring atmosphere with a particular focus on good health and nutrition, practiced in a space free from environmental hazards. According to Nourse (2000: 40), “it is widely recommended that the comprehensive care of HIV infected learners include:

- The prevention of unnecessary infections through the maintenance of a hygienic environment;
- The prevention of common illness through immunization;
- Regular medical follow-up of learners for developmental, nutritional and growth monitoring. This is recommended:
 - Every six months for learners with no symptoms;
 - Every three months for learners who are symptomatic;
 - Every two to three months for learners with AIDS;
- The early recognition, diagnosis and treatment of any illnesses or complications; and
- Prophylaxis (i.e. preventative medication) for some common problems such as pneumocystis carinii pneumonia (PCP)”.

Manaka (2002: 126) writes that: “Good nutrition is important for everyone and also for HIV positive learners. Optimal nutrition optimizes immune function, maintains health, ensures normal growth and development and improves quality of life. The effects of malnutrition are more severe for learners, because they are still growing and a poor nutritional state increases the risk of infection and the time it takes to recover from acute illness.” This indicates the importance of providing good care for learners living with HIV/AIDS. Nutritional and growth monitoring should be regularly done, and nutritional problems should be avoided.

According to Edwards (2002: 54), there are six main types of nutrients needed for HIV infected learners, namely:

- Proteins: body-building foods such as meat, fish, chicken, eggs, dairy products, nuts, beans, peanut butter and soya.
- Carbohydrates: energy foods such as mealie-meal, meali-rice, samp, rice, bread, cereal and porridges;
- Fats: concentrated energy foods such as oil, butter, margarine and avocado;
- Vitamins and minerals: micronutrients found in fruits, vegetables and other foods;
- Water: must be pure and drinkable.

From what has been said above, it is clear that learners living with HIV/AIDS need a high energy and high protein diet so that the immune system is supported and muscle wasting is avoided. The researcher’s opinion is that educators must provide correct nutritional information to learners and parents, and help them to

understand the importance of selecting nutritious food. Educators also need to be aware of those learners and families who, due to poverty, are unable to provide sufficient food for their children. These children should be included in school food programmes or any other community facilities and organisations providing nutritional support (Maree 2000).

3.6.4 HOW CAN THE SCHOOL ASSIST PARENTS LIVING WITH SICK LEARNERS?

It is the opinion of the researcher that schools are supposed to support sick learners at all cost. Learners are expected to attend classes in accordance with legal requirements for as long as they are able to function effectively, and pose no medically significant risk to others in the school. According to the National HIV/AIDS Policy Act (No 27 of 1996), “learners and students with HIV have the right to attend any school or institution. The needs of learners and students with HIV/AIDS with regard to their right to basic education should as far as possible be accommodated in the school or institution”.

In supporting the above, Nourse (2000: 110) states that: “Learners, if and when they become ill or pose a medically significant risk to others, should be allowed to study at home and academic work should be made available for this where possible ... parents should be allowed to educate them at home”. This implies that schools have a great responsibility of supporting sick learners so that they can also actualize their potential, irrespective of their illness. At the same time, schools need to be empowered to take care of and support HIV positive learners. Stewart (2002: 19) points out that ways to support sick learners in schools include:

- Discouraging learners from participating in strenuous sporting activities because they are weak and tire easily;
- Establishing a place of rest within the school;
- Putting a system in place where learners who need to take medication can do so in a private and confidential place;
- Developing home programs for learners to complete, should they be in hospital or recovering at home for lengthy periods of time;
- Protecting learners with HIV/AIDS from exposure to HIV negative learners;
- Developing a different set of outcomes and expectations for sick learners in terms of the amount of work that they can realistically complete; and
- Working with social workers to help the learner in his or her situation.

Van Zyl (2002: 116) mentions important things that the school can do in assisting parents living with HIV positive learners. Summarised as follows, schools should:

- Visit the parents of sick learners, to ask whether the school can assist in any way;
- Establish support groups for parents, so that parents with the same kind of problems can get together regularly to try and solve some of their problems;
- Invite social workers to explain social welfare assistance and support grants available; and
- Establish prayer groups in co-operation with religious institutions.

In the light of the above, it is clear that education is for all, even for those learners who are infected and affected by HIV/AIDS. Schools must ensure that all children have access to basic education of good quality. This implies creating an environment in schools in which learners are both able and enabled to learn. Such an environment must be friendly and welcoming to learners, healthy for learners, effective with learners and protective of learners (Louw 2002).

3.7 PRIMARY SCHOOL LEARNERS ORPHANED AS A RESULT OF HIV/AIDS

The researcher has observed that many children are orphaned due to their parents dying of AIDS. These children are negatively affected because they are grieving the loss of parents and may be stigmatized by society because of their association with HIV/AIDS. They are often plunged into economic crisis and insecurity and struggle without support systems or services within an impoverished community. They cannot pay school fees or afford school uniforms. Sometimes, they drop out of school early because of the financial burden. Kelly (2000: 91) writes that: “Large numbers of traumatized, malnourished and stunted AIDS orphans live outside community control and drop out of school”. This is true. In most cases, the parents are the breadwinners within the family, and the loss of the parents might mean loss of financial support for the children’s education. Absenteeism is also higher among orphans than non-orphans. The main reasons for the absenteeism ranges from attending funerals, attending to sick family members, needed at home, sent back home by school, lack of clean clothes to wear to school and lack of school fees (Kelly 2000). Some of the reasons for absenteeism suggest that HIV/AIDS could be impacting on school attendance of the children. Evian (2000: 70-71) points out six things to be done by schools in order to support needy children and orphans, namely:

- Keeping records of orphans and to monitor their home situation;
- Training educators in counseling and providing pastoral care to orphans;
- Providing a free school meal so that the nutritional needs of children are met;
- Providing free basic education and assistance to meet essential schooling costs for orphans;
- Designing a curriculum that is more relevant to employment needs; and
- Provide additional boarding facilities for orphans and other children who cannot be properly cared for.

Regarding caring for and supporting orphans, Jackson (2002: 12) mentions that “there are mechanisms that can be implemented to assist orphans”. They are summarised as follows:

- Promoting informal foster care for orphans by:
 - Mobilizing foster caregivers in the community;
 - Obtaining community agreement for volunteers to foster care;
 - Providing training, support and supervision for caregivers;
 - Helping to obtain the necessary resources;
 - Facilitating guardianship arrangements.

- Support foster parents or the extended family with:
 - Training, support and supervision if necessary;
 - Assistance with poverty relief and other resources;
 - Asking sponsors to pay the learner’s school fees and uniform, to give cash grants, food aid and blankets;
 - Facilitating guardianship arrangement.

- Support learner-headed households by:
 - Involving social workers and nurses who will provide food, health and financial assistance.
 - Providing developmental, emotional, spiritual and social support. This can be done by inviting pastors, occupational therapists and psychologists;
 - Ensuring that education, training and recreational needs are met; and
 - Providing more flexible opportunities for learning if they are often absent

- Protecting the property and inheritance rights, especially those of girls.

Stevens (2002: 22) also mentions other ways of assisting orphans, namely:

- Ask volunteers in the community to make their uniforms;
- Organize extra meals through religious organizations or NGO’s;
- Educate and train them so that they will not be exploited and will know where to find help;
- Teach parenting skills to teenagers who are looking after their siblings;
- Present vocational training programs in arts and crafts, hospitality and catering, so that they will be able to generate income;
- Establish a “buddy system” in which each learner has to take responsibility for other learners, talk about problems and establish each other in various ways; and

- Establish youth support groups, not larger than 6-8 learners. They should meet on a weekly basis for about 45 minutes and should be guided by an educator trained in counseling skills. For the sake of confidentiality, the group could be referred to as “the remedial enrichment group”.

From what has been mentioned above, it is clear that educators have a responsibility to show concern to the needs of primary school learners in difficult circumstances, including orphans. They should not send orphans home when they cannot meet some school requirements. The main problem facing orphans is that of basic survival - lack of basic needs, e.g. food, clothing, bedding, etc. Another problem facing orphans is that of discrimination by guardians. These have an impact on their schooling, in particular attendance, motivation and performance (Edwards 2002). The researcher believes that the starting point for responding effectively to the orphan's problems is to recognize them in different schools and know them very well. Another important thing is that orphans must have access to integrated prevention and support services that address their basic needs for shelter, health care, family care, information on HIV/AIDS education and protection from abuse and maltreatment. Orphans are not statistics or objects to be moved about at the will of adults. They are bereaved children who are likely to have experienced great trauma in ministering to their parents during a lengthy period of harrowing sufferings. But they remain aware of their own and welcoming family without separation from their siblings. It is essential that the community and other leaders ensure that orphans are given their rightful role in deciding how their needs should be met (Edwards 2002).

3.8 THE IMPACT OF HIV/AIDS ON THE EDUCATION SECTOR

HIV/AIDS is unlikely to stop population growth in Mpumalanga Province. 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 of orphaned children will increase and poverty will deepen, school enrolment rates will decline and dropout rates will rise. There may be negative school population growth in some places (Mpumalanga Department of Education Annual HIV/AIDS Unit Report: 2004). 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 (Department of Education 2004: 6).

The researcher predicts that 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 such factors as:

- Frequent educator absenteeism;
- Repeated bouts of educator's sickness;
- Increased reliance on less qualified educators;
- Sporadic student attendance;
- Low teacher 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 in the community;
- Fear by girls and young boys that they may be sexually abused or maltreated;
- Unhappiness and fear of stigmatization and ostracism on the part of both educators and learners who have been affected by HIV/AIDS; and
- Educator's uneasiness and uncertainty about personal HIV status".

The researcher contends that 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 drop out of school. This indicates that HIV/AIDS has a great impact on the education sector.

3.9 THE IMPACT OF HIV/AIDS ON PRIMARY SCHOOL LEARNERS

The HIV/AIDS epidemic is directly affecting learners in Mpumalanga Province. "Learners in primary 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" (Mpumalanga Newspaper, 13 June 2003). This indicates that fewer learners will be able to complete their education due to the disease HIV/AIDS. According to the Mpumalanga Department of Education HIV/AIDS Unit Desk Report (2003: 5), "girls in the age bracket 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 of all those impoverished by AIDS and the orphans are able to attend primary education, the majority cannot proceed to secondary level.

Some learners drop out of school to engage in income generating activities. Some may drop out of school to nurse sick parents or siblings. In a long-term perspective, this may reduce the hard-worn return on efforts to increase girls' 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 researcher has observed that 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).

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". The researcher has observed that 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 can deprecate their emotional well-being and thus interfere 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 primary school learners that are being abused, may live in families that are over-extended and are under pressure to contribute to family incomes as poverty deepens. This is supported by Kelly (2000: 150), when she states that: "Children are loosing 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.

3.10 THE IMPACT OF HIV/AIDS ON ORPHANS

The researcher has observed that 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 the World Health Organization Report (2003: 13), problems of the orphans 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 morbidity conditions; and
- Loss of property due to unclear and cumbersome inheritance procedures.

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

- Anxiety about abuse from adults;
- Witnessing the slow, miserable death of one, and possibly both parents;
- A move to an unfamiliar home and pattern of life, with no choice in the matter;
- School teachers 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 the 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 prospects 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 opportunities;
- Some caretakers take on orphan-caring responsibilities in the expectation of material gain, inherited property, or the relief items donated by AIDS service organizations.

In the light of the above, it is clear that HIV/AIDS has 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. The researcher has observed that orphans are sometimes difficult to care for by their fostering parents, because they display antisocial behaviour 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 develop positive attitudes and relationships with other learners in the school (Manaka 2002).

3.11 THE IMPACT OF HIV/AIDS ON 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 (Mpumalanga Department of Education HIV/AIDS Unit Desk Report 2003:4).

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 lose experienced educators and this will affect teaching and learning in schools. In supporting the above statement, Manaka (2002: 99) writes that: “AIDS cases and deaths among teachers have had various perceived negative impacts”. These are summarised 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 as such. This reduction of quality will, in a longer-term perspective, reduce parents’ willingness to enroll their children (Department of Education Report 2003). The researcher has observed funeral ceremonies in the communities, which are other dimensions that claim educators’ time. This may be more serious if the rates of deaths 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.

3.12 MANAGING THE SPREAD OF HIV INFECTION IN PRIMARY SCHOOLS

3.12.1 HEALTH ADVISORY COMMITTEE

It is the opinion of the researcher that primary schools should try by all means to manage the spread of HIV infection by establishing health advisory committees. According to the National Policy on HIV/AIDS for Educators and Learners Act (No. 27 of 1996), Section 13, the following important facts regarding health advisory committees are stipulated. The committee should:

- Be set up by the School Governing Body and should consist of educators and other staff representatives, the parents of learners, representatives of learners and representatives from medical or health care professions;
- Elect its own chairperson and should be a person with knowledge in the field of health care;
- Advise the School Governing Board on all health matters, including HIV/AIDS;
- Be responsible for developing and promoting a school plan of implementation on HIV/AIDS and review the plan from time to time; and
- Be consulted on the provisions relating to the prevention of HIV transmission in the code of conduct.

Evian (2000: 77) argues that: “All schools should establish the problem solving team also known as the school based support team”.

The main focus of the school is learning and development. The school has a responsibility towards all its learners, to care and support those in need. It is therefore imperative to establish systems that will assist learners with problems. The team should consist of the following members: the principal, two heads of departments, three educators and two School Governing Board members. Evian (2000: 77) emphasizes that these people should be chosen for their experience, wisdom, expertise, empathy and dedication.

The duties of the team are as follows:

- To meet once monthly, and class educators should provide information regarding learners who need assistance, beyond what has been initiated by the class educators;
- To identify and help learners who are experiencing learning barriers in their classrooms;
- To support orphans and learners who are caregivers; and
- To help HIV positive learners to continue with learning if possible and encourage them to go on with schooling and never give up in life.

The researcher is supporting the idea of health advisory committees by encouraging all primary schools to establish such a committee. If the school does not know who the infected or affected learners are, then the school will have to devise a system of identification in order to help, care and support learners living with HIV/AIDS, and also those orphaned by AIDS.

3.12.2 PRIMARY SCHOOL LEARNERS' RIGHTS AND HIV/AIDS

The researcher is aware that learners have rights that protect them from any form of discrimination, including those living with HIV/AIDS. The South African Resource Manual on HIV/AIDS and the law (1997: 67),

identified legislations and regulations providing protection for children's rights threatened by HIV/AIDS.

They are as follows:

- **Access to education:** A child cannot be excluded from any school because of his/her HIV status;
- **Right to sexuality education:** The Children's Rights Charter states that a child should have access to information that will help develop his/her physical and emotional wellbeing;
- **Testing of children and confidentiality:** The Childcare Act protects the rights of children, including their medical treatment. At the age of 14, a child can legally consent to an HIV test and she/he has the right to keep the results private;
- **Adoption:** Child Welfare requires that future parents be told if a child is HIV positive;
- **Right to contraception and reproductive health:** Children have the right to protect and control their reproductive health.

The South African Law Commissions Consultative Paper on children infected and affected by HIV/AIDS (1998: 63) specifies that:

- Learners with HIV/AIDS should not be unfairly discriminated against;
- No learner should be denied access to schools on the basis of his or her HIV status;
- Testing of learners for HIV for admission to or attendance at a school is prohibited;
- Needs of learners with HIV should be accommodated within the school environment;
- All learner's HIV status is confidential and may not be disclosed without consent;
- All schools should implement universal precautions to eliminate the risk of transmission of blood-borne pathogens, including HIV, in the school environment; and
- HIV/AIDS education programs should be implemented at all institutions for learners, educators and other staff.

The researcher believes that children's rights are also human rights. It is the responsibility of educators to make sure that children's rights are not violated in schools, and to make sure that learners exercise their rights over their bodies. The researcher has observed that sometimes, children are discriminated against on the basis of their age, their race, their sex and sexual orientation, their indigenous or minority status or their disability.

3.12.3 SCHOOL POLICY ON HIV/AIDS

It is the opinion of the researcher that children should be taken on board on issues around HIV/AIDS school policy. Louw (2002: 69) writes that: "Schools or institutions should develop their own policy on HIV/AIDS, in order to give operational effect to the national guidelines. Such a policy must be consistent with the

constitution and the law". This implies that all the 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 the Government Gazette No. 20372 (August 1999).

Kelly (2000: 100) also writes that: "The school has a responsibility to be a center of information and support on HIV/AIDS in the community it serves". This indicates that major role-players from the broader community, for example religious and traditional leaders, local health workers or traditional healers, should be invited to take part in developing a school policy on HIV/AIDS. It is also very important that the school policy on HIV/AIDS be reviewed as new scientific information becomes available, including advice from the national or provincial health or education authorities.

The researcher supports the idea of a school policy on HIV/AIDS that needs to be drawn up for educational institutions. In primary schools, HIV/AIDS policies can help prevent discrimination against learners living with HIV/AIDS and can also assist in prevention campaigns. For a HIV/AIDS policy to be effective, the researcher suggests that there should be consultation with all people concerned. Parents, principals, educators, learners and School Governing Boards should be involved in drawing up the policy. This will help prevent future conflict. All the principals in schools are responsible for the implementation of an HIV/AIDS policy. School Governing Boards are expected to take reasonable measures to supplement government allocations of health and safety equipment.

3.13 STAKEHOLDERS THAT CAN ASSIST PRIMARY SCHOOL LEARNERS IN THE BATTLE AGAINST HIV/AIDS

The researcher believes that primary schools cannot function alone or in isolation in the battle against HIV/AIDS. Schools need other stakeholders that are interested in education so that the school can function effectively and fight HIV/AIDS. This idea is supported by President Thabo Mbeki (9 October 1998), who stated: "The power to defeat the spread of HIV and AIDS lies in our partnership: as youth, as women and men, as business people, as workers, as religious people, as parents and teachers, 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". This implies that everyone should be involved in the struggle against HIV/AIDS. If that is not the case, then we will be fighting a losing battle. There are several stakeholders that are greatly concerned with the HIV/AIDS epidemic: the Government of National Unity, the Department of Education and all other Departments, parents, educator's organizations, student's organizations, universities, colleges, high schools and primary schools. For the purpose of this research, the focus will be on the primary schools, the parents, the Department of Education and other Departments, NGO's (Non-Governmental Organizations) and medical doctors.

3.13.1 THE PRIMARY SCHOOL AS A CENTER OF HOPE AND CARE IN THE COMMUNITY

The researcher believes that the school occupies a central position in the community with regard to everything that influences cultural development and change. It is for this reason that the school should be involved in a partnership with parents, families, caregivers, as well as the broader community, in order to ensure that learners receive effective education. Caesar (2003: 62) points out that: “Many principals and educators may despair, when they think of having learners in their school who are infected and affected by HIV/AIDS”. This is true, since the principals may think that the problems will be too much to handle. It is therefore very important to admit that the school cannot and should not do it alone. There is a lot of potential support that needs to be mobilized. Systems and programmes are already in place to address the problems, for example the Health Promoting Schools Project, which has a holistic approach to health issues. There are also laws and policies in place that ensure the rights of learners. “The school needs to find out who its available partners are, and in which creative way learners who are infected and affected by HIV/AIDS can be cared for and supported (Louw 2002: 89)”. Kelly (2000: 72) supports this when she states: “In the school system, the learner who is infected and affected by HIV/AIDS should be accepted as a learner like any other learner in school”. This implies that the learner living with HIV/AIDS may not be identified as a learner with special educational needs, unless it becomes obvious that she/he is experiencing problems that are influencing his/her learning development. These problems may range from problems with schoolwork or homework, to health problems (i.e. absent a lot due to illness), emotional problems (i.e. crying a lot, unusual aggression), relationship problems, alcohol and drug abuse or prostitution. Each learner will react differently to his or her circumstances (Jackson 2002).

3.13.2 PARENTS AS SCHOOL PARTNERS

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”. This implies that the parents and the school form part of a larger community that surrounds the school geographically and should support it in every possible way. 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, join forces - in short, do everything possible to ensure that each learner in the school develops normally and is educated according to his or her ability. The researcher has observed that, even though the parents are the primary educators and have to take responsibility for their children, many parents are not prepared for parenthood and cry out for help. The researcher suggests that principals and educators as professional people can assist parents with basic parenting skills. The educators who are trained for life skills and HIV/AIDS programmes can guide parents regarding sexuality education. The school has to take responsibility for making sure that parents will be effective sexuality educators, so that they can play their part in the prevention of abuse, rape,

teenage pregnancies and HIV infection. Manaka (2002: 79) mentions that: “In order to care and support learners infected and affected by HIV/AIDS, parents will have to be acknowledged and assisted, as we do not know which learners are infected, and as all learners are affected by HIV/AIDS in some way. All the parents should be incorporated into the partnership. They should be encouraged to take up their responsibilities”. This is true, since parents are naturally good educators and should be praised for that. Educators should respect them, so that they respond positively to the school. In the battle against HIV/AIDS, the researcher believes that parents need to be involved; they can help curb the disease and deal with its effects. Parents can be of great help in guiding their children towards responsible sexual behaviour, by helping them to practice skills, and by establishing attitudes and values that will protect them against pain, hurt and even death.

The researcher suggests that schools must ensure that there is a multi-disciplinary network in the community. The activities are co-coordinated in order to pool resources and to avoid duplication of services. Kelly (2000: 101) mentions some department partners that need to work in collaboration with schools. They are:

- The Department of Education;
- The Department of Social Welfare and Child Welfare organization;
- The Department of Health; and
- The Department of Safety and Security.

3.13.3 THE DEPARTMENT OF EDUCATION: REGIONAL OFFICE

According to the Education Policy White Paper 6 (2001: 20), the functions of the regional-based support teams are to:

- Evaluate and thoroughly support teaching and learning;
- Build the capacity of the schools and other learning centers;
- Recognize and assist in addressing severe learning difficulties and learning needs;
- Help educators in the management of HIV/AIDS in schools;
- Promote the implementation of universal precautions in schools; and
- Promote the full personal and academic development of learners infected and affected by HIV/AIDS.

3.13.4 THE DEPARTMENT OF SOCIAL WELFARE AND CHILD WELFARE ORGANIZATIONS

Nourse (2000: 27) indicates that: “The Department of Social Development and Child Welfare Organizations focuses on learners and families in distress, and can assist the schools in the following ways:

- Assessing the family situation in which the learner with HIV lives;
- Placing learners in foster care;
- Being responsible for adoption of learners;
- Counseling learners and their families;
- Assisting poor parents to apply for pension or other welfare grants;
- Assisting and counseling abused learners;
- Presenting prevention programs to parents and learners; and
- Training educators to identify, handle and report abuse”.

3.13.5 THE DEPARTMENT OF HEALTH

Kelly (2000: 102) stresses that: “The Department of Health renders excellent service to schools, for example:

- The school health service can provide information on HIV/AIDS, including testing and counseling at schools, better nutrition, etc.;
- Learners with health problems can be referred to the department’s local clinics; and
- Sexually active learners can be informed regarding STI’s and the prevention of HIV infection”.

3.13.6 THE DEPARTMENT OF JUSTICE

Edwards (2002: 110) emphasizes that: “The school should have good contact with the local police, Child Protection Unit, the office of the family’s advocate and the Commissioner of the Children’s Court in order to ensure that learners suffer the least possible harm if they are involved in the judicial process”.

3.13.7 NON-GOVERNMENTAL AND COMMUNITY-BASED ORGANIZATIONS, WHICH COULD ASSIST THE SCHOOL

Edwards (2002: 110) mentions that: “All schools should try and find out if there are some of the following organizations in the area who could also render an invaluable service regarding learners infected and affected by HIV/AIDS:

- The Mental Health Society for emotional support, counseling and prevention programmes;
- SANCA (South African National Council of Association) for prevention programmes on alcohol and drug abuse and treatment for addicts; and
- HIV/AIDS organizations in the community, i.e. AIDS training, information and counseling centers”.

3.13.8 PRIVATE MEDICAL DOCTORS, PSYCHOLOGISTS AND COUNSELORS

Nourse (2000: 220) indicates that: “The private medical doctors, psychologists and counselors are the people who could assist on a voluntary basis to examine, treat and counsel learners from poor families who do not have medical schemes, and they can also help learners who have been sexually abused or raped”.

3.13.9 VOLUNTEERS IN THE COMMUNITY

Van Dyk (2001: 71) indicates that: “Parents, housewives or other volunteers could assist in various ways, i.e. preparing food for orphans, providing spiritual and pastoral care for learners, parents and educators who experience illness or death of a loved one”.

In the light of the above, it can be argued that promoting a positive interaction between the school and the community is fundamental to the success and sustainability of any school improvement process. Community partnerships engender a sense of collaboration, commitment and communal ownership. Such partnerships also build public awareness and strengthen demand. Within the school health component of such improvement processes, parental support and cooperation allows education about health to be shared and reinforced at home. The involvement of the broader community can enhance and reinforce school health promotion and resources. These partnerships, which should work together to make schools more child-friendly, can jointly identify health issues that need to be addressed through the school and then help design and manage activities to address such issues. It seems as if schools alone cannot address all the problems surrounding learners infected and affected by HIV/AIDS. The necessary support can be brought in from somewhere (outside the community). It is therefore essential to mobilize the whole community regarding HIV/AIDS. All the primary schools have to take the initiative and make sure that there are support structures for learners and parents who need assistance.

3.14 STRATEGIES FOR BRINGING ABOUT HIV/AIDS AWARENESS IN PRIMARY SCHOOLS

In bringing about HIV/AIDS awareness in primary schools, Louw (2002: 116) stresses that: “HIV/AIDS programs should:

- Target children at an early age, from the day they enter school;
- Be linked with life skills programs that are primarily concerned with equipping learners with skills such as decision-making, problem-solving, effective communication, assertiveness and conflict resolution from Grade One until these learners reach proper adulthood;
- Be appropriate to the learner's age and phase of development;
- Be presented in a language learners can understand; and
- Be meaningful and relate to everyday experiences and to the life world of learners".

Louw (2002: 63) states that: "HIV/AIDS programs will encourage learners to:

- Abstain from or postpone sexual activity;
- Change their lifestyle, if sexual activity and/ or sexual intercourse has taken place;
- Practice responsible behaviour if sexual activity is continued or embarked upon, in other words the correct and consistent use of condoms".

Van Zyl (2002: 123) indicates that educators must teach learners about the disease so that they can be aware of the dangers and effects of HIV/AIDS. Van Zyl (2002: 123) emphasizes that: "HIV/AIDS education programs should:

- Involve learners in program design and delivery, with a firm focus on promoting peer education;
- Involve community members, especially local and religious leaders;
- Use participatory methods and experiential learning techniques;
- Provide more of a challenge to the idealism of young people (including making abstinence cool);
- Develop a learning climate that firmly and frequently re-affirms the principle of respect, responsibility and rights".

In promoting HIV/AIDS awareness in primary schools, Kelly (2000: 16) also stresses that: "HIV/AIDS programs need to:

- Make learners aware of the existence of HIV, and how it is spread, without stigmatizing the behaviour that lead to its transmission;
- Facilitate discussions about an individual or community's own vulnerability, and how to reduce it. This involves dissipating fear and prejudice against people who are already living with HIV/AIDS;
- Impart knowledge, counter stigma and discrimination, create social consensus on safer behaviour, and boost AIDS prevention and care skills".

According to a Department of Education Report (2000: 12), HIV/AIDS programs in primary schools should:

- Provide basic, accurate information about the risks of unprotected sex as well as methods of contraception;
- Enhance self-efficacy among the youth;
- Be implemented at an early age, before participants commence sexual activity;
- Be developed and evaluated in close consultation with the target community. HIV/AIDS programs should also be culture sensitive;
- Include the reinforcement of individual values and group norms against unprotected sex;
- Continually be evaluated with a view to discarding, improving or adapting them; and
- Involve learners as active participants in experiential activities. A variety of teaching-learning strategies are used, such as integrated role-playing, discussion, facilitation, classroom coaching, stress reduction techniques, decision-making techniques, refusal skills, assertiveness techniques and parent involvement.

According to the above, it seems as if HIV/AIDS programs can bring about significant and positive adolescent reproductive health benefits and behaviours, with the information and skills that can be acquired by primary school learners helping them to delay the initiation of sexual activity.

3.15 CONCLUSION

The researcher believes that the education sector is by its nature a unique tool for spreading HIV/AIDS information and awareness. The education sector often receives the lion's share of public revenues, and is usually the major employer of public staff in a country. If the education sector is effectively used as a channel for promoting HIV/AIDS awareness, one can reach a very large audience. Not only can educators and administrative staff in the education sector be reached, but also learners at all levels, their parents and extended families. The researcher suggests that educators need to be appropriately trained for the successful integration of life-skills and HIV/AIDS education programs, as well as working with peer educators. In order to get the message through to people, there is a need for governmental commitment both in terms of planning and advocacy. Support from the parents, community and non-government organizations is vital, but this cannot be obtained on a broader basis without substantial government effort.

In Chapter Four, the research methodology will be discussed.

CHAPTER 4

THE RESEARCH METHODOLOGY

4.1 INTRODUCTION

Having reviewed what the literature has to say about the primary school learner and HIV/AIDS in the previous chapter, this chapter will focus on the set of logical steps undertaken by the researcher in answering the research questions.

4.2 RESEARCH PROBLEM

The research problem can be stated in the following two questions:

Question 1: Which strategies can be used in order to bring about HIV/AIDS awareness in Mgwenya Circuit, with specific reference to Lekazi Primary School, Mpumalanga Province?

Question 2: What are the responsibilities of educators regarding the implementation of HIV/AIDS programs in primary schools?

4.3 AIMS OF THE RESEARCH

4.3.1 SPECIFIC AIM

The specific aim is devising strategies for bringing about HIV/AIDS awareness.

4.3.2 GENERAL AIMS

It is the general aim of the study to:

- Differentiate between HIV and AIDS;
- Explain the meaning of being HIV positive and of having AIDS;
- Provide accurate information on the transmission and prevention of HIV/AIDS;
- Identify the role of educators in bringing about HIV/AIDS awareness in primary schools;
- Probe the perception of educators with reference to their presentation of HIV/AIDS lessons in

primary schools;

- Identify responsibilities of educators regarding the implementation of HIV/AIDS programs in primary schools; and
- Design questionnaires for primary school learners in order to check the level of HIV/AIDS awareness.

4.4 METHOD OF RESEARCH

For the purpose of this study, the researcher will use the qualitative and quantitative research methods. In this study, data collection will consist of a mix of qualitative data, i.e. text or images as well as quantitative data, i.e. numbers. The researcher will combine both methods to best explain and explore a research problem (Creswell 2002).

4.5 QUANTITATIVE RESEARCH METHODOLOGY

Quantitative research is research that involves measuring quantities of things, usually numerical quantities. The issues of measurement are of primary importance (Neuman 2002). Quantitative analysis is based on the natural sciences, with emphasis on empirically quantifiable observations, which lends themselves by means of mathematical tools (Creswell 2002). For the purpose of this study, 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 approach does not deny or ignore personal experiences. It merely insists that these experiences be quantified and measured on some scale, before they can be scientifically studied. Within this framework, a dazzling variety of questions can be addressed (Punch 2000). In this study, quantitative research will be used to determine the primary school learner's level of awareness regarding HIV/AIDS. In order to use a larger sample, this will be done by designing questionnaires that will be suitable for primary school learners. The researcher and her two colleagues at Lekazi Primary School will also observe HIV/AIDS lessons presentations. By doing this, the researcher will be working quantitatively. Quantitative research has the purpose of making objective descriptions of a limited set of phenomena and also to find out whether or not certain interventions can be used to control the phenomenon. The initial quantitative studies of a research problem therefore involve a precise description of the phenomena and a search for pertinent variables and their interrelationships. Finally, a theory is formulated to account for the empirical findings (Creswell 2002).

4.6 QUALITATIVE VERSUS QUANTITATIVE RESEARCH

According to Neuman (2002: 147), “key features common to all qualitative methods can be seen when they are contrasted with quantitative methods. Most quantitative data techniques are data condensers. They condense data in order to see the big picture. Qualitative methods, by contrast, are best understood as data enhancers. When data are enhanced, it is possible to see key aspects of cases more clearly”. Neuman (2002: 147) tabulate quantitative style versus qualitative style as follows:

QUANTITATIVE STYLE	QUALITATIVE STYLE
<ul style="list-style-type: none"> ➤ Measure objective facts; ➤ Focus on variables; ➤ Reliability is key; ➤ Value free; ➤ Independent of context; ➤ Many cases, subjects; ➤ Statistical analysis; ➤ Researcher is detached. 	<ul style="list-style-type: none"> ➤ Construct social reality, cultural meaning; ➤ Focus on interactive processes, events; ➤ Authenticity is key; ➤ Values are present and explicit; ➤ Situational constrained; ➤ Few cases, subjects; ➤ Thematic analysis; ➤ Researcher is involved.

4.7 QUALITATIVE RESEARCH METHODOLOGY

Qualitative research is defined by De Vos (2002: 222) as an inquiry approach useful for approaching and understanding a central phenomenon. Qualitative analysis is the paradigm that is derived from the humanist with the emphasis based on holistic and qualitative information and interpretative approaches (De Vos 2002). In this study, the researcher will ask participants questions based on HIV/AIDS, collect the detailed views of participants in the form of words, and analyze the information for designing strategies that will be used for bringing HIV/AIDS awareness to primary school learners. From this data, the researcher will interpret the meaning of the information. The final structure of the final report will be flexible, and will display the researcher’s biases and thoughts (Creswell 2002). According to Neuman (2002: 137), qualitative methodology refers to research that produces descriptive data – generally people’s own written or spoken words. In this study, qualitative research will be used by conducting focus group interviews in order to design strategies that can be used for bringing HIV/AIDS awareness to primary school learners. The researcher has also chosen this method because of a number of reasons, some of which are stated in Neuman (2002: 138):

- Gaining direct access to interact with the respondents in collecting data;
- Allowing for interviewing of a relevant target population in their own environment and observing the participants in the research; and
- Allowing the researcher to know people personally and to see them as they are, and to experience their daily struggles when confronted with real-life situations.

The qualitative research methods will further enable the researcher to interpret and to describe the actions of people (Neuman 2002).

In relation to this study, the qualitative research method will have the following advantages for the researcher as stated by Creswell (2002: 191):

- The researcher will be concerned primarily with process rather than outcomes or products;
- It will involve fieldwork. The researcher will physically go to the people, setting, site or institution to observe or record behaviour in its natural setting;
- The study will be descriptive, in that the researcher will be interested in process, meaning and understanding gained through words or pictures; and
- The research methods will make the study to be inductive, in that the researcher will build abstractions, concepts, hypothesis and theories from details.

The nature of the study is such that it will be a pilot study and primary schools will use it for future research projects. The researcher will conduct focus group interviews, formulate questionnaires and make use of observations as methods to collect data. Interviews will be conducted in order to get the educators', learners' and parents' opinions in designing strategies that can be used in bringing about HIV/AIDS awareness. The researcher will design questionnaires specifically for Lekazi Primary School learners. This will be done in order to determine their level of knowledge regarding HIV/AIDS.

4.8 RESEARCH DESIGN

Punch (2000: 149) defines research design as the overall plan for a piece of research, including four main ideas: the strategy, the conceptual framework, the question of who or what will be studied, and tools to be used for collecting and analyzing empirical materials. For the purpose of this study, the research design will form the most important part in the research as it indicates the whole set-up procedure for conducting the study. The research design thus serves as a point of departure for this study, that is, without the design it will be impossible for the researcher to conduct the proposed scientific study.

Creswell (2002: 191) reflects the steps that can be used in the qualitative and quantitative data collection processes, namely:

- Obtaining permission to conduct the study - identifying units of analysis, securing different types of permissions and obtaining informed consent from participants;
- Selecting participants and sites purposefully to best understand the phenomenon, specifying a population and sample, using probability sampling, and choosing the size of the sample;
- Identifying data from various sources such as observations, focus group interviews and questionnaires; and
- Administering and recording data by using the tape recorder in the focus group interviews.

The above-mentioned steps will be applicable in this study during the data collection process.

4.9 GAINING ENTRY INTO THE FIELD

Access to the field shall be gained in the following way:

- The researcher will write a letter to the circuit manager of Mgwenya, requesting permission to conduct the study. After permission has been granted, the researcher will then access the field. (See annexure A for the letter)

4.10 DATA COLLECTION METHODS RELAVANT TO QUALITATIVE APPROACH

4.10.1 OBSERVATIONS

The researcher has decided to use the observational material **in order to investigate the nature, the success or lack of the teaching skills employed by educators in presenting HIV/AIDS lessons. The researcher wants to see the practical application of the teaching skills used by educators in a classroom situation.** Creswell (2002: 198) regards observation as the process of gathering first hand information by observing people and places at a research site. This technique will be used by the researcher to determine how individuals or groups of persons react under specific circumstances, either natural or artificial (Creswell 2002).

In this study, the researcher will observe the presentation of HIV/AIDS lessons by educators during the Life Skills periods for the foundation phase and Life Orientation periods for the intermediate and senior

phases at Lekazi Primary School in Mgwenya Circuit. Nine HIV/AIDS lessons will be observed by three different observers at Lekazi Primary School, namely the researcher and her two colleagues. The reason for doing this is to get more reliable observations. The researcher will observe three classes that will be randomly selected, representing the three different phases found in Lekazi Primary School. The researcher will ask her two colleagues to observe the same classes that were observed by the researcher. The researcher and her two colleagues will use an observation guide form during the observations (See Annexure E for the guide). Spradley in Mertens (2002: 317) identifies five types of methods used in observations, namely:

- Non-participant: The lowest level of involvement and is usually accomplished by watching a video tape of the situation;
- Passive participation: The researcher is present but does not interact with the participants;
- Moderate participation: The researcher attempts to balance the insider or outsider roles by observing and by participating in some but not all of the activities;
- Active participation: The researcher does what the others do, generally, but does not try to blend in completely;
- Complete participation: The researcher becomes a natural participant, which has a disadvantage of trying to collect data and maintaining a questioning and reflective stance.

4.10.2 METHOD OF OBSERVATION

For the purpose of this study, the researcher will use the passive participation as a method of observation. She will play the role of a passive observer. She will be present but will not interact with the participants, which will be pure observation. The researcher will be sitting at the back of the classroom watching and writing down the activities without being involved in the activities of the participants. HIV/AIDS lessons presentations will be evaluated by considering the following:

- The introduction;
- Subject matter;
- Method of teaching;
- Conclusion; and
- Application.

The HIV/AIDS lessons presentations will be evaluated according to the format that is used by the Department of Education.

Marks will be allocated to each HIV/AIDS lesson presentation according to the items mentioned above. Information will be captured by using the frame below:

ITEM EVALUATED	MARKS ALLOCATED	MARKS OBTAINED
Introduction	10	
Subject matter	40	
Method of teaching	20	
Conclusion	20	
Application	10	
Total	100	

In the introduction, the researcher will give marks while taking the following into consideration:

- How is the lesson introduced or begun?
- How did participants (learners) respond or react to what was said?

In the subject matter, marks will be allocated while taking the following into consideration:

- What is being discussed?
- What is the response of the learners?
- What are the variations in how participants are engaging in the lesson?
- Which learning aids are used by educators in clarifying the subject matter?

In the method of teaching, marks will be allocated by considering the following:

- Which method does the educator use?
- Is the method involving the learners?
- Is the teaching method successful?

In the conclusion, marks will be allocated taking the following into consideration:

- What are the signals that the lesson unit is ending?
- How do learners react to the ending of the lesson?
- How is the completion of the lesson related to other program activities and future plans?

In the application, marks will be allocated by taking the following into consideration:

- What assignment or written work does the educator give the learners at the end of the lesson?

Neuman (2002: 110) mentions the following advantages and disadvantages of observations:

- The advantage of observation is that real-life behaviour can be perceived, studied and verified. Misunderstanding can also be clarified on the spot;
- The disadvantage is that the target group may feel that an outsider is interrupting them in their work and they may become uncomfortable. The nett result of the observation will then not be a true picture of real-life behaviour.

In view of the above disadvantage, educators will introduce the researcher to the learners and briefly spell out the purpose of the visit and the researcher will remain unobtrusive. She will ensure that a good relationship exists between her and the participants.

In view of the fact that the researcher will be targeting Lekazi Primary School, she will spend an hour per class as informed by the educator's school timetable. This implies that in the school, she will spend an hour a day, and will take three days to complete the observations. One day will be allocated to one phase for proper observations. After observation, the researcher will withdraw slowly from the site, thank the participants and inform them of the use of the data and the availability of the summary of result when the study is completed (Creswell 2002).

4.11 FOCUS GROUP INTERVIEWS

4.11.1 EXPLAINING THE TERM "FOCUS GROUP INTERVIEW"

According to De Vos (2002: 314), "A focus group interview could be described as a purposive discussion of a specific topic or related topics taking place between six to ten individuals with a similar background and common interests. Focus groups in essence are group interviews that rely, not on a question and answer format of interview, but on the interaction within the group (Neuman 2002). This reliance on interaction between participants is designed to elicit more of the participant's point of view than would be evidenced in more researcher dominated interviewing. According to Manion (2000: 160), focus groups are described as contrived settings, bringing together a specifically chosen sector of the population to discuss a particular given theme/topic, where the interaction with the group leads to data and outcomes. Cohen (2000: 123) also defines focus groups as unnatural settings, yet they are very

focused on a particular issue and they produce a large amount of data in short period of time.

Watts & Ebbuts (in Morrison *et al*, 2000) stipulates the following advantages of focus group interviews as a means of collecting data that will be useful in this study:

- They include the potential for discussion;
- They yield a wide range of responses than individual interviews;
- They are often quicker than individual interviews;
- They are time saving and involve minimal disruption;
- They can bring together people with varied opinions or as representatives of different collectivities; and
- They are less intimidating than individual interviews.

4.11.2 THE FOCUS GROUP PROCESS

In this study, the focus group interviews will be divided into specific phases, namely:

- Foundation phase educators;
- Intermediate phase educators;
- Senior phase educators;
- School Governing Body; and
- Senior phase learners.

For the purpose of the study, the focus group interviews will be conducted as an open conversation on strategies for bringing about HIV/AIDS awareness. Each participant will be allowed to make comments, ask questions of other participants or respond to comments by others, including the researcher (De Vos 2002). The focus group interview will enable the researcher to design strategies for bringing HIV/AIDS awareness to primary school learners.

For the sessions to be more effective, the researcher will do the following when conducting the focus groups interviews:

- Introduce herself and the research project;
- Obtain consent from the interviewee to participate in the study;
- Hand out the consent forms;
- Begin with the focus group once everything is signed; and

- End the focus group with a short summary of the main ideas.

Throughout the whole process, participants can ask questions and nobody will be forced to participate if they do not wish to do so. The researcher will make use of a tape recorder to record what is happening in the sessions. Participants' permission to tape the sessions will be requested. The researcher will inform the participants that the information will be used for research purposes only. The aim of the focus group will be to devise some strategies for bringing about HIV/AIDS awareness.

Questions that will be asked during the focus group interviews have been designed to stimulate debate and discussion. In this study, the role of the researcher will change to functioning more as a moderator or facilitator, and less as an interviewer. The process will not be one of alternate question and answer, as in the traditional interview. The researcher will be facilitating, moderating and monitoring group interaction. The group interaction will be directed by questions supplied by the researcher (Punch 2000).

In order to yield the desired results, the researcher will ensure that the focus group is not too small or too big. Twelve participants will be an optimum size. Participants will be selected through random sampling. Only five groups will be interviewed, namely:

- Life skills educators for the foundation phase;
- Life orientation educators for the intermediate phase;
- Life orientation educators for the senior phase;
- Senior phase learners from Lekazi primary school; and
- The School Governing Body, i.e. parents' representatives.

Only one group shall be interviewed in one day. This implies that the group interviews shall be conducted over five days. The researcher will guard against one participant dominating the group and against personal matters emerging during the interviews.

4.11.3 PHYSICAL ARRANGEMENT OF THE GROUP

The objective of focus group interviews is discussion (De Vos 2002). In this study, participants will normally be seated around a table to ensure maximum opportunity for eye contact with the researcher as well as the other participants. In order to enhance rapport among all participants, nametags will be placed on the table in front of them.

In these focus group interviews, the researcher will use open-ended questions. De Vos (2002: 149) defines open-ended questions as questions that allow individuals to respond in any way they wish. For the purpose of this study, open-ended questions will allow interviewees to develop answers much more fully than they could if they were completing questionnaires. De Vos (2002: 149) also mentions that: “Open-ended questions are used where the issue is complex, where relevant dimensions are not known, and where a process is being explored”. Because the focus group is a ‘guided’ discussion, the researcher as a facilitator will have a list of five to seven questions to ask during the 1 hour to 2 hour session. The questions will be used in a semi-structured way to ensure coverage of important issues, yet allow for flexibility in responding to group initiated concerns. One of the benefits of focus group sessions is the additional insight gained from the interaction of ideas among the group participants (Mertens 2002). **In this study, the researcher will conduct focus group interviews in order to determine strategies that can be used by educators, parents and learners in bringing HIV/AIDS awareness to Lekazi Primary School learners.** Different focus group interviews will be conducted. The main goal shall be to analyze and to interpret data so as to determine what this study may reveal in the light of designing strategies for bringing about HIV/AIDS awareness.

4.11.3.1 Questions that will be asked during the foundation phase focus group interviews are as follows:

1. How can you present a lesson on the following topics?
 - The definition of HIV and AIDS;
 - The transmission of HIV/AIDS;
 - The prevention of HIV/AIDS.
2. What are your responsibilities regarding the implementation of HIV/AIDS programs in the foundation phase?
3. What are the greatest obstacles in bringing about HIV/AIDS awareness?
4. In your opinion, is it necessary to teach learners about HIV/AIDS from the moment they start school?
5. Which strategies can be used for bringing HIV/AIDS awareness to the foundation phase learners?

4.11.3.2 Questions that will be asked during the intermediate phase focus group interviews are as follows:

1. How can you present a lesson on the following topics?

- The difference between HIV and AIDS;
 - Transmission of HIV/AIDS among primary schools learners;
 - The significance of universal precautions;
 - Practices that cannot lead to HIV infection; and
 - The importance of confidentiality and HIV/AIDS counselling.
2. What are your responsibilities regarding the implementation of HIV/AIDS programs in the intermediate phase?
 3. Which strategies can be used for bringing HIV/AIDS awareness to the intermediate phase learners?

4.11.3.3 Questions that will be asked during the senior phase focus group interviews are as follows:

1. How can you present a lesson on the following topics?
 - Definition of the two concepts HIV and AIDS;
 - Factors promoting the spread of HIV;
 - Transmission and prevention of HIV/AIDS;
 - Testing for HIV; and
 - Medication for HIV/AIDS.
2. What are your responsibilities regarding the implementation of HIV/AIDS programs in the senior phase?
3. Which strategies can be used for bringing HIV/AIDS awareness to the senior phase learners?

4.11.3.4 Questions that will be asked during the learners focus group interviews are as follows:

1. What is HIV?
2. What is AIDS?
3. How is HIV transmitted?
4. How can a person prevent HIV infection?
5. Do you believe that you have sufficient information about HIV and AIDS?
6. What are your responsibilities regarding the prevention of HIV infection?
7. Do you have any suggestions or comments on strategies that can be used in bringing about HIV/AIDS awareness?

4.11.3.5 Questions that will be asked during the parent's focus group interviews are as follows:

1. In your opinion, is it right to talk to children about sexual matters, including HIV and AIDS?
2. How can you explain the difference between HIV and AIDS to your children?
3. In your opinion, how can you be involved in the implementation of HIV/AIDS programs in primary schools?
4. Do you believe that your children have sufficient information regarding HIV/AIDS?
5. Do you have any suggestions on strategies that can be used for bringing about HIV/AIDS awareness in primary schools?

Questions on the presentation of HIV/AIDS lessons will be asked to verify the hypothesis that teaching skills used by educators for bringing about HIV/AIDS awareness are poor.

Participants will be allowed to take part in more than one focus group, because the researcher would like to cover as many ideas as possible. Participants will be made aware that the opinion of each and every individual is valued and that they need not reach consensus on the topic under discussion. For recording purposes, only one person will be allowed to speak at a time.

The exit will be the last stage of the interview, where the researcher will thank the respondents, assuring them of the confidentiality of the responses and leaves. She will go to a quiet private place to edit the interview and record other details while they are fresh. Details may include the date, time and place of the interview.

4.12 DATA COLLECTION METHODS RELEVANT TO QUANTITATIVE APPROACH

4.12.1 QUESTIONNAIRES

One of the main instruments of research to be used shall be the appropriate questionnaire designed for Lekazi Primary School learners who will be selected randomly to answer them. A structured questionnaire with close-ended questions designed for the learners will be provided. **The reason for designing questionnaires is that the researcher wanted to determine the learner's 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". In this study, the researcher will weave questions together so that they flow smoothly. She will include introductory remarks and instructions for clarification and will measure each variable with one or more survey

questions (Neuman 2003). Questionnaires will be used in this study because of the following advantages as stated by Neuman (2002)

- A questionnaire is relatively economical, can ensure anonymity and questions can be written for specific purposes;
- Respondents have time to think about the answers to questions in the questionnaire;
- A large number of respondents distributed over a large geographical area can be reached.

The disadvantage according to Neuman (2002: 149) is that the researcher is not at hand to explain uncertainties, which may result in biased or distorted answers by the participants. To avoid such a problem, the researcher will include introductory remarks and instructions on how to complete the questionnaires. Questions will be formulated in a simple, precise language that will be understood by all participants.

An explanatory note will be attached to the questionnaire indicating the aim of the research, to convey to respondents its importance, to assure them of confidentiality, and to encourage their replies (Morrison 2000).

For the purpose of this study, questionnaires will be distributed amongst learners of Lekazi Primary School. At Lekazi Primary, there are 300 learners in the foundation phase, 200 learners in the intermediate phase and 100 learners in the senior phase. Ten percent of learners from each phase will be selected through random sampling. It is only these learners who will be requested to respond to the questionnaires, as described below.

Table 2 shows distribution of the questionnaires.

PHASE	NUMBER OF QUESTIONNAIRES TO BE DISTRIBUTED
Foundation	30
Intermediate	20
Senior	10
TOTAL	60

According to Neuman (2002: 150), there is a key principle for good survey questions, namely to avoid confusion and keep the respondent's perspective in mind.

To comply with the above principle, questionnaires will be formulated taking into consideration the various phases found in Lekazi Primary school, namely:

- Foundation phase;
- Intermediate phase; and
- Senior phase.

The questions that will be included in the questionnaire will be relevant to the research problem. The researcher will formulate the foundation phase questionnaires in their home language, i.e. Siswati, so that they can understand and be able to respond correctly. The questionnaire will also be translated into English (See Annexure B). The intermediate phase and the senior phase questionnaire will be formulated in English because these learners are already introduced to English as a Language of Learning and Teaching. The level of development of the learners will be taken into account when formulating the questionnaires, i.e. the degree of complexity varies according to phases. In this study, the researcher will use closed-ended (structured, fixed response) questions. Neuman (2002: 160) defines a closed-ended question as a question that both asks a question and gives the respondent fixed responses from which to choose. The researcher will use multiple-choice questions. In these questions, four response options will be offered, with the “don’t know” option of the dichotomous question as one response possibility (Neuman 2002). The following is an example of the closed-ended question that will be used by the researcher in this study:

- Choose the answer that you think is the most appropriate, underline the response. For example,

HIV /AIDS can be transmitted by:

- (a) Sharing the same utensils;
- (b) Using the same toilet;
- (c) Hugging a friend;
- (d) Being involved in sexual intercourse without using a condom;
- (e) Don’t know

(See Annexures B, C & D for more questions).

Table 3 shows the content of the questionnaires for the foundation phase:

ASPECTS	NUMBER OF QUESTIONS
Basic facts about HIV/AIDS	3
Transmission and prevention of HIV/AIDS	2
Practicing universal precautions	1
Avoiding sexual abuse	2
Caring for and supporting learners living with HIV/AIDS	2

Table 4 shows the content of the questionnaires for the intermediate phase:

ASPECTS	NUMBER OF QUESTIONS
Basic facts about HIV/AIDS	4
Transmission and prevention of HIV/AIDS	2
Practicing universal precautions	1
Caring for and supporting learners living with HIV/AIDS	2
Parental involvement in the implementation of HIV/AIDS programs	1

Table 5 shows the content of the questionnaires for the senior phase:

ASPECTS	NUMBER OF QUESTIONS
Transmission and prevention of HIV/AIDS	2
Caring for and supporting learners living with HIV/AIDS	3
Medication for HIV/AIDS	1
The impact of HIV/AIDS to the learners	2
Learner's rights	1
The window period	1

Questions regarding the basic facts about HIV/AIDS, transmission and prevention of HIV/AIDS, and caring for learners living with the disease are in the majority in all the phases for the reason of determining the learner's knowledge about HIV and AIDS.

The method of circulating the questionnaires will involve personal delivery by the researcher to the principal and educators of the targeted population. After a week, the researcher will collect completed questionnaires from Lekazi Primary School.

4.13 TARGET POPULATION AND SAMPLING

4.13.1 TARGET POPULATION

Cresswel (2002: 159) stipulates that individuals drawn from a larger group of persons are called the population. De Vos (2002: 190) defines population as a group of participants sharing a cultural or sub-cultural tradition, which distinguishes the participants from their neighbours.

For the purpose of this study, participants to provide the data required will be drawn from the following population:

- Learners from Lekazi Primary School;
- Educators teaching Life Skills;
- Educators teaching Life Orientation; and
- School Governing Body, i.e. parents' representatives.

The researcher has decided to make use of educators and parents as the target population, because she has noted that they are reliable sources to be used in bringing HIV/AIDS awareness to the young ones, and they are a lively group of people who are not afraid to air their opinions. The learners are also included in the target population because the researcher cannot adequately and justifiably design strategies for bringing HIV/AIDS awareness at the exclusion of the actual people that are to be taught about the disease.

4.13.2 SAMPLING STRATEGIES

The nature of the study necessitates that a probability sample can be a suitable strategy for sampling purposes. Morrison (2000: 99) states that a probability sample is useful if the researcher wishes to make generalizations, because it seeks representativeness of the wider population.

For the purpose of this study, both the stratified and random samples will be used.

(a) Stratified sampling

The researcher chose stratified sampling because it involves dividing the population into homogenous groups, each group containing subjects with similar characteristics (Morrison 2000). In this study, a population will be divided into different, clearly recognizable subpopulations or strata, namely:

- Life skills educators for the foundation phase;
- Life Orientation educators for the intermediate phase;
- Life Orientation educators for the senior phase;
- Senior phase learners; and
- School Governing Body, i.e. members representing the parents.

The researcher will then select elements for the sample randomly from each of the different strata of the population.

(b) Simple random sampling

Simple random sampling means that each member of the population has an equal and independent chance of being selected (Mertens 2002). The method involves selecting at random from a list of the population, the required number of subjects for the sample (Morrison 2000). In this study, the population shall consist of the strata identified above. The researcher will draw names randomly out of a box containing the names of educators, learners and parents until the required number is reached. Each sample will consist of six participants.

Application of the above-mentioned sampling technique would contribute towards validity and reliability, and to a large extent eliminate bias (Mertens 2002).

4.14 HYPOTHESIS

A hypothesis as defined by Mertens (2002: 110) “is an instrument of control for the actual research; it enables the researcher to determine what he or she wants to know about the research problem”.

For the purpose of this study, the following hypothesis can be stated:

- a) Learners do not have sufficient information about HIV/AIDS;
- b) Teaching skills used by educators for bringing HIV/AIDS awareness to the learners are not effective.

The research to be conducted will reflect the truth of this hypothesis from the analysis of the responses and findings.

4.15 RELIABILITY AND VALIDITY

Reliability can be defined as the extent to which test scores are consistent and stable (De Vos 2002). Validity can be divided into two categories, namely external validity and internal validity. External validity refers to the extent to which the result of a study can be generalized to the wider population, while internal validity measures the extent to which the test actually measures the correct variables (De Vos 2002). In this study, validity will mean the truth generated from the research on designing strategies for bringing about HIV/AIDS awareness. It is through validity that the researcher will be able to determine whether the information collected is in relation with what actually happens or not in the classroom situation. Through observations, focus group interviews and questionnaires, the researcher will therefore be able to determine the validity of the study. Quantitative research rests on the foundations of reliability and validity. In the quantitative research, the aim is to prove something by using statistics, while in qualitative research, the aim is to understand the individual and the context that surrounds them. In qualitative research, emphasis falls on the concepts of transferability and credibility. Transferability refers to how the research finding can be applied to other contexts (De Vos 2002). Terms like applicability and fittingness have also been used in conjunction with this idea. When it comes to transferring data to another context, a description that provides information on the themes, labels and constructs of a study can provide the researcher and the reader with enough information to judge the appropriateness of applying the information to other settings (De Vos 2002).

From what has been explained above, the results of this study will be made available for use by various departments, circuit offices, primary schools and libraries.

4.15.1 RELIABILITY OF OBSERVATIONAL DATA

Adler and Adler in Mertens (2002: 198) suggest the following ideas for enhancing the validity and reliability of observational data, which are also applicable to this study:

- Use multiple observers or teams, diverse in age and gender, if possible;
- Compare observational findings with other researchers and eliminate inaccurate interpretations;

- Describe the research setting and findings in such a way that the reader can “see and feel” what it was like; and
- Address reliability by making observations in various settings, at various times of the days of the week, and months of the year.

In complying with the above recommendations, the researcher will enhance reliability and validity by doing the following:

- Requesting two colleagues of the researcher responsible for life skills to go and observe the presentation of HIV/AIDS lessons at Lekazi Primary School. The officials will be requested to observe the same classes that were observed by the researcher. The two colleagues will be asked to use the observation guide that has been drawn by the researcher for observations to promote standardization (See annexure E for the guide);
- Comparing the results of the two officials with her own results, and thereby arriving at the decision. If the results of the researcher agree with the results of the officials, this will indicate the reliability and validity of the observational data.

4.16 ETHICAL REQUIREMENTS

De Vos (2002: 230) indicates that ethics “are considered to deal with beliefs about what is right or wrong, proper or improper, good or bad”. In this study, the researcher will ensure that ethics such as honesty, confidentiality and anonymity, to mention but a few, are respected throughout the study. The researcher is ethically responsible for protecting the rights and welfare of the population while the study is being conducted (De Vos 2002). The researcher will make sure that the participants know how she can be contacted.

The researcher will also take into account the following measures as stipulated by Morrison (2000: 66-67) to satisfy the demands of ethical research during the study:

- Ensuring confidentiality of the information gained in the research project, no confidential data will be recorded or published. If confidentiality cannot be guaranteed, the participants will be informed by the researcher. Confidentiality also implies that participants will never be compelled to reveal their names or write them on the questionnaires. In order to meet the ethical requirements, the researcher will:
 - Always and under all circumstances report the truth and will never present the truth in an unbiased manner. The researcher will not deceive the participants. She will explain

clearly the nature of the research and how the information gathered will be used;

- Emphasize that participation in the study shall be voluntary; participants will under no circumstances be forced or coerced to participate in the study;
- Stress that access to information shall be strictly controlled and has to be negotiated;
- Indicate that the results of the research will be made available to the respondents once the study is completed, if they ask to see it. This is important because their thoughts and ideas will form an integral part of this study.

4.17 DATA ANALYSIS

4.17.1 DATA ANALYSIS TECHNIQUES

Once the researcher has completed the data collection process, an in-depth analysis of the data will be made. Creswell (2002: 260) states the following technique for data analysis, which will also be applicable in this study: transcription. It is defined as a process of converting audio tape recordings or field notes into text data. The researcher will utilize the following guidelines to ensure that data from the tape recorder is analysed:

- Leave extra space between the interviewer's comments and the interviewee's comments. This will enable the reader of a transcript to clearly distinguish between speakers during data analysis;
- Answer the questions that will be asked by the interviewees during the focus group interviews;
- Use complete detail headers that contain information about the focus group interviews and observational sessions; and
- Will use percentages to analyze data from observations and questionnaires.

In this study, the researcher will design her own strategies for bringing HIV/AIDS awareness to primary school learners. The researcher will make recommendations on the responsibilities of educators in the implementation of HIV/AIDS programs. The researcher will also acknowledge the strategies of the focus group interviews. The results of the focus group interviews will be used to answer the research questions, namely:

- Which strategies can be used in order to bring about HIV/AIDS awareness in Mgwanya Circuit, with specific reference to Lekazi Primary School, Mpumalanga Province?
- What are the responsibilities of educators regarding the implementation of HIV/AIDS programs in primary schools?

4.18 CONCLUSION

The research design serves as a point of departure for the entire study; it is a prerequisite for a scientific study of this nature. Addressing the empirical research will be the basis of the next chapter.

CHAPTER 5

THE EMPIRICAL RESEARCH

5.1 INTRODUCTION

This chapter deals mainly with the empirical findings. Attempts have been made to present the findings as they were indicated in the responses, observations, questionnaires and focus group interviews. The observational data consisted of nine HIV/AIDS lessons that were observed at Lekazi Primary School. The nine observations were done by the researcher and her two colleagues. The researcher observed three lessons, while her two colleagues observed three lessons each. The two colleagues observed the same classes that were observed by the researcher.

5.2 ANALYSIS AND INTERPRETATION OF DATA FROM THE OBSERVATIONS

5.2.1 OBSERVATIONS THAT WERE OBSERVED BY THE RESEARCHER

5.2.1.1 THE FOUNDATION PHASE OBSERVATIONS

LESSON ONE

On the first day, the researcher observed the presentation of an HIV/AIDS lesson to the foundation phase learners. The foundation phase observations consisted of sixty-seven learners and the educator as participants. The educator introduced the researcher to the learners, and spelt out the purpose of the visit. The researcher used the passive participation method when observing the presentation of HIV/AIDS lessons. She did not interact with participants. In these observations, the researcher evaluated each lesson by considering the introduction, subject matter, method of teaching, conclusion and application.

THE LESSON WAS PRESENTED AS DESCRIBED BELOW:

Topic: What is HIV/AIDS?
Duration: 1 Hour
School: Lekazi Primary School
Class: Grade Three
Date: 8 March 2005

The following is a summary of questions that were asked by the educator, the responses given by the learners and the educator's comments during lesson presentation.

INTRODUCTION

Question: How many learners have visited the doctor?

Response: The participants gave answers that reflected their own personal stories regarding sickness. They indicated that they have all visited the doctor.

Educator's comments: The educator added to what learners had said by emphasizing that it is good for people to visit a doctor when they are not feeling well.

Question: What kind of sickness might lead a person to consult a doctor?

Response: In response to this question, the participants indicated that a person consults a doctor when that particular individual is sick.

Educator's comment: The educator stressed that it is only sick people who can consult a doctor. If a person is not sick, then there is no need to consult a doctor.

Question: Why do people have sores?

Response: In responding to this question, participants mentioned reasons that might cause people to have sores as follows:

- They get the sores from germs;
- By scratching themselves;
- From car accidents.

Educator's comments: The educator indicated that people could have sores through sickness. Some people suffering from cancer and sugar diabetes end up by having incurable sores.

Question: What do you do when you have sores?

Response: There were no misunderstandings in this question. Participants responded adequately to the question by stating that they visit a doctor or clinic when they have sores, so that the doctor or nurse can cover their sores with bandages.

Educator's comment: The educator emphasized that learners should not play with dirty water because they will get germs that might cause sores.

SUBJECT MATTER

The following is a summary of questions asked by the educator, the responses given by the learners and the educator's comments in the deliberation of the subject matter.

Question: What is a germ?

Response: The participants highlighted different ideas regarding a germ. Some participants indicated that a germ is something that looks like a star. Others indicated that germs look like bacteria. One participant also indicated that some germs are in an oval shape, they look like eggs.

Educator's comments: The educator explained that one cannot see a germ with his naked eyes, but it can be seen through a microscope.

Question: What should a person do when he is coughing?

Response: Participants highlighted that one should cover his/her mouth with a handkerchief when coughing, so that a person does not spread germs to other people.

Educator's comment: The educator explained that it is very important for everyone to cover his/her mouth when coughing or sneezing.

Question: Which type of a germ can a person get from the blood?

Response: The participants indicated that HIV is a dangerous germ; a person can get the virus from the blood. Participants also explained that HIV is a virus that causes AIDS.

Educator's comment: The educator did not comment on the answer given by the participants.

Question: Which is the most dangerous disease that affects all of us?

Response: The participants responded adequately to the question by saying that HIV and AIDS is a dangerous disease that affects the whole world.

Educator's comment: The educator added to what learners had said by emphasizing that learners should try by all means to protect themselves from HIV infection.

Question: What is HIV?

Response: Participants explained that HIV is a virus that causes AIDS.

Question: What is AIDS?

Response: AIDS is a disease that is caused by HIV.

The educator did not comment on the answer given by the learners.

Question: How HIV is transmitted?

Response: In response to the question, participants indicated that HIV could be transmitted through:

- Playing with old injections;
- Touching someone's blood;
- Touching someone's wounds or sores.

Educator's comments: The educator added to what learners had said by saying that HIV can be transmitted in the following ways:

- Through mother-to-child transmission. Here, the educator explained that sometimes children could contract HIV from their mothers during birth and through breast-feeding.

Question: How can someone prevent HIV infection?

Response: Regarding this question, participants indicated that a person can prevent HIV infection by doing the following:

- By not sleeping with an opposite sex;
- By avoiding touching someone's blood;
- By covering sores and wounds with a bandage;
- By using a condom when involved in sexual activities.

Educator's comment: The educator emphasized that HIV could also be prevented in the following ways:

- By abstaining from sexual activities. The educator explained that learners should not involve themselves in sexual activities. They should wait until they are grown-ups;
- By being faithful to the partner. The educator explained that adults should be honest in their marriages by sticking to their wives;
- By reporting sexual abuse cases to the parents;
- By using a condom when involved in sexual activities. Here, the educator was referring to adults.

Question: What can be done to assist someone with nose bleeding?

Response: In response to this question, participants had different views regarding assisting someone with nose bleeding. On the one hand, participants indicated that they would call the police, call the ambulance, and take the one who is bleeding to the clinic. On the other hand, participants indicated that they would call the principal, take the one who is bleeding home and they would also tell the educator.

Educator's comment: The educator explained in detail that if there is someone with a nose bleeding in the classroom, learners should call an adult for help. The educator warned learners that they should not touch anyone's blood with bare hands; they should rather use a plastic bag without holes. If there are latex hand gloves available in the school, learners should use them to cover their hands. The reason is that no one knows who is HIV positive and who is not.

Learning aids used by the educator in presenting the subject matter: The teacher used the picture of a microscope when explaining that a germ is a small tiny thing that can only be seen through a microscope.

Method of teaching: The educator used the question and answer methods in introducing her lesson and also in the deliberation of the subject matter. Learners were not actively involved in the lesson. Only five learners were answering questions that were asked by the educator. The method used by the educator was not successful, because most of the learners were not actively involved in the lesson.

Conclusion: There were no signals that the lesson unit was ending. Learners were not given a chance to ask questions where they did not understand. The completion of this lesson was not related to other program activities and future plans. Nothing was said about the next lesson.

Application: Learners were not given work to do at home. No tasks were assigned to them.

LESSON EVALUATION

The researcher allocated marks for each and every HIV/AIDS lesson presentation according to its introduction, subject matter, method of teaching, conclusion and application.

Table 6 shows a summary of the lesson evaluation, and the marks obtained by the participant:

ITEM EVALUATED	MARKS ALLOCATED	MARKS OBTAINED
Introduction	10	6
Subject matter	40	26
Method of teaching	20	8
Conclusion	20	2
Application	10	2
TOTAL	100	44

The researcher's comments: The table reveals that the participant performed very well in the introduction and subject matter. The participant performed poorly in method of teaching, conclusion and in the application. The participant obtained 44%. According to the researcher, this means that the participant's performance in this lesson presentation was poor.

5.2.1.2 THE INTERMEDIATE PHASE OBSERVATIONS

LESSON TWO

On the second day, the researcher observed the presentation of HIV/AIDS to the intermediate phase learners. The intermediate phase observations consisted of sixty-nine learners and the educator as participants. The educator introduced the researcher to the learners and spelt out the purpose of the visit. The researcher used the passive participation method when observing the presentation of the HIV/AIDS lesson. She did not interact with the participants.

THE LESSON WAS PRESENTED AS DESCRIBED BELOW:

Topic: Transmission and prevention of HIV/AIDS.
Duration: 1 Hour.
School: Lekazi Primary School.
Class: Grade Five.
Date: 9 March 2005.

The following is a summary of questions that were asked by the educator, the responses given by learners and the educator's comments during lesson presentation.

INTRODUCTION

Question: Name five different diseases that you know?

Response: In answering the question, participants mentioned the following diseases:

- Tuberculosis;
- Cancer;
- Sugar diabetes;
- HIV and AIDS; and
- Asthma.

Educator's comment: The educator indicated that it is good that they have mentioned HIV/AIDS as one of the diseases that they know. She further indicated that the topic for today was based on the transmission and prevention of HIV/AIDS.

Question: Which is the most dangerous disease?

Response: The participants responded without any hesitation that HIV and AIDS is the most dangerous disease.

Educator's comment: The educator added to what learners had said by explaining that HIV/AIDS is a fatal disease. People suffering from this disease end up dying.

SUBJECT MATTER

Question: How HIV is transmitted?

Response: The participants stated that HIV could be transmitted by:

- Having sex with someone;
- Touching someone's blood; and
- Being pregnant.

Educator's comment: Firstly, the educator explained that the term "transmission" means the way in which diseases are spread from one person to another. She further explained that HIV could be transmitted through:

- Having sex without using a condom;
- Mother-to-child transmission during pregnancy; and
- Contaminated blood.

The educator also stressed that a person cannot get HIV from:

- Hugging;
- Kissing;
- Sharing the same toilet;
- Using the same glass for drinking water;
- Playing together with sick learners;
- Sharing the same classroom.

The educator also explained that learners should not discriminate against learners living with HIV/AIDS. Regarding the prevention of HIV/AIDS, the educator asked the learners the following questions:

Question: How can a person prevent HIV infection?

Response: In response to the question, participants mentioned that HIV can be prevented by:

- Visiting a clinic on a regular basis;
- Consulting a doctor;
- Not sleeping with the opposite sex; and
- Using a condom.

Educator's comment: The educator emphasized that HIV can be prevented by:

- Not playing with old injections;
- Using a condom when involved in sexual activities;

- Being faithful to your partner.

Question: What should a girl do when called by a stranger?

Response: One participant responded to the question by saying that she will tell her mother. Another participant stated that she could call the police, or tell her dad about it.

Educator's comment: The educator highlighted that learners should not make friends with strangers. They should also report cases related to sexual abuse. The educator stressed that learners should not allow anyone to touch their private parts.

Learning aids used by the educator: The educator used two posters with pictures of girls who were demonstrating refusal skills to sexual abuse in clarifying the subject matter.

Method of teaching: The educator used the question and answer method when delivering the subject matter. Out of sixty-nine learners, only seven learners were actively involved in the lesson. These learners were answering questions that were asked by the educator. The method was not successful because the rest of the learners were not actively involved in the lesson.

Conclusion: There were no signals that the lesson unit was ending. No summary was given to the learners. The educator concluded by giving learners the topic for the following week.

Application: Learners were not given classwork or homework.

LESSON EVALUATION.

Table 7 shows a summary of lessons evaluation, and the marks obtained by the participant:

ITEM EVALUATED	MARKS OBTAINED	MARKS OBTAINED
Introduction	10	8
Subject matter	40	26
Method of teaching	20	6
Conclusion	20	3
Application	10	2
Total	100	45

The researcher's comments: The above table reveals that the participant performed well in the introduction and subject matter. The participant performed poorly in the method of teaching, conclusion

and application. The participant obtained 45%. It is the opinion of the researcher that the participant who had selected the topic should have scored better than this.

5.2.1.3 THE SENIOR PHASE OBSERVATIONS

LESSON THREE

On the third day, the researcher observed the presentation of HIV/AIDS lessons to the senior phase learners. The senior phase observations consisted of fifty-seven learners and the educator as participants. The educator introduced the researcher to the learners and spelt out the purpose of the visit. The researcher used the passive participation method in observing the presentation of the HIV/AIDS lesson in the senior phase. She did not interact with the participants.

THE LESSON WAS PRESENTED AS DESCRIBED BELOW:

Topic: Caring for people living with HIV and AIDS.
Duration: 1 Hour.
School: Lekazi Primary School.
Class: Grade Seven.
Date: 10 March 2005.

The following is a summary of questions that were asked by the educator, the responses given by learners and the educator's comments during lesson presentation.

INTRODUCTION

Question: How can you show love, care and support for people living with HIV/AIDS?

Response: In response to this question, participants replied as follows: They can show love, care and support to people living with HIV and AIDS by doing the following:

- Visiting them at hospitals;
- Not discriminating against them;
- Buying get well cards for them;
- Not gossiping about their disease; and
- Giving them love and support.

SUBJECT MATTER

After responding to the question, participants were given a chance to read a story about Karabo and Nduku. The story was as follows:

Karabo is a grade seven learner whose parents have died of HIV/AIDS related illness. Karabo is thirteen years old and is also HIV positive. Her classmates did not want to be with her in the classroom. They insisted that Karabo should be separated from other learners because of her HIV status. Nduku was her best friend before he knew that Karabo was HIV positive. Karabo died at the age of fourteen. Doctors related the cause of her death to worrying. The doctor indicated that Karabo died because of worry.

After learners had read the story, they were given a chance to comment about the story in their various groups. After that, the educator asked learners the following:

Question: What caused the death of Karabo's parents?

Response: In response to this question, participants gave very detailed answers that reflected their personal views regarding HIV and AIDS. One participant indicated that Karabo's parents died because of HIV/AIDS. Another participant disagreed by saying that it might happen that it is not HIV/AIDS that has killed Karabo's parents. It might have happened that both parents were also suffering from heart failure or sugar diabetes. It might also have been one of those diseases that might have killed them and not HIV/AIDS.

Educator's comment: The educator added to what learners had said by explaining that Karabo's parents died due to HIV/AIDS-related illnesses as mentioned in the story.

Question: Is it right to discriminate against people living with HIV and AIDS?

Response: In response to this question, participants were divided. Some of the participants felt that people living with HIV and AIDS should have their own HIV/AIDS centres where they can be kept. The reason for this is that the disease is infectious. Some of the participants stressed that people living with HIV and AIDS should be separated from the uninfected ones. Even learners living with HIV/AIDS should have their own schools. Other participants disagreed, stating that people living with HIV/AIDS are also human beings and should be respected. They have rights that also protect them against any form of discrimination. Participants also stated that learners living with HIV/AIDS should not have their own schools.

Educator's comment: The educator concluded the conversation by saying that it is not right to discriminate against people living with HIV/AIDS.

Question: What lesson did you get from the story?

Response: In response to the question, participants indicated that from the story, they have learned that people should not discriminate against people living with HIV/AIDS. They should love them, care for them and give them the necessary support they need.

Educator's comment: The educator explained that worry alone can kill a person faster than any crime.

Question: What is it that they would do for Karabo to show that they cared for her?

Response: In response to this question, participants indicated that they would do the following:

- Lend her their books;
- Share their food with her;
- Appreciate it to have her in their classroom;
- Give her the necessary support; and
- They would not discriminate against her.

Educator's comment: The educator explained that learners living with HIV/AIDS should not be discriminated against. Uninfected learners should show love and respect for them. The educator also highlighted that being HIV positive does not mean that the person will die tomorrow; there is life after testing HIV positive.

Learning aids used by the educator in presenting the subject matter: The educator used two pictures of people living with HIV/AIDS who have already disclosed their HIV status. He used these pictures in order to stress that people living with HIV/AIDS need to be loved, cared for and supported by their family members and also by other people in their communities.

Method of teaching: The educator has used the question and answer method together with the group discussion method. Learners were divided into five groups, i.e. ten learners per group. Learners were given a chance to discuss their own views regarding Karabo and Nduku's story. Learners were also asked questions regarding caring for and supporting people living with HIV and AIDS. All learners were actively involved in the lesson. The presentation of this lesson was learner-centred. All learners were encouraged to speak in their groups.

Conclusion: There were no signals that the lesson unit was ending. The main elements of the lesson were not summarized. Learners were not given a chance to ask questions, especially where they did not understand. The completion of this lesson unit was not related to other program activities and future plans.

Application: No classwork, assignments, homework or projects were given to the learners.

LESSON EVALUATION

Table 8 shows a summary of lesson evaluation, and the marks obtained by the participant:

ITEM EVALUATED	MARKS ALLOCATED	MARKS OBTAINED
Introduction	10	8
Subject matter	40	20
Method of teaching	20	15
Conclusion	20	2
Application	10	2
Total	100	47

The researcher's comments: According to the above table, the participant performed very well in the introduction, subject matter and in the method of teaching. The participant performed very poorly in the conclusion and in the application. The participant obtained 47%. According to the researcher, this means that the participant has poor skills in presenting the HIV/AIDS lesson.

Table 9 shows the total marks that were obtained by the three participants that were observed by the researcher

FOUNDATION PHASE	INTERMEDIATE PHASE	SENIOR PHASE
44	45	47

5.3 OBSERVATIONS BY THE COLLEAGUES OF THE RESEARCHER

Two colleagues of the researcher observed the presentation of HIV/AIDS lessons at Lekazi Primary School. The colleagues observed the same classes that were observed by the researcher. This was done in order to get more reliable observations of the HIV/AIDS lessons.

5.3.1 OBSERVATIONS BY THE FIRST COLLEAGUE OF THE RESEARCHER

5.3.1.1 THE FOUNDATION PHASE OBSERVATIONS

LESSON FOUR

On the first day, the colleague of the researcher observed the presentation of an HIV/AIDS lesson to the foundation phase learners. The foundation phase learners' observations consisted of sixty-seven

learners and the educator as participants. The educator introduced the colleague of the researcher to the learners and spelt out the purpose of the visit. The colleague of the researcher also used the passive participation method in observing the presentation of the HIV/AIDS lesson. She did not interact with the participants.

THE LESSON WAS PRESENTED AS DESCRIBED BELOW:

Topic: Children's rights, including those who are living with HIV and AIDS.
Duration: 1 Hour.
School: Lekazi Primary School.
Class: Grade Three.
Date: 5 April 2005.

The following is a summary of questions that were asked by the educator, the responses given by learners and the educator's comments during lesson presentation.

INTRODUCTION

Question: What are rights?

Response: Responding to this question, participants were not sure about the answer. After a few minutes, one participant responded by stating that rights are the ways in which people should behave. Another participant also indicated that rights are the people's way of living.

Educator's comment: The educator added to what learners had said by explaining that children's rights are also human rights, and they can be described as something that is morally or socially correct or just, fair treatment. The educator also explained that even learners living with HIV and AIDS share the same rights with learners who are not infected and affected by HIV/AIDS.

SUBJECT MATTER

Question: Name the children's rights that you know of?

Response: In responding to this question, participants, without any hesitation, mentioned that children have the right to:

- Be born;
- Be given food at homes; and
- Be educated.

After the learners had finished mentioning their rights, the educator listed and explained the following children's rights. The educator stressed that children have the right to:

- Be taken seriously - the educator explained that no-one has got the right to undermine children, whether they are HIV positive or not;
- Quality medical care - the educator said that if they are sick, parents should take them to doctors or clinics;
- Good education - the educator highlighted that all children are supposed to be at school. No-one should stay at home without any valid reason;
- Be loved and protected from harm - the educator explained that every adult should protect children from any danger, including those who are HIV positive;
- Get special care for special needs - the educator mentioned that all children have to be treated with respect and care;
- Make mistakes - the educator mentioned that making a mistake is not a crime, but learners should avoid making the same mistakes;
- Be well fed - the educator indicated that it is the responsibility of parents to provide their children with food;
- To a safe and comfortable home - the educator indicated that it is the responsibility of parents to protect their children from danger;
- To be proud of their heritage and beliefs - the educator said that children should be allowed to inherit their parents' possessions. He also mentioned that children should respect others' origins and beliefs.

Learning aids used by the educator: The educator did not use learning aids in clarifying the subject matter.

Method of teaching: The educator used the question and answer methods in his introduction and in the deliberation of the subject matter. Learners were not actively involved in the lesson. It was only the five learners who were answering questions who participated in the lesson.

Conclusion: There were no signals that the lesson unit was ending. The main elements of the lesson were not summarized. Learners were not given a chance to ask questions about the learning content. The completion of this lesson was not related to other program activities and future plans.

Application: Learners were not given classwork or homework.

LESSON EVALUATION

Table 10 shows a summary of lesson evaluation, and the marks obtained by the participant:

ITEM EVALUATED	MARKS ALLOCATED	MARKS OBTAINED
Introduction	10	6
Subject matter	40	25
Method of teaching	20	5
Conclusion	20	2
Application	10	2
Total	100	40

The researcher's comment: From the table, it can be seen that the participant performed very well in the introduction and in the subject matter. The participant obtained low marks in the method of teaching, conclusion and in the application. The participant obtained 40%, which is not good. According to the researcher, this indicates that the participant's performance in this lesson presentation was poor.

5.3.1.2 THE INTERMEDIATE PHASE OBSERVATIONS

LESSON FIVE

On the second day, the colleague of the researcher observed the presentation of an HIV/AIDS lesson to the intermediate phase learners. The intermediate phase observations consisted of sixty-nine learners and their educator as participants. The educator introduced the observer to the learners, and spelt out the purpose of the visit. The observer also used the passive participation method. She did not interact with the participants.

THE LESSON WAS PRESENTED AS DESCRIBED BELOW:

Topic: Prevention of HIV transmission during sports.
Duration: 1 Hour.
School: Lekazi Primary School.
Class: Grade Five.
Date: 6 April 2005.

The following is a summary of questions that were asked by the educator, responses given by learners and the educator's comments during the lesson presentation.

INTRODUCTION

In the introduction, the educator explained the meaning of HIV transmission to the learners. The educator mentioned that on that day, they were going to learn about the things that they were supposed to do during sports activities so that they can prevent the transmission of HIV.

SUBJECT MATTER

The educator explained that HIV could be prevented in the following ways during extramural activities:

- By covering open wounds, sores or breaks with bandages. The educator also said that learners should remind their parents to cover their wounds;
- By not participating in contact play or contact sports with an open wound;
- By not participating in sport when bleeding;
- By using the first aid kit when players are injured; and
- By not touching anyone's blood during sports.

The educator stressed that for learners to be safe, they need to treat anyone as if he/she was HIV positive.

Learning aids used by the educator: No learning aids were used by the educator in clarifying the subject matter.

Method of teaching: The educator used the narrative/telling method in introducing the lesson and also in the deliberation of the subject matter. The educator explained the learning content to the learners without checking whether learners followed the subject matter or not. Learners were not actively involved in the lesson.

Conclusion: There were no signals that the lesson unit was ending. Learners were not given a chance to ask questions based on the learning content.

Application: Learners were given a classwork to write, which was based on the learning content.

LESSON EVALUATION

Table 11 shows a summary of the lesson evaluation, and the marks obtained by the participant:

ITEM EVALUATED	MARKS ALLOCATED	MARKS OBTAINED
Introduction	10	4
Subject matter	40	25
Method of teaching	20	4
Conclusion	20	5
Application	10	8
Total	100	46

The researcher's comments: The table shows that the participant performed very well in the application. However, the participant performed very poorly in the introduction, subject matter, method of teaching and in the conclusion. The participant obtained 46%. According to the researcher, this suggests that the participant had poor skills in the presentation of an HIV/AIDS lesson.

5.3.1.3 THE SENIOR PHASE OSERVATIONS

LESSON SIX

On the third day, the colleague of the researcher observed the presentation of an HIV/AIDS lesson to learners in the senior phase. The senior phase observations consisted of fifty-seven learners and their educator as participants. The educator introduced the observer to the learners and spelt out the purpose of the visit. The observer used the passive participation method. She did not interact with the participants.

THE LESSON WAS PRESENTED AS DESCRIBED BELOW:

Topic: The HIV test result of a child.

Duration: 1 Hour.

School: Lekazi Primary School.

Class: Grade Seven.

Date: 7 April 2005.

The following is a summary of the questions that were asked by the educator, responses given by the learners and the educator's comments during the lesson presentation.

INTRODUCTION

Question: How can a person know whether she/he is HIV positive or not?

Response: In responding to the question, some participants mentioned the following:

- By asking the doctor;
- By being admitted to the hospital; or
- By being admitted to the intensive care unit.

Other participants answered the question by saying that for the person to know his/her HIV status, the individual should undergo an HIV test.

Educator's comment: The educator emphasized that it is only the HIV test result that can detect whether a person is HIV positive or not.

Question: Can you judge by merely looking whether a person is HIV positive or not?

Response: In response to this question, there were some disagreements among the participants. On the one hand, participants responded by saying yes, it is easy to identify a person who is HIV positive. They stressed that HIV positive people can be seen by means of the following:

- They are always coughing;
- They are thin like needles;
- They have thin hair;
- They lose their appetites;
- Sometimes they are vomiting a lot;
- They are suffering from diarrhoea; or
- They have white sores on the mouth and on the tongue.

On the other hand, participants responded to the question by stating clearly that the HIV status of a person can only be determined by an HIV test result and nothing else.

Educator's comment: The educator emphasized that a person cannot be judged by merely looking at him or her whether she or he is HIV positive or not, but this can be determined by the HIV test results.

SUBJECT MATTER

In explaining the learning content, the educator stated that learners have their own rights regarding their HIV status.

The educator emphasized that learners should know the following:

- At the age of 14, a child can legally consent to an HIV test for himself/herself;
- They have the right to keep the result to themselves;
- Confidentiality is their common law right. No one is forced to disclose his/her HIV status. The educator insisted that even principals and educators have no right to force learners to disclose their HIV status.

- If the child is under 14 years, that child is under the supervision of his parents. They can take him/her for an HIV test if they want, but they are not allowed to tell anyone about his/her HIV status. The person to whom the information is disclosed should be legally responsible for the child.

Learning aids: There were no learning aids used by the educator in clarifying the subject matter.

Method of teaching: The educator used the question and answer method in the introduction and also in delivering the subject matter. Out of fifty-seven learners, only twelve learners were actively involved in the lesson.

Conclusion: There were no signals that the lesson unit was ending. The educator did not summarize the learning content. Learners were not given a chance to ask questions where they did not understand.

Application: Learners were given handouts, i.e. copies of notes based on the learning content to study at home.

LESSON EVALUATION

Table 12 shows a summary of lesson evaluation, and the marks obtained by the participant.

ITEM EVALUATED	MARKS ALLOCATED	MARKS OBTAINED
Introduction	10	6
Subject matter	40	26
Method of teaching	20	8
Conclusion	20	2
Application	10	6
Total	100	48

The researcher's comment: The table reveals that the participant obtained good marks in the introduction, subject matter and in the application. The participant obtained low marks in the method of teaching and in the conclusion. The participant obtained 48%, which is not good. It is the researcher's opinion that some of the teaching skills of the participant were not good.

Table 13 shows the total marks that were obtained by the three participants that were observed by the first colleague of the researcher:

FOUNDATION PHASE	INTERMEDIATE PHASE	SENIOR PHASE
40	46	48

5.3.2 THE OBSERVATIONS OF THE SECOND COLLEAGUE OF THE RESEARCHER

5.3.2.1 THE FOUNDATION PHASE OBSERVATIONS

LESSON SEVEN

On the first day, the colleague of the researcher observed the presentation of an HIV/AIDS lesson to the foundation phase. The foundation phase observations consisted of sixty-five learners and the educator as participants. The educator introduced the observer to the learners and spelt out the purpose of the visit. The observer used the passive participation method to observe the lesson. She did not interact with the participants.

THE LESSON WAS PRESENTED AS DESCRIBED BELOW:

Topic: Protecting the body from HIV infection.
 Duration: 1 Hour.
 School: Lekazi Primary School.
 Class: Grade Three.
 Date: 10 May 2005.

The following is a summary of questions that were asked by the educator, the responses given by learners and the educator's comments during the lesson presentation.

INTRODUCTION

In the introduction, the educator explained to the learners that it is very important for them to protect their bodies from HIV infection. She mentioned that HIV/AIDS is a dangerous disease that might lead to death.

SUBJECT MATTER

Question: What are you supposed to do to show that you care for your bodies?

Response: Learners answered the question by listing a few things they would do, namely:

- Wash their bodies everyday;
- Brush their teeth so that they don't smell bad;
- Wear jerseys in winter so that they can protect their bodies from the cold;
- Have enough time to sleep so that they can rest;
- Tell their parents when they are sick; and
- Cover their mouths when coughing and sneezing so that they do not spread germs to others.

Educator's comment: The educator added to what learners had said by listing things that they were supposed to do in order to protect their bodies from HIV infection, namely:

- Not to allow anyone to touch their private parts because they are so special. She also stressed that children should report any form of abuse. They can tell their parents or the police about the abuse. The educator gave the learners the Police emergency number, which is 10111, for reporting any form of abuse;
- Not to touch anyone's sores or wounds. The educator explained that it is dangerous to touch someone's sores, as one might contract HIV infection; and
- To cover their wounds with bandages.

Question: Why is it important for you to protect your bodies?

Response: Participants indicated that it is important to care for their bodies so that they:

- Can keep their bodies strong and healthy;
- Cannot be easily affected by contagious diseases;
- Can grow and become responsible adults; and
- Can have a brighter future.

Educator's comment: The educator added to what the learners had said by stating the following reasons for protecting their bodies:

- Because HIV is dangerous. The educator explained that they need to be careful because once they are infected with HIV, the virus is going to be there forever. There is no cure for HIV/AIDS;
- So that they can be responsible adults with a bright future;
- They are special in such a way that they are unique and irreplaceable. The educator indicated that their bodies are so special because God created them;
- If they do not protect their bodies themselves, no-one will do that for them. The educator stressed that learners should be responsible for taking care of their bodies.

Learning aids: There were no learning aids that were used by the educator in explaining the learning content. Only a few learners were involved in the learning content. These were the learners who were answering the questions.

Method of teaching: The educator used both the narrative and question/answer methods as a way of delivering her lesson. Only ten learners were actively involved in the lesson.

Conclusion: There were no signals that the lesson unit was ending. The educator did not summarize the lesson. Learners were not given a chance to ask questions regarding the lesson. Learners were not asked whether they understood the learning content or not. The completion of this lesson was not related to other program activities and future plans.

Application: Learners were not given classwork or homework.

LESSON EVALUATION

Table 14 shows a summary of the lesson evaluation and the marks obtained by the participant:

ITEM EVALUATED	MARKS ALLOCATED	MARKS OBTAINED
Introduction	10	5
Subject matter	40	23
Method of teaching	20	10
Conclusion	20	2
Application	10	2
Total	100	42

The researcher's comment: The table shows that the participant obtained average marks in the introduction, subject matter and method of teaching. The participant obtained low marks in the conclusion and in the application. The participant obtained 42%, which is not a good percentage. It is the researcher's opinion that this indicates that the participant has poor skills in presenting HIV/AIDS lessons.

5.3.2.2 THE INTERMEDIATE PHASE OBSERVATIONS

LESSON EIGHT

On the second day, the colleague of the researcher observed the presentation of an HIV/AIDS lesson to the intermediate phase learners. The intermediate phase learners consisted of sixty-five learners and the educator as participants. The educator introduced the observer to the learners and spelt out the purpose

of the visit. The observer used the passive participation method. She did not interact with the participants.

THE LESSON WAS PRESENTED AS DESCRIBED BELOW:

Topic: What does it mean to be HIV positive?
Duration: 1 Hour.
School: Lekazi Primary School.
Class: Grade Five.
Date: 11 May 2005.

The following is a summary of questions that were asked by the educator, responses given by the learners and the educator's comments during the lesson presentation.

INTRODUCTION

Question: What is HIV?

Response: Participants responded differently by stating that HIV is:

- A virus that makes a person to be sick;
- A germ that kills the white blood cells;
- A virus that causes AIDS.

Educator's comment: The educator added to what the learners had said by emphasizing that HIV stands for:

- H – Human
- I – Immune
- V – Virus

The educator mentioned that the virus is only found in human beings and not in animals. She further explained that the virus attacks the white blood cells that fight off different diseases.

Question: How is HIV transmitted?

Response: In response to this question, there were no gross misinterpretations of how HIV is transmitted. The participants stated that HIV is spread through having sex with an infected person, sharing needles, by touching contaminated blood and from mother-to-child.

Educator's comment: In adding to what the participants had said, the educator stated that HIV could be transmitted by:

- Having sex with an infected person without using a condom;
- Touching someone's blood with bare hands;

- Not being faithful to the partner. The educator related this to the adults only;
- Not abstaining. The educator indicated that if they do not stay away from sexual activities, learners would be creating chances of being infected with HIV;
- Transmission through mother to child;
- Touching the wounds or sores of an HIV positive person.

Question: Why do people protect themselves from HIV infection?

Response: In responding to this question, participants were divided. There were disagreements on this issue. Some participants stated that people do not protect themselves from HIV infection. This can be seen in their sexual behaviour. Participants stated facts that show carelessness of people in not protecting themselves from HIV infection. Participants mentioned the following reasons:

- Most people have got more than two sexual partners;
- Some people are sleeping around without using a condom;
- Older people are not faithful to their partners;
- Most of the people are not abstaining; and
- HIV/AIDS statistics are going up every day.

Other participants stated that some people do protect themselves from HIV infection because they:

- Use condoms when involved in sexual activities;
- Are faithful to their partners by sticking to their wives. Participants related this to some pastors in churches; and
- Abstain from sexual activities.

The participants concluded this discussion by indicating that although the statistics of HIV infection goes up every day, there are some people who have already changed their sexual behaviour.

SUBJECT MATTER

Educators comment: The educator explained that learners should try by all means to protect themselves from HIV infection, due to the following reasons:

- Presently, there is no cure for HIV/AIDS;
- The disease is fatal. The educator mentioned that some people infected and affected by HIV/AIDS end up dying.

The educator stressed that learners need to take care of themselves by not involving themselves in sexual activities. The educator further explained that a HIV positive person is infected with the virus and does not necessarily feel or look sick, and does not yet have AIDS. She explained that to be HIV

positive means that the person is infected with the virus as confirmed by a positive blood test result. The educator indicated that having HIV is not the same as having AIDS. A person with HIV infection can feel perfectly fine and healthy for a long time. The educator concluded this discussion by stating that a person with HIV infection can feel perfectly fine and healthy for a long time.

Learning aids: There were no learning aids used by the educator in explaining the learning content.

Method of teaching: The educator used the telling and question/answer methods in delivering the subject matter. Learners were not actively involved in the lesson.

Conclusion: There were no signals that the lesson unit was ending. No summary was given to the learners regarding the subject matter. The completion of the lesson was not related to other programme activities and future plans.

Application: The educator gave learners some notes to study at home.

LESSON EVALUATION

Table 15 shows a summary of the lesson evaluation, and the marks obtained by the participant.

ITEM EVALUATION	MARKS ALLOCATED	MARKS OBTAINED
Introduction	10	7
Subject matter	40	26
Method of teaching	20	8
Conclusion	20	2
Application	10	4
Total	100	47

The researcher's comment: According to the above table, the participant performed well in the introduction and in the subject matter. The participant obtained low marks in the method of teaching, in the conclusion and application. The participant obtained 47%, which is not good. According to the researcher, this means that the participant's skills in lesson presentation were poor.

5.3.2.3 THE SENIOR PHASE OBSERVATIONS

LESSON NINE

On the third day, the colleague of the researcher observed the presentation of an HIV/AIDS lesson to learners in the senior phase. The senior phase observations consisted of fifty-seven learners and the educator as participants. The educator introduced the observer to the learners and spelt out the purpose of the visit. The observer used the passive participation method. She did not interact with the participants.

THE LESSON WAS PRESENTED AS DESCRIBED BELOW:

Topic: Sexually Transmitted Infections.
Duration: 1 Hour.
School: Lekazi Primary School.
Class: Grade seven.
Date: 12 May 2005.

The following is a summary of questions asked by the educator, responses given by the learners and the educator's comments during the lesson presentation.

INTRODUCTION

The educator explained to the learners that there are sexually transmitted infections that are dangerous in such a way that they might cause HIV infection. The educator mentioned that learners should take care of themselves. They should not involve themselves in sexual activities because they are still young. They should rather abstain. The educator asked learners whether they knew of any sexually transmitted infections. There was no response to this question. One participant indicated that although they knew that there are sexually transmitted infections, they did not know them by name.

SUBJECT MATTER

The educator explained that the presence of sexually transmitted infections might lead to HIV infection. The educator indicated that sexually transmitted infections may create an entry point to HIV.

The educator mentioned sexually transmitted infections that might contribute to HIV infection, and they are summarized below:

- Herpes – The educator explained that this is a chronic disease with no cure. Symptoms of the disease are flu, mouth sores, itching and burning genitals;
- Chlamydia – The educator explained that Chlamydia is a bacterial infection treated with antibiotics. The effect of the disease on men and women is to be unable to have children;
- Gonorrhoea – The educator stressed that this is a bacterial disease. The disease produces a thick white or yellow discharge from the vagina or penis;
- Syphilis – The educator explained that it is caused by certain bacteria. Symptoms of the disease are a yellow, creamy discharge in the underwear;
- Genital Warts – The educator indicated that this is a virus that affect boys, by having small bumps all over the penis, scrotum or around the rectum. Girls usually get the small bumps in or around the vagina.

Learning aids: There were no learning/teaching aids used by the educator in presenting the subject matter.

Method of teaching: The educator used the narrative method in explaining the learning content to the learners. Learners were not actively involved in the lesson.

Conclusion: There were no signals that the lesson was ending. The educator did not summarize the lesson. Learners were not checked whether they understood the subject matter or not. The completion of this lesson was not related to other programme activities and future plans.

Application: Learners were given some notes to study at home.

LESSON EVALUATION

Table 16 shows a summary of the lesson evaluation and marks obtained by the participant.

ITEMS EVALUATED	MARKS ALLOCATED	MARKS OBTAINED
Introduction	10	4
Subject matter	40	25
Method of teaching	20	8
Conclusion	20	4
Application	10	4
Total	100	45

The researcher's comment: The table reveals that the participant performed well in the subject matter. The participant obtained low marks in the introduction, method of teaching, conclusion and application. The participant obtained 45%, which is not good. It is the opinion of the researcher that the participant demonstrated poor skills in presenting the HIV and AIDS lesson.

Table 17 shows the total marks that were obtained by the three participants that were observed by the second colleague:

FOUNDATION PHASE	INTERMEDIATE PHASE	SENIOR PHASE
42	47	45

Table 18 shows a summary of all the lessons observed by the three observers and marks obtained by participants in HIV/AIDS lessons presentations:

Lessons observed by the researcher	Marks obtained by participants
Lesson One	44
Lesson Two	45
Lesson Three	47
Lessons observed by the first colleague	Marks obtained by participants
Lesson Four	40
Lesson Five	46
Lesson Six	48
Lessons observed by the second colleague	Marks obtained by participants
Lesson Seven	42
Lesson Eight	47
Lesson Nine	45
Total	404
Average	45%

From the above table, the following can be deduced:

- Percentages obtained by the participants in the first observations are close to the percentages of the second observations;
- The difference between the first, second and third observations is much smaller.

5.4 THE AVERAGE PERCENTAGES FOR THE NINE OBSERVATIONS

The average percentage for the nine HIV/AIDS lessons observations was calculated by adding the total marks obtained by each participant, divided by the number of lessons observed, which is $404/9 = 45\%$.

Table 19 reveals the average percentages obtained by the participants in the three different observations that were done by the three different observers.

OBSERVATIONS BY THE RESEARCHER	OBSERVATIONS BY THE FIRST COLLEAGUE	OBSERVATIONS BY THE SECOND COLLEAGUE
45%	45%	45%

The above table reveals the following:

- The average percentage for all nine HIV/AIDS lessons that were observed by the three different observers at Lekazi Primary School is 45%;
- The results of the researcher agree with the results of the two officials;
- The average percentages confirm that the skills used by participants in the presentation of HIV/AIDS lessons are not effective.

According to the researcher, the similarity of the results indicates that the reliability and validity of the results are high.

5.5 THE FOCUS GROUP INTERVIEWS

5.5.1 THE FOUNDATION PHASE FOCUS GROUP INTERVIEW

The foundation phase focus group interview consisted of eight educators as participants. All eight the participants were educators of Lekazi Primary School and taught life skills and life orientation. The researcher allowed participants from the intermediate and senior phase to participate in the foundation phase focus group interviews. The reason for this is that the researcher wanted to gain much information regarding strategies that can be used for bringing HIV/AIDS awareness to the foundation phase learners. The researcher acted as a facilitator, and less as an interviewer. Participants were interviewed while seated around a table with their nametags in front of them. All participants were assured of the confidentiality of the focus group interview.

THE FOUNDATION PHASE FOCUS GROUP INTERVIEW WAS CONDUCTED AS DESCRIBED BELOW:

Apparatus: Tape Recorder.
Duration: 1 hour.
Date: 14 March 2005.
Time: 13h30.
Venue: Lekazi Primary Library Centre

The questions used to elicit participant's views were:

1. How can you present a lesson on the following topics?
 - The definition of HIV and AIDS;
 - The transmission of HIV and AIDS;
 - The prevention of HIV and AIDS.
2. What are your responsibilities regarding the implementation of HIV/AIDS programs in the foundation phase?
3. What are the greatest obstacles in bringing about HIV/AIDS awareness?
4. In your opinion, is it necessary to teach learners about HIV/AIDS from the moment they start school?
5. Which strategies can be used for bringing HIV/AIDS awareness to the foundation phase learners?

The respondents gave very detailed answers that reflected their knowledge regarding HIV/AIDS. The following is a summarized account of the respondent's answers.

In response to the first topic, participants had different perceptions on the presentation of this lesson. Some participants stated that learners know about HIV and AIDS, since they learn about it from the radio and television. Nevertheless, they further indicated that they would explain the term "HIV" by saying that HIV is a germ that eats all blood ingredients, and the person becomes weaker and weaker until that individual is attacked by different diseases which might result in AIDS. Some participants stated that they would ask learners to give their own definition of HIV, after which they would add the

information where necessary. One participant also stated that she would define HIV as a virus that causes AIDS. She further indicated that she would define AIDS as a dangerous disease that is caused by HIV.

Regarding the second topic, participants mentioned that they would ask learners the meaning of transmission. After they had received the learner's responses, they would give them the correct meaning of transmission. Participants stated that before they teach learners about transmission of HIV/AIDS, they would ask learners the various modes of HIV transmission that they know of. After the learner's response, the participants would teach learners that HIV could be transmitted through:

- Touching someone's blood with bare hands;
- Being involved in sexual activities without using a condom;
- Mother-to-child transmission;
- Breastfeeding, when the mother is HIV positive;
- Playing with old injections;
- Not being faithful to the partner; and
- Touching infected blood.

Regarding the prevention of HIV/AIDS, participants responded adequately. There were no major misunderstandings. Participants stated that they would teach learners that the disease can be prevented by:

- Abstaining from sexual activities. Participants stressed that this is the only 100% method of preventing HIV infection;
- Not touching anyone's blood;
- Avoiding sexual abuse;
- Being faithful to the partner. This was related to adults;
- Using a condom when involved in sexual activities. Participants stressed that learners should not attempt to use condoms, they should rather abstain;
- Keeping away from accident scenes;
- Not touching another learner's sores or wounds;
- Covering their hands with latex gloves when assisting someone with bleeding; and
- Covering the sores and wounds with bandages.

During this conversation, participants mentioned that the only way of discovering one's HIV status is through undergoing an HIV test. Another participant emphasized that she would teach learners to treat everyone as if he/she was HIV positive, since one does not know who is HIV positive and who is not.

In response to the second question, responsibilities mentioned by participants on the implementation of HIV/AIDS programs are as follows:

- Teach learners about HIV and AIDS;
- Support and care for learners living with HIV/AIDS;
- Teach learners not to discriminate against learners living with HIV/AIDS;
- Teach learners that it is safe to share their food with learners living with HIV /AIDS;
- Visit learners who are sick at hospitals and at homes;
- Teach the infected learners to eat healthy food that will boost their immune system; and
- Encourage learners to make their own gardens at home, where they can grow vegetables.

Regarding the question on the greatest obstacles in bringing about HIV/AIDS awareness, the responses were as follows:

- Some people deny that HIV/AIDS exist;
- Most people say that all human beings will eventually die, HIV positive or not;
- People are afraid to disclose their positive HIV status because of the stigma attached to it;
- Some educators find it difficult to talk about HIV /AIDS;
- Some educators are HIV positive; they become more concerned about their ill health and therefore become nervous and depressed; and
- HIV positive educators' attitude to work deteriorates, and they become unable to perform well.

In answering question four, participants said that they believe it is necessary to teach learners about HIV/AIDS from the moment they start school. This was related to the high rate of sexual abuse of children. One participant added that learners should be taught about HIV/AIDS while they are still young, at school level. This will assist learners in acquiring accurate information about HIV/AIDS from the school rather than learners learning about the disease from their friends, neighbours, relatives or from the streets. Another participant stressed that they should be an example to learners by being friendly to people living with HIV /AIDS.

In response to the last question, participants mentioned the following strategies that can be used for bringing HIV/AIDS awareness to the foundation phase learners:

- Dramatization: learners can play drama demonstrating the transmission and prevention of HIV/AIDS;

- Poems and rhymes: learners should be encouraged to compose songs on the effects and dangers of HIV/AIDS. They can also say rhymes on HIV/AIDS;
- Invite people from the Department of Health to come and address learners around HIV/AIDS issues; and
- Invite people living with HIV/AIDS to come and share their knowledge and experiences with the learners regarding the disease.

5.5.2 THE INTERMEDIATE PHASE FOCUS GROUP INTERVIEW

The intermediate phase focus group interview consisted of eight educators as participants. The participants were all educators at Likazi Primary School. The researcher allowed participants from the foundation phase and senior phase to join the intermediate phase focus group interview. This was done in order to get more strategies that can be used for bringing HIV/AIDS awareness to the intermediate phase learners. The researcher acted as a facilitator, and less as an interviewer. All participants were interviewed while seated around a table with their nametags in front of them. Participants were assured of the confidentiality of the focus group interviews.

THE INTERMEDIATE PHASE FOCUS GROUP INTERVIEW WAS CONDUCTED AS DESCRIBED BELOW:

Apparatus: Tape Recorder.
Duration: 1 hour.
Date: 15 March 2005.
Time: 13h30.
Venue: Lekazi Primary School.

Questions that were used to elicit participants' views were as follows:

1. How can you present a lesson on the following topics:

- The difference between HIV and AIDS;
- Transmission of HIV and AIDS;
- The significance of universal precautions;
- Practices that cannot lead to HIV infection; and
- The importance of confidentiality and HIV/AIDS counselling.

2. What are your responsibilities regarding the implementation of HIV/AIDS programs in the intermediate phase?
3. Which strategies can be used for bringing HIV/AIDS awareness to the intermediate phase learners?

With regard to the first topic, there were no disagreements; participants indicated that when teaching about the difference between HIV and AIDS, they would start from the known to the unknown. This could be done by asking learners to name the different diseases that they know. After they had mentioned the different diseases, including HIV /AIDS, the educator would introduce the lesson. Participants mentioned without hesitation that they would define HIV as a virus that causes AIDS. They would define AIDS as a disease caused by HIV. One participant stressed that she would further explain that the two concepts are not the same, but are related. Another participants added by saying that she would explain the difference between a person who is HIV Positive and a person who has got AIDS by stating that:

- An HIV positive person can look healthy and strong and may take years for symptoms to develop;
- A person with AIDS is sick and always lying in bed. There is nothing he can do. He is weak and cannot eat food because he does not have an appetite. Many diseases get a chance to attack that person and he ends up dying.

In response to the second topic, participants mentioned that they would introduce the lesson by indicating that flu can be prevented by wearing a jersey in winter.

On the question of how HIV is prevented, participants further stated that they would ask learners a question on how HIV is prevented. After learners had mentioned their own views regarding prevention of HIV/AIDS, participants indicated that they would teach learners that HIV can be prevented by:

- Abstaining from sexual activities;
- Treating everyone as if he/she was HIV positive;
- Using a condom when involved in sexual activities;
- Being faithful to the partner;
- Not touching anyone's blood; and
- Avoiding touching anyone's wounds or sores.

Participants also chatted about condoms. On the issue of condoms, participants were divided. Some participants indicated that learners should not be encouraged to use condoms. Instead of doing that, educators should encourage learners to abstain from sexual activities until they reach adulthood and become responsible adults. They also felt that encouraging learners to use condoms would lead to promiscuity and would also encourage learners to be more involved in sexual activities. Some participants pointed out that learners who are sexually active should be encouraged to use condoms since they fail to abstain. Their argument was that primary school learners involve themselves in sexual activities while they are still young. Participants insisted that if they discourage learners to use condoms, then they would be allowing HIV to spread faster. The problem of “sugar daddies”, i.e. old married men, was also mentioned as one of the methods of spreading HIV faster. Participants said that some learners are forced by circumstances to be involved in sexual activities. Girls from disadvantaged families are forced by circumstances to be in love with sugar daddies, because the sugar daddies could provide them with groceries and money for school funds. One participant indicated that educators should encourage learners to abstain from sexual activities, even those who are known to be sexually active. Participants stressed that the issue of condoms cannot be entertained at primary school level. They insisted that learners who want to use condoms, could use them at their own risks. Schools should not distribute condoms to learners. If learners wanted to use condoms, they could go and fetch them from the clinics on their own. Another participant concluded by saying that learners should be taught survival skills that would assist them in protecting themselves from HIV infection. She stressed that learners should be taught to ask rapists to use condoms if they find themselves in such situations. For learners to use condoms was definitely not seen in a very positive light in this argument.

In response to the third topic of universal precautions, participants indicated that they would teach learners the following:

- Explain that universal precautions are a means of avoiding HIV transmission;
- They would mention abstinence as one example of universal precautions;
- Since there is no cure for HIV/AIDS, learners would be encouraged to take measure precautions in order to avoid HIV infections;
- Warn them about the 2010 World Soccer games, by indicating that people from other countries will be here in South Africa to watch the games. Learners should not involve themselves in sexual activities with these people; and
- Discourage learners not to stab one another with pens, especially the boys.

In conclusion, one participant indicated that she would give learners homework based on the significance of universal precautions, so that she could see whether learners had mastered the subject matter or not.

With regard to the topic of practices that cannot spread HIV, participants mentioned the following:

- HIV cannot be transmitted by:
 - Hugging or shaking hands;
 - Sharing the same classrooms;
 - Sharing the same toilet;
 - Eating the same food;
 - Sleeping in one bed;
 - Playing together with HIV positive learners; or
 - Sharing the same utensils.

Participants emphasized that they would teach learners not to discriminate against people living with HIV/AIDS. At the end of the lesson, participants indicated that they would check whether they had achieved the outcomes of the lesson by asking learners to mention the activities that would not lead to HIV infection.

In response to the topic of confidentiality, participants stated that they would teach learners the following:

- Confidentiality means to treat information with respect and release it to relevant people who could use the information for the benefit of an HIV positive person;
- The HIV status of any person is confidential. No-one is forced to disclose his/her HIV status;
- Nurses, doctors and HIV/AIDS counsellors are not allowed to tell anyone about someone's HIV status without the consent of that particular individual; and
- It is their right to keep their HIV status confidential.

On the topic of HIV/AIDS counselling, participants overwhelmingly stated that they would encourage learners to do the following:

- Go for counselling before and after the HIV test; and
- Go for HIV testing, since this would alleviate the stress of sickness.

In response to question two, participants mentioned the following responsibilities regarding the implementation of HIV/AIDS programs in the intermediate phase:

- Teaching learners about the disease;
- Teaching learners that red ribbons symbolize caring for people living with HIV/AIDS;
- Searching for more information regarding HIV/AIDS from the Internet, newspapers and also reading more books on HIV/AIDS so that they can answer all questions that will be asked by learners;
- Inviting people from the Department of Health to come and address learners on HIV/AIDS;
- Attending HIV/AIDS workshops that would be organized by the Department of Education;
- Organizing HIV/AIDS Indaba conferences at school level, where there would be speeches on HIV/AIDS. The school would choose the Health Minister, the President of the country and the guest speaker of the day. Learners would be given a chance to air their views on the effects and dangers of HIV/AIDS; and
- Educators should lead by example. They should love and support people living with HIV/AIDS, so that learners could learn from them that discriminating against people living with HIV/AIDS is not good.

In responding to question three, participants mentioned the following strategies that can be used for bringing HIV/AIDS awareness to the intermediate phase learners:

- Organize drama on HIV/AIDS for learners;
- Use audiovisual learning aids, for example educators can bring video cassettes on people living with HIV/AIDS in order to make learners aware that HIV/AIDS exist;
- Compose songs on HIV/AIDS so that learners can sing them during life skills periods;
- Teach HIV/AIDS lessons through games, for children learn faster when they are playing;
- Organize HIV/AIDS conferences at school level, where there would be the guest speaker on HIV/AIDS; and
- Invite people who have already disclosed their HIV status to come and share their knowledge with the learners.

5.5.3 SENIOR PHASE FOCUS GROUP INTERVIEW

The senior phase focus group interview consisted of twelve educators as participants. All twelve participants were educators at Lekazi Primary School and were teaching different learning areas. The researcher allowed educators teaching other learning areas to join the senior phase focus group interview because she wanted to get the ideas of other educators regarding strategies that can be used

for bringing about HIV/AIDS awareness. The researcher acted as the facilitator. All participants were interviewed while seated around a table with their nametags in front of them.

THE SENIOR PHASE FOCUS GROUP INTERVIEW WAS CONDUCTED AS DESCRIBED BELOW:

Apparatus: Tape recorder.
Duration: 1 hour.
Date: 16 March 2005.
Time: 13h30.
Venue: Lekazi Primary Library Centre.

THE QUESTIONS USED TO ELICIT PARTICIPANTS VIEWS WERE:

1. How can you present a lesson on the following topics:
 - Definition of HIV and AIDS;
 - Factors promoting the spread of HIV;
 - Transmission and Prevention of HIV/AIDS;
 - Testing for HIV; and
 - Medication for HIV/AIDS.
2. What are your responsibilities regarding the implementation of HIV/AIDS programs in the senior phase?
3. Which strategies can be used for bringing HIV/AIDS awareness to the senior phase learners?

Participants seemed very confident to air their views. There was less disagreement in this group than in the previous focus groups.

Participants mentioned the following pertaining to the lesson presentation on the definition of HIV and AIDS:

- They would define “HIV” as a human immune virus that causes AIDS;
- They would define “AIDS” as a dangerous disease that is caused by HIV.

One participant added that he would indicate to the learners that AIDS patients get thinner and have difficulty in walking and eating.

Responding to the topic of factors promoting the spread of HIV, participants said that they would introduce this lesson by asking learners to mention any factors that they know of, that would promote the spread of HIV. After that, participants would add to what learners had mentioned by stating the following factors that might also promote the spread of HIV:

- Poverty: participants emphasized that poverty could force learners from poor families to be involved in sexual activities with old men who are HIV positive;
- Not testing for HIV: The participants pointed out that most people do not go for HIV tests and spread the virus unknowingly;
- High rate of rape: Participants stated that many orphans live in dire poverty and they have turned to prostitution in order to survive.

With regard to the presentation of a lesson on the transmission of HIV/AIDS, participants indicated that they would proceed as follows:

- Divide learners into groups where they would discuss the various modes of HIV transmission. Each group would have a scribe, a reporter and a group leader who would report on behalf of the group;
- Check the various modes of HIV transmission mentioned by learners. If there were mistakes, participants would correct them by writing various modes of HIV transmission on the chalkboard.

The participants also chatted about HIV testing. They indicated that as educators, they needed to lead by example. This means that they should go for HIV testing before they could encourage learners to do the same. One participant added to what others had said by mentioning that it does not end at the testing. Educators should share their HIV results with the learners. Another participant added by saying that if the results are HIV negative, then the educator would be proud of his HIV status. If the results are HIV positive, then the educator should always use a condom when involved in sexual activities so that he does not transmit the disease to innocent people.

Responding to the topic on medication for HIV/AIDS, participants pointed out that they would teach learners the following:

- Presently, there is no cure for HIV/AIDS;
- Sick learners should to visit their doctors on regular basis; and
- The best remedy is to abstain from sexual activities.

They would also encourage sick learners to:

- Take medication;
- Develop a positive attitude towards life and accept their HIV status; and
- Eat balanced food that will boost their immune system.

With regard to question two, participants mentioned the following responsibilities in the implementation of HIV/AIDS programs:

- Teaching learners about HIV and AIDS should not be the responsibility of the Life Skills and Life Orientation educators only, but it should be the responsibility of all educators. All educators should say something about HIV/AIDS in their different learning areas;
- To emphasize dangers and effects of HIV/AIDS in the morning devotions to the learners;
- To care for learners living with HIV/AIDS;
- To visit sick learners in hospitals; and
- To encourage learners to eat healthy food that will boost their immune systems.

In responding to question three, participants mentioned the following strategies that can be used in bringing HIV/AIDS awareness to the senior phase learners:

- Dramatizing - learners should play drama on the consequences of HIV/AIDS. The aim would not be to 'scare' learners but rather to make them aware that HIV/AIDS exist;
- Organizing debating groups among the learners, with topics based on HIV/AIDS;
- Advertisements, where learners should be encouraged to write their own advertisements on the impact of HIV/AIDS;
- Encouraging parents to speak openly about HIV/AIDS to their children;
- Organizing educational tours where learners will be visiting AIDS patients;
- Asking for posters on HIV/AIDS from the clinics so that they can be displayed in the classrooms; and

- Educators should use audiovisual aids, so that learners can watch a video cassette on people living with HIV/AIDS.

5.5.4 PARENTS' FOCUS GROUP INTERVIEW

The parents' focus group interview consisted of six School Governing Body members as participants. These are the parents' representatives of Lekazi Primary School. The researcher decided to conduct a parental focus group interview in order to get their ideas on strategies that can be used for bringing HIV and AIDS awareness to primary school learners. The researcher acted as a facilitator. All participants were interviewed while seated around a table with their nametags in front of them. The researcher informed the participants that the information would be used for research purposes only.

THE PARENTS' FOCUS GROUP INTERVIEW WAS CONDUCTED AS DESCRIBED BELOW:

Apparatus: Tape recorder.
Duration: 1 hour.
Date: 17 March 2005.
Time: 13h30.
Venue: Lekazi Primary library centre

THE QUESTIONS USED TO ELICIT PARTICIPANTS' VIEWS WERE:

1. In your opinion, is it right to talk to children about sexual matters, including HIV and AIDS?
2. How can you explain the difference between HIV and AIDS to your children?
3. In your opinion, how can you be involved in the implementation of HIV/AIDS programs in primary schools?
4. Do you believe that your children have sufficient information regarding HIV/AIDS?
5. Do you have any suggestions or comments on strategies that can be used for bringing HIV/AIDS awareness to primary school learners?

Initially, participants seemed very hesitant to voice their opinions, but as the interview session proceeded, they opened up.

With reference to question one, participants were divided. Some of the participants responded by saying 'YES'. This response ignited a very heated debate among the participants. They felt that talking to children about sexual matters and HIV/AIDS would be proper. One participant emphasized that the education of the child starts at home. Learning about HIV /AIDS for children should also start at home,

so that they can be aware of the disease. Another participant added that, if parents do not talk to their children about HIV/AIDS, then it means that they are also increasing the spread of HIV. She also mentioned that children should get accurate information about HIV/AIDS from their parents. If parents keep quiet, then children will get inaccurate information elsewhere. She further stated that friends may provide incorrect information and much damage can be done. She emphasized that parents should not rely on information from the television, radio and magazines regarding sexual matters. Here, participants emphasized the fact that on television, the negatives of sexual activity are very seldom indicated, for example, the bed scenes in a soapy do not show that this can lead to HIV infection.

On the other hand, some participants felt that talking to children about sexual matters will make them to be actively involved in sexual matters. Another participant indicated that if they can keep on talking to children about sexual matters, this will indicate that they are giving them permission to experiment with sex, and they may even fall pregnant. Some participants felt that talking to children about sexual matters would be embarrassing. They felt that even if they can talk to their children about HIV/AIDS, their children might not listen to them. Other participants mentioned that very often, children see their parents as judgmental, not very open-minded, strict and out of touch with the modern lifestyle. One participant also indicated that her culture does not allow her to talk to children about sexual matters.

There was much disagreement about whether parents should talk to their children about sexual matters and HIV/AIDS or not. However, participants reached a consensus that parents should talk to their children about sexual matters and HIV/AIDS.

About the difference between HIV and AIDS, participants were not sure about the answer. Nevertheless, they stated that they would define HIV as a virus that causes AIDS. They would define AIDS as a disease that is caused by HIV.

Concerning the question of involving parents in the implementation of HIV/AIDS programs in primary schools, participants mentioned the following:

- Parents should work hand-in-hand with the educators. They must support the schools in bringing HIV/AIDS awareness to their children;
- Schools should organize workshops for parents on HIV/AIDS;
- Parents should visit the schools on regular basis;
- Educators should create a chance to discuss HIV/AIDS issues with the parents at least once per quarter;
- During parent's meetings, parents should be given a chance to ask questions about HIV/AIDS;

- Parents should be invited to school conferences, where they would be given a slot on HIV/AIDS; and
- Parents should assist educators in inviting people living with HIV/AIDS so that they can address their children.

In response to the question of sufficient information regarding HIV and AIDS, participants indicated that their children do not have much information about HIV/AIDS. This was related to children who used to play with condoms, blowing them up and making balloons. One participant explained that the knowledge of learners regarding HIV/AIDS can be determined by what learners had learned at school. Another participant mentioned that one cannot measure sufficient information, but gaining knowledge is an ongoing process. Participants reached a consensus that their children are still in the process of learning about the disease.

With regard to strategies that can be used for bringing about HIV/AIDS in primary schools, participants mentioned the following:

- Schools should invite people living with HIV/AIDS to come and share their knowledge and experiences regarding the disease;
- Educators should use teaching/learning aids in clarifying the subject matter;
- Learners should be encouraged to abstain from sexual activities;
- Educators should be encouraged to integrate life skills programs with other learning areas;
- Educators should be encouraged to work hand-in-hand with educators; and
- Educators should organize debates on HIV and AIDS.

5.5.5 LEARNERS' FOCUS GROUP INTERVIEW

The learners' focus group interview consisted of twelve grade seven learners as participants. Their ages ranged from 10 to 13. The researcher decided to conduct a learners' focus group interview because she wanted to get their own views on strategies that can be used for bringing about HIV and AIDS awareness. The researcher acted as a facilitator and less as an interviewer. All participants were interviewed while seated around a table with their nametags in front of them. The participants were assured of confidentiality of the focus group interview.

THE LEARNER'S FOCUS GROUP INTERVIEW WAS CONDUCTED AS DESCRIBED BELOW:

Apparatus: Tape recorder.
Duration: 1 Hour.
Date: 18 March 2005.
Time: 1 Hour.
Venue: Lekazi Primary library centre.

THE QUESTIONS USED TO ELICIT PARTICIPANT'S VIEWS WERE:

1. What is HIV?
2. What is AIDS?
3. How is HIV transmitted?
4. How can a person prevent HIV infection?
5. Do you have sufficient information about HIV and AIDS?
6. What are your responsibilities regarding the prevention of HIV and AIDS?
7. Do you have any suggestions or comments on strategies that can be used in bringing about HIV/AIDS awareness?

With reference to questions one and two, a few of the participants were not sure of the exact definition of HIV and AIDS. Nevertheless, one participant mentioned that HIV is a virus that causes AIDS, and AIDS is the disease caused by HIV.

In response to question three, there were no gross misinterpretations of how HIV is transmitted. Participants stated that HIV could be transmitted through:

- Having sex without using a condom;
- Mother-to-child transmission;
- Using old injections used by HIV positive people;
- Touching someone's blood;
- Sharing toothbrushes with someone whose gums are bleeding;
- Using a razor used by someone else; and
- Using injections that had not been sterilized.

With regard to question four, there was no division among the participants. They stated that a person could prevent HIV infection by:

- Using a condom during sexual activities;
- Eating healthy food;
- Using latex hand gloves when touching someone's blood;
- Exercising everyday; and
- Not touching some one who is HIV positive.

In response to question five, participants were divided. Some participants responded positively to the question. They stated that the radio and television provided them with much information about HIV and AIDS. One participant further indicated that the government was trying its best to make children aware of HIV and AIDS. He related this to the "LOVE LIFE" awareness programs. Some participants responded negatively to the question. They mentioned that they do not have sufficient information regarding HIV and AIDS, but they know some of the information, for example, how HIV is transmitted. One participant added to what has been said by stating that they cannot say that they have sufficient information about HIV and AIDS, because acquiring information is an ongoing process.

Responding to the question of their responsibilities regarding the prevention of HIV, participants mentioned that they should:

- Abstain from sexual activities;
- Stay away from alcohol and drugs;
- Do exercises everyday;
- Eat healthy food;
- Educate their parents and community members on how HIV is transmitted and prevented;
- Encourage people to use condoms when involved in sexual activities;
- Protect themselves from sexual abuse;
- Listen to their parents and educator's advices regarding HIV and AIDS;
- Encourage people to go for HIV testing; and
- Encourage people to consult their doctors when they are sick.

In response to question seven, participants listed various strategies that can be used for bringing about HIV AIDS awareness. They are as follows:

- Educators should teach learners about the disease on daily basis;
- HIV/AIDS programs should be included in the school timetable;

- Learners, including those living with HIV/AIDS, should be taught about their rights and responsibilities;
- Educators should teach learners more about the transmission and prevention of HIV/AIDS;
- Parents should be involved in the implementation of HIV/AIDS programs;
- Older children should teach the younger ones about the disease;
- All the schools should have libraries so that learners can read more books on HIV/AIDS;
- Schools should invite nurses to come and address learners on issues around HIV and AIDS; and
- Learners should stay away from sex and wait for the right time.

5.6 ANALYSIS AND INTERPRETATION OF DATA FROM THE QUESTIONNAIRES

5.6.1 INTRODUCTION

Two sets of questionnaires were distributed to Lekazi Primary School learners. The researcher will start with the discussion of the first set of questionnaires.

5.6.2 THE FIRST SET OF QUESTIONNAIRES

There were 60 questionnaires that were distributed to Lekazi Primary School learners. Thirty (30) questionnaires were distributed to the foundation phase learners. Twenty (20) questionnaires were distributed to the intermediate phase learners and 10 questionnaires were distributed to the senior phase learners. All the questionnaires were returned. The researcher personally collected the questionnaires.

5.6.2.1 RESPONSES OF THE FOUNDATION PHASE

Table 20 shows the marks obtained by the foundation phase respondents:

Marks obtained by foundation phase respondents	Number of respondents who obtained the same marks	Total marks of the respondents
60	2	120
50	6	300
40	10	400
30	2	60
20	3	60
10	7	70
Total	30	1010

The above table reveals the following:

- Eight (8) out of 30 respondents (27%) obtained more than 50% of the marks;
- Twenty-two (22) out of 30 respondents (73%) obtained less than 50% of the marks.

5.6.2.2 THE AVERAGE PERCENTAGE FOR THE FOUNDATION PHASE RESPONDENTS

The average percentage for the foundation phase respondents was calculated by adding together the total marks of all respondents, divided by the number of respondents, which is $1010/30 = 34\%$.

Therefore, the average percentage for the foundation phase is 34%. This proves that the knowledge of the foundation phase respondents regarding HIV and AIDS is poor

5.6.2.3 RESPONSES OF THE INTERMEDIATE PHASE

Table 21 shows the marks obtained by the intermediate phase respondents:

Marks obtained by the intermediate phase respondents	Number of respondents who obtained same marks	Total marks of the respondents
70	3	210
60	4	240
30	5	150
20	6	120
10	2	20
Total	20	740

The table reveals the following:

- Seven (7) out of 20 respondents (35%) obtained more than 60% of the marks;
- Thirteen (13) out of 20 respondents (65%) obtained less than 50% of the marks.

5.6.2.4 THE AVERAGE PERCENTAGE FOR THE INTERMEDIATE PHASE RESPONDENTS

The average percentage for the intermediate phase respondents was calculated by adding together the total scores of all respondents, divided by the number of respondents, which is $740/20 = 37\%$.

Therefore, the average for the intermediate phase is 37%. This indicates that the knowledge of the intermediate phase respondents regarding HIV and AIDS is poor.

5.6.2.5 RESPONSES OF THE SENIOR PHASE

Table 22 shows the marks obtained by the senior phase respondents:

Marks obtained by the senior phase respondents	Number of respondents who obtained same marks	Total marks of the respondents
60	1	60
50	4	200
40	3	120
30	2	60
Total	10	440

A study of the above table reveals the following:

- Five (5) out of 10 respondents (50%) obtained more than 50% of the marks;
- Five (5) out of 10 respondents (50%) obtained less than 50% of the marks.

5.6.2.6 THE AVERAGE PERCENTAGE FOR THE SENIOR PHASE RESPONDENTS

The average percentage for the senior phase respondents was calculated by adding all the total marks of the respondents, divided by the number of respondents, which is $440/10 = 44\%$.

Therefore, the average percentage for the senior phase respondents is 44%. This suggests that the senior phase respondent's level of knowledge about HIV and AIDS is not good. However, the senior phase respondents performed much better than the foundation and intermediate phase respondents.

5.6.2.7 RESPONSES OF THE THREE PHASES OF LEKAZI PRIMARY SCHOOL

Table 23 shows the total marks that were obtained by the respondents in the three phases:

Foundation phase	Intermediate phase	Senior phase
1010	740	440
Total	2190	

5.6.2.8 THE AVERAGE PERCENTAGE FOR THE THREE PHASES OF LEKAZI PRIMARY SCHOOL

The average percentage for the foundation, intermediate and senior phase respondents was calculated by adding the total marks of the phases, divided by the number of respondents, which is $2190/60 = 37\%$.

Therefore, the average percentage for all three phases found in Lekazi Primary School is 37%. This indicates that the respondents' level of knowledge regarding HIV and AIDS is low.

5.6.3 THE SECOND SET OF QUESTIONNAIRES

Questionnaires that were distributed to sixty learners of Lekazi Primary School were also distributed to thirty learners that were randomly selected by the researcher. This was done in order to promote the reliability and validity of the results. The thirty learners were randomly selected from the different phases found in Lekazi Primary School, such that ten learners represented each phase. This means that there were 30 questionnaires that were distributed to Lekazi Primary School learners. All questionnaires were returned. The researcher personally collected the questionnaires.

5.6.3.1 RESPONSES OF THE FOUNDATION PHASE

Table 24 shows the marks obtained by the foundation phase respondents:

Marks that were obtained by the foundation phase respondents	Number of respondents who obtained same marks	Total marks of the respondents
50	2	100
40	3	120
30	1	30
20	2	40
10	2	20
Total	10	310

The above table reveals the following:

- Two (2) out of 10 respondents (20%) obtained more than 50% of the marks;
- Eight (8) out of 10 respondents (80%) obtained less than 50% of the marks.

5.6.3.2 THE AVERAGE PERCENTAGE FOR THE FOUNDATION PHASE RESPONDENTS

The average percentage for the foundation phase respondents was calculated by adding the total marks of the respondents, divided by the number of respondents, which is $310/10 = 31\%$.

Therefore, the average percentage for the foundation phase respondents is 31%. This reveals that the foundation phase respondents' knowledge regarding HIV and AIDS is poor.

5.6.3.3 RESPONSES OF THE INTERMEDIATE PHASE

Table 25 shows the marks obtained by the intermediate phase respondents:

Marks obtained by the intermediate phase respondents	Number of respondents who obtained same marks	Total marks of the respondents
70	2	140
60	1	60
40	3	120
20	2	40
10	2	20
Total	10	380

The table reveals the following:

- Three (3) out of 10 respondents (30%) obtained more than 60% of the marks;
- Seven (7) out of 10 respondents (70%) obtained less than 50% of the marks.

5.6.3.4 THE AVERAGE PERCENTAGE FOR THE INTERMEDIATE PHASE RESPONDENTS

The average percentage for the intermediate phase respondents was calculated by adding the total marks of the respondents, divided by the number of respondents, which is $380/10 = 38\%$.

Therefore, the average percentage for the intermediate phase respondents is 38%. This indicates that the intermediate phase respondents' knowledge about HIV and AIDS is poor.

5.6.3.5 RESPONSES OF THE SENIOR PHASE

Table 26 shows the marks obtained by the senior phase respondents.

Marks obtained by the senior phase respondents	Number of respondents who obtained same marks	Total marks of the respondents
70	3	210
50	2	100
30	3	90
10	2	20
Total	10	420

The above table shows the following:

- Five (5) out 10 respondents (50%) obtained more than 50% of the marks;
- Five (5) out of 10 respondents (50%) obtained less than 50% of the marks.

5.6.3.6 THE AVERAGE PERCENTAGE FOR THE SENIOR PHASE RESPONDENTS

The average percentage for the senior phase respondents was calculated by adding the total marks of the respondents, divided by the number of respondents, which is $420/10 = 42\%$.

Therefore, the average percentage for the intermediate phase respondents is 42%. This implies that the senior phase respondents' knowledge regarding HIV and AIDS is below average. The senior phase respondents performed much better than the foundation phase and intermediate phase respondents.

Table 27 shows the total marks that were obtained by respondents in the three phases:

Foundation phase	Intermediate phase	Senior phase
310	380	420
Total	1110	

5.6.4 THE AVERAGE PERCENTAGE FOR THE THREE PHASES OF LEKAZI PRIMARY SCHOOL RESPONDENTS

The average percentage for the foundation phase, intermediate phase and senior phase was calculated by adding the total marks of the phases, divided by the number of phases, which is $1110/3 = 37\%$.

Therefore, the average percentage for the three phases found in Lekazi Primary School is 37%. This indicates that the respondents' level of knowledge regarding HIV and AIDS is low.

5.6.5 COMPARISON OF THE TWO SETS OF QUESTIONNAIRES

The two sets of questionnaires will now be compared.

Table 28 reveals the average percentages obtained by each phase in the questionnaires and the average percentage for the school.

PHASE	FIRST SET OF QUESTIONNAIRES	SECOND SET OF QUESTIONNAIRES
Foundation Phase	34%	31%
Intermediate Phase	37%	38%
Senior Phase	44%	42%
School average percentage	37%	37%

From the above table, the following can be deduced:

- The average percentages of the foundation phase respondents are close to each other;
- The difference between the intermediate phase respondents is much smaller;

- The average percentages of the senior phase respondents are close to each other; and
- The average percentages for all the phases found in Lekazi Primary School are the same.

Therefore, the above findings confirm that Lekazi Primary School learners have a low level of knowledge regarding HIV and AIDS. This has several implications, namely:

- Methods of teaching that were used by educators in presenting HIV/AIDS lessons were not effective;
- Educators have not succeeded in imparting HIV/AIDS knowledge to the learners; and
- The learning content may have been above the learners' level of understanding.

5.7 CONCLUSION

In this chapter, data from observational material, questionnaires and focus group interviews was analyzed and interpreted. The observational material was based on HIV/AIDS lesson presentations. The questionnaires were based on basic knowledge regarding HIV/AIDS. The focus group interviews were based on HIV/AIDS lesson presentations and strategies that can be used for bringing about HIV/AIDS awareness.

This chapter leads to the next chapter on findings and recommendations.

CHAPTER 6

FINDINGS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter will focus on findings and recommendations. In this chapter, research questions will be answered and recommendations made on teaching skills that can be used by educators in presenting HIV and AIDS lessons. The researcher will also make recommendations on strategies that can be used for bringing HIV and AIDS awareness to primary school learners. Responsibilities of the educators regarding the implementation of HIV/AIDS programs will also be recommended.

6.2 LITERATURE FINDINGS

6.2.1 Concerning knowledge that children should have regarding HIV and AIDS, the literature has revealed the following:

- Some children have inaccurate information regarding HIV and AIDS (Edwards 2002: 16);
- The prevention of HIV and AIDS is a collective responsibility of all people (Nourse 2000: 68);
- Children who are not infected with HIV do not associate freely with HIV positive children (Van Dyk 2001: 120);
- Children living with HIV/AIDS have their own traumatic experiences and fears, which include fear of loneliness, fear of pain and fear of death (Kelly 2000: 98);
- Most children are not aware of the existence of HIV/AIDS centres and the assistance they offer (Maree 2000: 52);
- HIV and AIDS have contributed to the high rate of crime (Edwards 2002: 73);
- Some children are not aware that their parents, including those living with HIV/AIDS, have rights that protect them from any form of discrimination (Mpumalanga Newspaper, 18 November 2004).

6.2.2 Concerning primary school learners and HIV/AIDS, the literature review has revealed the following:

- Life skills programs do not lead to promiscuity, but they help primary school learners to delay the initiation of sexual activities (Louw 2002: 94);

- HIV and AIDS cannot be taught in isolation. Life skills programs should always be included (Louw 2002: 95);
- Primary school learners can prevent HIV infection by implementing the universal precautions (The National Policy Act, No. 27 of 1996);
- Accepting the HIV positive status can alleviate the stress of sickness (Michele 2000: 109);
- Primary schools can assist sick learners by establishing a place of rest (sick room) within the school (Steward 2002: 119);
- The spread of HIV and AIDS in primary schools can be managed by establishing a school based support team (McGeary 2001: 77).
- All primary schools should have an HIV and AIDS policy that will protect learners living with HIV/AIDS from any form discrimination (The National Policy Act, No. 27 of 1996); and
- Orphans drop out of school early because of financial burden (Kelly 2000: 99).

6.3 FINDINGS FROM THE OBSERVATIONS OF EDUCATORS

- Finding number one: 70% of the participants did not succeed in applying relevant methods of teaching. (Tables 6, 7, 10, 11, 12, 15 and 16);
- Finding number two: 60% of the participants did not use learning aids in clarifying the learning content (HIV/AIDS lessons presentations);
- Finding number three: 90% of the participants did not conclude their lessons (Tables 6-16);
- Finding number four: 60% of the participants performed poorly in the application (Tables 6, 7, 8, 10, 14, 15 and 16);
- Finding number five: Teaching skills used by participants in presenting HIV/AIDS lessons are not effective (Table 19).

6.4 FINDINGS FROM FOCUS GROUP INTERVIEWS

- Finding number one: Some participants assume that learners have sufficient knowledge about HIV/AIDS (Foundation phase focus group interview);
- Finding number two: Participants emphasized abstinence to the learners without mentioning the advantages of abstinence (Foundation phase focus group interview);
- Finding number three: Some participants have inaccurate information regarding HIV and AIDS (Foundation phase focus group interview);
- Finding number four: Some parents believe that bringing HIV/AIDS awareness to their children is the responsibility of the school (Parents focus group interview); and
- Finding number five: Some parents find it difficult to talk to their children about sexual matters and HIV/AIDS (Parents focus group interview).

6.5 FINDINGS FROM THE QUESTIONNAIRES OF THE LEARNERS

6.5.1 FINDINGS FROM THE FIRST SET OF QUESTIONNAIRES OF THE LEARNERS

➤ Most learners demonstrated a low level of knowledge regarding HIV and AIDS, as indicated below:

- 73% Foundation phase (Table 20);
- 65% Intermediate phase (Table 21);
- 50% Senior phase (Table 22)

➤ The average percentage for the three phases is 37% (Table 23)

6.5.2 FINDINGS FROM THE SECOND SET OF QUESTIONNAIRES OF THE LEARNERS

➤ Finding number two: Most learners demonstrated a low level of knowledge regarding HIV and AIDS, as indicated below:

- 80% Foundation phase (Table 24);
- 70% Intermediate phase (Table 25);
- 50% Senior Phase (Table 26).

➤ The average percentage for the three phases is 37% (Table 27).

The above findings confirm that learners of Lekazi Primary School demonstrated a low level of knowledge regarding HIV and AIDS.

6.6 TESTING THE HYPOTHESIS

HYPOTHESIS 1: Lekazi Primary School learners do not have sufficient information about HIV/AIDS.

FINDING: The findings have revealed that learners' level of knowledge regarding HIV/AIDS is low.

HYPOTHESIS 2: Teaching skills used by educators in bringing HIV/AIDS awareness to the learners are not effective.

FINDING: The findings have revealed that teaching skills used by educators in bringing HIV/AIDS awareness to the learners are not effective.

Therefore, hypothesis numbers 1 and 2 are accepted.

6.7 LIMITATIONS OF THE STUDY

6.7.1 OBSERVATIONS

During the observations, the researcher observed that some participants were not paying their full attention. For instance, they would do the following:

- Make a noise;
- Ask to be excused to go to the toilet.

For the above reasons, participants had to be called to order from time to time.

Therefore, the results of the observations may not have reflected the true ability of the participants.

6.7.2 FOCUS GROUP INTERVIEWS

The focus group interviews were conducted in the afternoon. Participants were not always keen to participate, giving excuses such as hunger, rushing for transport and busy with schoolwork. The results of the focus group interviews did not represent the views of the groups, but only those of the members who dominated the discussions.

6.8 RECOMMENDATIONS

6.8.1 RECOMMENDATIONS BASED ON LITERATURE

- All children should be taught about the basic awareness of HIV and AIDS, as early in their lives as possible;
- All children in the communities should be trained on survival skills that will help them to adopt behaviours that will protect them from HIV infection;
- Children should be taught that there is no need to unfairly discriminate against children living with HIV and AIDS, since there are other factors that may not cause the disease;

- Children living with HIV and AIDS should be made aware that being HIV positive does not mean that the person will eventually die. There is life after being tested HIV positive;
- Primary school learners should be taught about home-based care services, palliative care services and also about anti-retrovirals, which control the HIV and slows down its growth;
- Life skills programs in primary schools should be intensified;
- Primary schools should respond effectively to the orphan's problems by assisting them in accessing grants to make their lives better. Orphans can be referred to the social workers for assistance;
- Primary school 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 with in their communities;
- Primary school learners should be encouraged to play their role in the struggle against HIV/AIDS; and
- All stakeholders and departments should join hands in the battle against HIV and AIDS.

6.8.2 RECOMMENDATIONS BASED ON OBSERVATIONS

- Life skills and life orientation educators should be trained on effective teaching methods that can be implemented in presenting HIV and AIDS lessons;
- Educators should always use learning aids in clarifying the learning content. Learning aids should not be regarded as an additional to teaching, but as an integral part of teaching;
- HIV and AIDS lessons should not just fade away without any conclusion. Educators should summarize the main elements of the lessons. This can be done by asking learners a few questions based on the learning content;
- After HIV/AIDS lesson presentations, educators should give learners assignments, written work, projects or homework based on the learning content. This will provide educators with information regarding their teaching effectiveness;
- Further training should be provided by the Department of Education for life skills and life orientation educators on appropriate teaching skills that can be used in presenting HIV and AIDS lessons;
- Principals should encourage teamwork among educators, since teamwork is better than work done alone; and
- When preparing the HIV/AIDS lessons, educators should always take into consideration the learner's level of understanding and development.

6.8.3 RECOMMENDATIONS BASED ON FOCUS GROUP INTERVIEWS

- Educators should provide learners with accurate information regarding HIV and AIDS;
- Learners should be taught about the advantages of abstinence. The consequences of abstaining from sexual activities should also be emphasized;
- HIV/AIDS workshops need to be conducted on regular basis. This will assist educators in gaining more knowledge about the disease;
- Parents should be provided with training on HIV and AIDS awareness programs. Their responsibilities regarding the implementation of HIV/AIDS programs should be emphasized; and
- Parents should be trained to talk freely to their children about sexual matters and HIV/AIDS.

6.8.4 RECOMMENDATIONS BASED ON THE QUESTIONNAIRES OF THE LEARNERS

- Educators should make sure that HIV/AIDS programs are implemented in the school on a weekly basis;
- Educators should attend HIV/AIDS workshops so that they can be up to date with HIV/AIDS knowledge;
- Educators should make sure that the learning support material for HIV and AIDS is available in the school;
- Learners should be encouraged to visit libraries, where they will get more information about HIV/AIDS;
- Primary schools should have their own libraries where learners can have more access to search for more information regarding HIV/AIDS;
- HIV/AIDS posters should be displayed in the classrooms from time to time; and
- Principals should organize school-based HIV/AIDS workshops, where educators can discuss relevant issues around HIV/AIDS.

6.9 RECOMMENDATIONS BASED ON TEACHING SKILLS THAT CAN BE USED BY EDUCATORS IN PRESENTING HIV/AIDS LESSONS

According to the researcher, knowledge of the subject matter is not the only requirement for effective teaching. Educators should also implement the following teaching skills during HIV/AIDS lesson presentations:

- **MOTIVATION SKILLS:** The researcher feels that educators should motivate learners to have more interest in learning about HIV and AIDS. This can be done by developing a passion for learning about HIV/AIDS, in such a way that learners will wish to research for knowledge regarding HIV and AIDS on their own. This can be achieved through:
 - Choosing an appropriate introduction to a lesson;
 - Asking stimulating questions;
 - Encouragements and rewards;
 - Setting meaningful objectives;
 - The conclusion of the lesson, which stimulates curiosity.

- **PRESENTATION SKILLS:** The researcher feels that educators need to improve their presentation skills. This can be done by improving the following areas:
 - Narrative skills;
 - Art of questions;
 - Reaction to learner's participation;
 - The leading of discussions;
 - Explanatory skills; and
 - Reinforcing learner reaction.

- **ORGANIZATION SKILLS:** These skills are essential during planning and during presentation of HIV/AIDS lessons. Organization skills are needed for all activities the educator has to carry out to start the learning action and to keep it going. The organization skills that must be used when planning a lesson include:
 - The ability to analyze the subject matter correctly;
 - Formulating objectives;
 - Selection of teaching methods; and
 - Creating a conducive learning environment.

The researcher believes that these organization skills will assist educators in controlling the thoughts, activities and attitudes of learners.

- **EVALUATION SKILLS:** The researcher feels that educators should use evaluation skills such as observations, testing and asking questions. Evaluation skills will assist educators to determine the degree of success with which the lesson has progressed, as well as whether the set of objectives have been reached by the conclusion of a lesson. Evaluation skills requires the

educator's ability to evaluate the learner's readiness to participate in a lesson, the period of time spent on homework, and the ability to answer questions, both orally and in writing. The researcher suggests that evaluation should not take place only at the end of the lesson, but throughout the lesson. This will enable educators to perceive incorrect thinking and comprehension of learners in time and to rectify these within the context of the lesson.

6.9.1 HIV/AIDS PLANNING OF LESSONS

The researcher recommends that educators take the following into consideration when planning HIV/AIDS lessons.

- **INTRODUCTION:** The researcher feels that when introducing the HIV/AIDS lessons, educators should make sure that they gain the general attention of learners. This can be done by directing learners specifically and making sure that they go in the right direction. Once a learner's attention is not gained in the introduction of the lesson, he/she will be lost for the whole period;
- **SUBJECT MATTER:** The researcher suggests that when choosing the subject matter, educators should consider the learners' cognitive abilities. Educators should check the learners' level of understanding before choosing any lesson on HIV and AIDS.
- **METHOD OF TEACHING:** The researcher feels that when planning the HIV/AIDS lessons, educators should first determine which basic form of teaching he/she is going to use to convey the subject matter. Educators should make sure that they see methods of teaching as a dynamic, interactive process, involving both the learners and educators. Educators should mediate the learning experience in order to determine the potential learning ability of learners.
- **LEARNING AIDS:** It is the researcher's opinion that when choosing learning aids, educators must keep the learning objectives in mind. The researcher recommends the following learning aids that, among others, can be used successfully in presenting HIV/AIDS lessons:
 - Tape recorder;
 - Overhead projector;
 - Film strips;
 - Slides;
 - Video cassettes;
 - Pictures;
 - Illustrations;
 - Flannel board; and
 - Flip board.

- **CONCLUSION:** The researcher believes that the introduction to, and conclusion to a lesson are narrowly related and should serve to complement each other. It is essential that there should be a very clear connection between the beginning and the ending of a lesson. In the conclusion of HIV/AIDS lessons, the researcher suggest that educators should:
 - Plan the conclusion before the lesson starts. This will provide learners and the educator with a sense of direction during the coarse of the lesson;
 - Consolidate what learners have learnt and focusing their attention on the main points of the lesson;
 - Make sure that the learning outcomes have been achieved;
 - Summarize the main elements of the lesson;
 - Ask learners a few questions based on the learning content;
 - Give learners some work to do, based on the learning content.

6.9.2 STRATEGIES FOR BRINGING HIV/AIDS AWARENESS TO PRIMARY SCHOOL LEARNERS

The researcher will now present strategies for bringing HIV/AIDS awareness to primary school learners according to phases found in primary schools

6.9.2.1 FOUNDATION PHASE STRATEGIES

For the foundation phase learners, the researcher recommends the following strategies:

- **SELF-ACTIVITY:** The researcher recommends this method as the best method of teaching HIV and AIDS lessons. When applying this method, educators should make sure that learners are active, because the more they read, hear, see, say and do, the more they learn and the more they remember. Self activity can be demonstrated by:
 - Role-play in the form of a mini sketch or play. The researcher suggests that educators organize a play on the prevention of HIV and AIDS to be performed for 45 minutes. The play should be interesting, full of humour, yet informative. After the role-play has been performed, educators would then ask learners a few questions to find out whether they have grasped the important aspects of the lesson. This strategy can also be used in the intermediate phase but it is more suitable for the foundation phase.

- Rhymes and songs: The researcher feels that learners can mime, for example things like “Do not touch my body, if you touch me, I will call the police”. The researcher believes that songs are a valuable strategy that can be employed to ensure maximum comprehension of certain facts about HIV and AIDS. Learners can be taught songs like “AIDS is a killer disease”. The whole class can sing this song. The educator can therefore summarize the lesson by asking few questions about the song. The educator can summarize his/her lesson by emphasizing the main aspects of the song.

The researcher believes that the self-activity method will encourage learners to acquire knowledge on their own. Self acquired knowledge and experiences are not easily forgotten. When the self-activity method is applied, learners have more responsibility. Educators act as facilitators and give guidance. The researcher suggests that educators should implement the outcome-based education (OBE), which focuses on a learner-centred approach. Learners should do 90% of the work during the presentation of HIV/AIDS lessons and 10% of the work should be done by educators. Educators should remember that their role is to facilitate the learning process. There is a focus shift from an educator-centred approach to a learner-centred approach.

6.9.2.2 THE INTERMEDIATE PHASE STRATEGIES

SELF EXPRESSION: The researcher suggests that this method can be practiced by the intermediate phase learners through:

- Telling a story about the transmission of HIV and AIDS;
- Writing stories related to HIV/AIDS issues, e.g. Nkosi Johnson's life history;
- Writing poems about HIV and AIDS;
- Dramatization: The researcher feels that educators can give learners certain scenes to dramatize. Such scenes should carry the message of HIV and AIDS awareness;
- Speeches on HIV and AIDS: The researcher suggests that educators give learners certain topics to prepare for speech on HIV/AIDS, for example “The detrimental effects of HIV and AIDS”. Learners can compete in groups for a certain prize;
- Dialogue: The researcher feels that educators can also use this strategy during the presentation of HIV and AIDS lessons. When applying this strategy, educators should allow learners to talk to one another about HIV and AIDS. Learners can be given topics, for example, “the advantages of abstinence”;
- Debate: The researcher suggests that learners be given a topic that they have to debate, following certain rules. There can be two or more groups whereby opposing views on a given topic are entertained and interrogated. For example, condoms should be used by adults only. In these debates, the advantages of abstinence should be emphasized to the learners.

Disadvantages of being involved in sexual activities while they are still young should also be emphasized.

6.9.2.3 STRATEGIES RECOMMENDED FOR THE SENIOR PHASE LEARNERS

For the senior phase learners, the following strategies are recommended:

- **BRAINSTORMING:** The researcher feels that educators can use this strategy to set learners thinking about a chosen topic. When applying this strategy, educators pose a problem, and the learners react by giving information (facts) on the topic. The educator can write the topic on the chalkboard to be discussed afterwards. The educator should be firmly in control of the situation, have the attention and co-operation of the whole class, and be very clear about the objectives that must be reached.
- **BUZZ GROUP:** When applying this strategy, the researcher suggest that educators should divide learners into small groups of about ten learners who will discuss a certain topic freely and informally for about five minutes, e.g. caring for and supporting learners living with HIV and AIDS. Each group should have a leader, a recorder and a reporter who will report to the whole class on behalf of the group.
- **CLASS QUIZ:** When using this strategy, the researcher suggests that learners should be given certain topics. This can be done by two groups asking each other questions. Points should be allocated according to certain rules. The two groups can compete with each other for the highest score. Learners can be actively involved by formulating questions, asking and answering those questions. A class quiz can be used as a means of reinforcement or revision of a section of learning content that has been completed.
- **SELF-DISCOVERY:** The researcher feels that learners should be encouraged by their educators to discover information for themselves. When applying this strategy, educators should assume the role of facilitators rather than dictators. Educators should arouse interest for learning by raising challenging problems that will interest the learners so that they will want to investigate. It is the researcher's opinion that during HIV and AIDS lesson presentations, educators should foster an atmosphere of earnest thinking, free debate, open discussions, and above all, freedom for the learners to think things out without fear or reprisal or humiliation for possible mistakes in their reasoning. The researcher feels that educators need to be careful when applying this strategy; they should not force learners to discover or arrive at a predetermined

conclusion. Individual learners or a group of learners can use self-discovery or problem-solving methods, because it seems to be a natural way to learn.

- **AUDIOVISUAL MEDIA:** The researcher feels that the senior phase learners can use a lot of audiovisual media to bring about HIV and AIDS awareness. These can be documented videos and films concerning the pandemic. After watching these videos and films, learners can break into groups to discuss a specific topic e.g. how HIV can be prevented?
- **PUBLIC SPEECHES:** It is the researcher's opinion that this strategy can be used by the senior phase learners for bringing about HIV/AIDS awareness. When implementing this strategy, educators can give learners research topics about HIV and AIDS. Time can be made available in the school program where all learners in this phase compete in groups through symposia and debates. The best speakers of the day can be rewarded with incentives like a small amount of cash, a dictionary or a school bag. The researcher suggests that there should be those in the affirmative side and those in the negative side to make the public speaking more interesting.
- **EXPERIMENTAL LEARNING:** It is the opinion of the researcher that educators should promote experimental learning that will actively involve learners and allow them to experience learning for themselves. Educators can promote experimental learning by doing the following:
 - Provide opportunities for learning by doing;
 - Give learners opportunities to use their experiences;
 - Allow learners to add new knowledge to their own experiences;
 - Encourage learners to explore what they know;
 - Give learners opportunities to express themselves;
 - Allow learners to make mistakes;
 - Give learners opportunities to practice skills;
 - Allow learners to work in groups;
 - Encourage creativity; and
 - Use new methods to ensure learner participation.

6.10 STRATEGIES FOR BRINGING ABOUT HIV/AIDS AWARENESS THAT CAN BE USED IN THE THREE PHASES FOUND IN PRIMARY SCHOOLS ARE:

- **PEER TUTORING:** The researcher suggest that a group of learners, representing each phase found in a primary school, be selected as a peer support team to reinforce and strengthen the HIV and AIDS awareness programs in a school. Educators can oversee and co-ordinate the program. The main purpose of peer tutoring will be to saturate the school environment with activities, information

and events that will reinforce the key messages around HIV and AIDS issues. The researcher feels that it should be stressed that peer educators are not there to take the place of educators. They should not be made to be more important than their peers.

- **DEMONSTRATION METHODS:** According to the researcher, demonstration of a lesson still remains a valuable strategy that can be employed to enhance this project of bringing HIV and AIDS awareness to primary school learners. When applying the demonstration method, educators can demonstrate the practicing of universal precautions. Educators can demonstrate this lesson by doing the following:

- Cover his or her hands with latex hand gloves when assisting someone with nose bleeding;
- If there are no latex hand gloves, educators can use plastics bags that are without holes to cover the hands;
- Show learners that they are not supposed to touch anyone's blood with bare hands.

Educators can also use the demonstration method to:

- Demonstrate refusal skills to sexual abuse;
- Demonstrate assertive skills that might assist learners to say with confidence about things they do not want to do; and
- Demonstrate the use of the first aid kit.

The researcher suggests that, when applying the demonstration method, educators should allow learners to ask questions without fear. Educators must create a scene that is conducive enough for learners to ask questions freely and to voice their concerns.

- **LECTURE DISCUSSION METHOD:** It is the opinion of the researcher that educators should use the lecture discussion method in presenting HIV and AIDS lessons instead of using the narrative method. When using this method, educators should be able to do the following:

- Capture and hold learner's attention. This means that educators should not only know the subject matter, but they should also be competent storytellers;
- Give a clear description of the learning content;
- Use this method in conjunction with other methods and steer clear of monotony and boredom in learners;
- Be in full command of their language and the way they use their voices;

- Know that vocabulary, voice production and variations are important factors when educators talk to learners.
- QUESTION AND ANSWER METHOD. The researcher suggest that when applying this method, educators should do the following:
 - Encourage all learners to participate. It should be emphasized that all learners are supposed to answer questions that would be asked by the educator;
 - Get learners to become actively involved in the lesson; and
 - Give learners opportunities to express themselves.

The researcher believes that encouraging all learners to answer questions will assist them in participating. Dominance of answering questions by a few learners only will be avoided.

- REFLECTION: The researcher suggests that when HIV and AIDS lessons are over, educators should give learners a chance to ask questions based on the learning content, to think back and recap important points. This will assist learners to internalize what they have learned.
- REGULAR INTERDEPARTMENTAL CO-OPERATION: The researcher believes that primary schools cannot succeed in bringing about HIV/AIDS awareness alone. Interdepartmental partnerships should be established. There should be partnerships between the Department of Education, Department of Health, Department of Social Services and the Department of Safety and Security. Periodically, officials from the Department of Health can be invited to the school and address learners around HIV/AIDS issues. People from the Department of Social Services can be invited to the school to come and address orphans on issues around social grants and dependency grants. People from the Department of Safety and Security, i.e. the Child Protection Unit, can also be invited to come and address learners at school level on the following issues:
 - Skills that learners can use in order to avoid sexual abuse;
 - Procedures that need to be followed when reporting sexual abuse cases; and
 - How abused children should behave in court.
- PARENTAL INVOLVEMENT: The researcher believes that parents should be involved in bringing HIV/AIDS awareness to their children. Primary schools should train parents around HIV and AIDS matters. Parents should be encouraged to talk openly and freely to their children about sexual matters and HIV/AIDS. Parents can be of great help in guiding their children towards

responsible sexual behaviour, by helping them to practice survival skills that will protect them from HIV infection.

6.11 RECOMMENDATIONS BASED ON RESPONSIBILITIES OF EDUCATORS REGARDING THE IMPLEMENTATION OF HIV/AIDS PROGRAMS IN PRIMARY SCHOOLS ARE AS FOLLOWS:

- Provide accurate information to the learners regarding HIV/AIDS;
- Set a good example to learners by showing good sexual behaviour;
- Make sure that learners are taught about HIV and AIDS on a weekly basis;
- Assist orphans and the destitute in receiving their social and dependency grants;
- Make sure that learner's questions regarding HIV and AIDS are answered in a satisfactory way. This can be done by introducing a question box in the school where learners will write their questions regarding HIV and AIDS anonymously. Educators at morning devotions could answer these questions;
- Make sure that HIV and AIDS programs are implemented in their schools;
- Assist learners in implementing what they have learned, for example abstaining from sexual activities;
- Teach learners about the advantages of abstinence;
- Teach learners about the aims of HIV/AIDS programs;
- Encourage learners to abstain from sexual activities until they are responsible adults;
- Set good examples by not being involved in sexual matters with the learners;
- Make sure that they involve parents in the implementation of HIV/AIDS programs;
- Ensure that learners who had disclosed their HIV status are provided with proper counselling and support;
- Ensure that messages of HIV and AIDS awareness are effectively communicated in the school;
- Make sure that all learners are practicing universal precautions that will protect them from HIV infection; and
- Try by all means to minimize the chances of HIV and AIDS transmission in the school.

6.12 CONCLUSION

Primary school learners, like all other children, are growing up in a world with HIV and AIDS. The Acquired Immune Deficiency Syndrome is one of the most devastating diseases the world has had to face. Many families in the country have been affected by HIV/AIDS, because many people have been infected with HIV and as result have become sick and even died. HIV/AIDS knows no boundaries, no

class, no sex and no race. Though this is so, it is ironic that HIV/AIDS seems to be more devastating to the poor and the destitute. To illustrate this, Africa has 10% of the world population, and 70% of people infected with HIV/AIDS in the world (World Health Report 2004).

Presently, there is no cure for HIV/AIDS. The researcher believes that the only weapon at our disposal is education. It is therefore imperative that strategies used by educators in bringing HIV/AIDS awareness to learners should be effective, so that the battle against HIV/AIDS can be won. It is the opinion of the researcher that educators should always expose themselves to new and accurate information about HIV/AIDS, so that primary school learners can benefit. Successful strategies will result in learners having increased knowledge about HIV and AIDS. Learners will therefore internalize and implement what they have learned by applying the universal precautions and other methods for preventing HIV infection. It is hoped that the teaching skills and strategies recommended in this study, when implemented, will make a difference in the lives of primary school learners. Education is our only HIV vaccine; this is the message our learners should hear clearly, again and again. The researcher believes that education about HIV/AIDS can have an impact on the disease. Therefore, it is very important for learners to have accurate information regarding HIV/AIDS. This study is therefore an effort towards this noble goal.

ANNEXURE A

P O Box 1116
KANYAMAZANE
1214
19 June 2002

The Circuit Manager
Mgwenya Circuit
Private Bag x 1002
KANYAMAZANE
1214

Dear Sir

APPLICATION FOR PERMISSION TO DO RESEARCH AT LEKAZI PRIMARY SCHOOL:
MGWENYA CIRCUIT

I hereby apply for permission to visit Lekazi Primary School in Mgwenya Circuit.

I have persuaded the Masters in Learner Support, Guidance and Counselling with the University of Pretoria. I intend doing research with primary school learners, educators and the School Government Body, by means of questionnaires and interviews.

My topic for research is:

“Strategies for bringing HIV/AIDS awareness in primary schools, with specific reference to Lekazi Primary School, Mpumalanga Province”.

I shall appreciate it highly if my application will receive your immediate attention.

Thanking you in advance.

Yours faithfully

S M Vilakazi

EXPLANATORY NOTE OF THE QUESTIONNAIRE

Strategies for bringing HIV/AIDS awareness in primary schools with specific reference to Lekazi primary school, Mpumalanga Province

This questionnaire is aimed at determining your knowledge with regard to HIV and AIDS. You are requested to choose the answer that you think is the most appropriate one. Please bear the following in mind when you complete the questionnaire:

- Do not write your name on the questionnaire, it remains anonymous.
- There are no correct or incorrect answers.
- Your first spontaneous reaction is probably the most valid. Work quickly and accurately.
- This questionnaire should take about 30 minutes of your time to complete.
- Please return this questionnaire to your life skills/life orientation educators as soon as possible after completion.

Thank you kindly for your cooperation

FOUNDATION PHASE QUESTIONNAIRE

INSTRUCTIONS FOR QUESTIONNAIRE

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

Multiple-choice questions.

Choose the answer that you think is the most appropriate by underlining the correct statement, e.g. The abbreviation HIV stands for:

- a) Healthy individuals.
- b) Healthy important issues.
- c) Human immune virus.
- d) Healthy independent people.
- e) Don't know.

1. HIV can be best described as a:

- a) Very small germ that causes AIDS.
- b) Disease that causes epilepsy.
- c) Disease that causes diarrhoea.
- d) Very small germ that causes tuberculosis.
- e) Don't know.

2. HIV is dangerous because:

- a) It makes people to live in fear.
- b) It destroys the immune system by killing the white blood cells that protect the body.
- c) It kills animals and human beings.
- d) It makes people to be sick for a short period of time.
- e) Don't know.

3. People with HIV in their bodies eventually become sick with:
 - a) Asthma.
 - b) Diabetics.
 - c) Heart attack.
 - d) AIDS.
 - e) Don't know.

4. Learners can avoid sexual abuse by doing one of the following:
 - a) By walking alone during the night.
 - b) By making friends with males.
 - c) By going with strangers.
 - d) By not allowing everyone to touch their private parts.
 - e) Don't know.

5. When someone is bleeding in the classroom, learners should:
 - a) Call an educator or an adult for help.
 - b) Assist him/her immediately.
 - c) Ignore him/her.
 - d) Tell his friends to assist him/her.
 - e) Don't know.

6. HIV can be transmitted by means of one of the following ways:
 - a) By having sex without using a condom.
 - b) By sharing food during break times.
 - c) By sitting next to the learner who is HIV positive.
 - d) By borrowing a book from a learner living with HIV and AIDS.
 - e) Don't know.

7. HIV can be prevented by doing one of the following:
- a) By abstaining from sex.
 - b) By not being faithful to your partner.
 - c) By sharing razor blades.
 - d) By not playing with children living with HIV/AIDS.
 - e) Don't know.
8. If you have been raped, you must do one of the following:
- a) Keep quiet, don't say anything about it.
 - b) Tell your mother or go to the police station and tell the police.
 - c) Tell your friends, neighbours and classmates.
 - d) Share your experiences with your friends.
 - e) Don't know.
9. Learners can keep their bodies healthy and strong by doing one of the following:
- a) By not playing with learners living with HIV and AIDS.
 - b) By eating tasty food.
 - c) By sometimes practicing safe sex.
 - d) By taking care of their bodies and by preventing HIV infection.
 - e) Don't know.
10. Learners living with HIV and AIDS should be:
- a) Avoided by other learners.
 - b) Loved and supported by their peers.
 - c) Separated from other learners and have their own classrooms.
 - d) Expelled from school.
 - e) Don't know.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

FOUNDATION PHASE QUESTIONNAIRE (SISWATI)

CAPHELA:

1. Sebentisa ibholipheni hhayi ipeniseli.
2. Zama kuphendvula yonkhe imibuto.

Imibuto yekukhetsa timphendvulo.

Khetsa imphendvulo locabanga kutsi ingiyo ibe yinye kuleti letilandzelako bese uyayidvwebela: kanje:

HIV umele kutsi:

- a) Bantfu labaphilile ngamunye
- b) Tintfo letibalulekile tekuphila
- c) Ligciwane lelibamba bantfu
- d) Bantfu labatimele labaphilile
- e) angati

1. Ligciwane le HIV lingachazwa njenge :

- a) ligciwane lelenta umuntfu abenesifo seAIDS.
- b) sifo lesibangela kuwa njalo.
- c) sifo lesenta umuntfu asheke.
- d) sifo lesenta umuntfu abenesifo sesifuba.
- e) angati

2. Ligciwane le HIV liyingoti ngoba :

- a) lenta bantfu baphile ngekwesaba futsi bahlale balwa.
- b) libulala takha mtimba emtimbeni.
- c) libulala bantfu kanye netilwane.
- d) lenta bantfu bagule kodvwa baphindze baphile saka.
- e) angati

3. Bantfu labaneligciwane le HIV emitimbeni yabo bagcina bagula nge :
- a) sifuba
 - b) sifo sashukela
 - c) sifo senhlitiyo
 - d) ngengculazi
 - e) angati
4. Bafundzi bangavikela khlukunyetwa ngetemacansi ngekutsi bente kunye kwaloku lokulandzelako.
- a) ngekuhamba bodvwa ebusuku.
 - b) ngekuba nebangani labadvuna.
 - c) ngekuhamba nebantfu labangabati.
 - d) ngekungavumeli noma ngabe ngumuphi umuntfu atsintse titfo temtimba tangasese.
 - e) angati
5. Nangabe kukhona lowophako ekilasini, bafundzi kumele:
- a) babite thishela noma lomdzala longasita.
 - b) bamsite lowo lowophako masinyane.
 - c) bente shengatsi abamboni.
 - d) batjele bangani bakhe bamsite.
 - e) angati
6. Ligciwane le HIV lingandza ngaletindlela letilandzelako:
- a) ngekuya emacansini ngaphandle kwekusebentisa ikhondomu.
 - b) ngekuhlanganyela kudla ngebrea.
 - c) ngekuhlala eceleni kwemfudzi lonaleligciwane le HIV.
 - d) ngekuboleka umfundzi lonengculazi libhuku lakho.
 - e) angati.

7. Ligciwane le HIV lingavikelwa ngekutsi kwentiwe kunye kwaloku lokulandzelako:
- a) ngekungayi emacansini.
 - b) ngekungatsembeki emnganini wakho wetemacansi.
 - c) ngekubolekana emareza.
 - d) ngekudlala ngemijovo noma ngetinalitsi letisetjentiswe ngumuntu loneligciwane le HIV.
 - e) angati
8. Uma udlwenguliwe kumele wente kunye kwalokhu lokulandzelako:
- a) bindza utsi dvu, ungasholutfo.
 - b) tjela make wakho noma uye esiteshini semaphoyisa uyowatjela.
 - c) tjela bangani, bomakhelwane kanye nalabo lofundza nabo ekilasini.
 - d) cocela bangani bakho ngako konke lokubonile noma lokwentekile.
 - e) angati
9. Bafundzi bangacina umtimba wabo uphilile futsi ucinile ngekutsi bente kunye kwaloku lokulandzelako :
- a) bangadlali nebantwana labaneligciwane lengculazi.
 - b) ngekungadli kudla lokunemphilo.
 - c) ngekutimbandanyeka kutemacansi ngaphandle kwekusebentisa ikhondomu.
 - d) ngekunakekela imitimba yabo , baphindze bativikele nasegciwaneni lengculazi iHIV.
 - e) angati
- 10 Bafundzi labaphila neligciwane lengculazi kumele:
- a) bakhethwe ngegunyanywa.
 - b) batsandvwe futsi banakekelwe bontsanga.
 - c) abuswe kulabanye bafundzi, babe nemakilasi abo bodwana.
 - d) Mabacoshwe etikolweni.
 - e) angati

NGIYABONGA KWEKUTSI NIGCWALISE LEQUESTIONNAIRE

INTERMEDIATE PHASE QUESTIONNAIRE

INSTRUCTIONS FOR QUESTIONNAIRE:

1. Use an ink pen. Do not use a pencil.
2. Do not write your name and surname.
3. Please try and answer all questions.

Multiple-choice questions.

Choose the answer that you think is the most appropriate by underlining the correct statement, e.g.

HIV/AIDS is a disease that:

- a) Affects gays and lesbians only.
- b) Affects white people and black people only.
- c) Affects all human beings irrespective of race.
- d) Affects homogeneous groups only.
- e) Don't know.

1. Which of the following best defines HIV?

- a) Affecting people and animals.
- b) A known killer disease.
- c) Human immune virus.
- d) Healthy individuals.
- e) Don't know.

2. Which of the following best defines AIDS?

- a) Different diseases in the body.
- b) Acquired immune deficiency syndrome.
- c) Acquired immune different syndrome
- d) Acquired by individuals in society.
- e) Don't know.

3. HIV can be transmitted by means of one of the following ways:
 - a) Sharing the same utensils.
 - b) Using the same toilets.
 - c) Hugging a friend.
 - d) Through sexual intercourse without using a condom.
 - e) Don't know.

4. HIV and AIDS can be prevented in the following ways:
 - a) By not sitting next to an HIV positive learner.
 - b) By abstaining from or postponing sexual activity.
 - c) By discriminating against learners living with HIV and AIDS.
 - d) By not sharing books.
 - e) Don't know.

5. Learners living with HIV and AIDS have a right to:
 - a) Be excluded from any school because of their HIV status.
 - b) Have their own classrooms so that they do not infect others.
 - c) Have their dignity respected and protected.
 - d) To be taught by educators living with HIV and AIDS.
 - e) Don't know.

6. Having AIDS means that:
 - a) A person has a series of illnesses, because the body no longer has what it needs to fight off diseases or infections.
 - b) A person always looks very thin and is coughing a lot.
 - c) A person always has a lung infection.
 - d) A person is always suffering from Tuberculosis.
 - e) Don't know.

7. When practicing universal precautions, learners must remember to:
- a) Share toothbrushes, blades or sharp objects that could have been in contact with blood.
 - b) Touch someone's blood with bare hands.
 - c) Play with needles used by an infected person.
 - d) Use rubber gloves or cover the hands with plastic bags when helping a bleeding person.
 - e) Don't know.
8. Having HIV in the body means that:
- a) Someone has got serious illnesses.
 - 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) Don't know.
9. You can 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 showing 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) Don't know.
10. Parents should talk to their children about HIV and AIDS because:
- a) They always have much information about HIV and AIDS.
 - b) They are always more experienced than educators.
 - c) They can always easily influence their children.
 - d) It is a dangerous disease and is fatal.
 - e) Don't know.

THANK YOU FOR COMPLETING THIS QUESTIONNAIR

SENIOR PHASE QUESTIONNAIRE

INSTRUCTIONS FOR QUESTIONNAIRE

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

Choose the answer that you think is the most appropriate by underlining the correct statement, e.g.

HIV destroys the immune system by doing one of the following:

- a) Infecting and killing the white blood cells.
- b) Attacking the heart.
- c) Causing the shortage of blood in the body.
- d) Causing asthma.
- e) Don't know.

1. HIV and 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) Don't know.

2. HIV infection in primary schools can be prevented by:

- a) Sometimes avoiding sexual intercourse.
- b) Reporting cases on sexual abuse all the time.
- c) By not allowing anyone to touch their genitals.
- d) By not implementing the universal precautions.
- e) Don't know.

3. At the present moment HIV/AIDS can be cured:
- a) By taking African herbs as medication.
 - b) By taking certain antibiotics.
 - c) Cannot be cured.
 - d) By taking antiretroviral drugs
 - e) Don't know.
4. A person living with HIV and AIDS can cope with the disease by doing one of the following:
- a) By not socializing with other people.
 - b) By attending HIV/AIDS support groups.
 - c) By accepting the disease and be more involved in sexual activities.
 - d) By visiting the clinic once a year.
 - e) Don't know.
5. Which one of the following is part of universal precautions?
- a) First aid kit with rubber gloves.
 - b) Cleaning blood with bare hands.
 - c) Having direct contact with another person's body fluids.
 - d) Having sexual intercourse with many partners.
 - e) Don't know.
6. If the learner has a nose bleeding, the first action must be to try to:
- a) Stop the bleeding by putting a towel on the nose.
 - b) Put his/her finger on the nose.
 - c) Go outside and lie under the tree until the bleeding stops.
 - d) Apply pressure to the bridge of his/her nose.
 - e) Don't know.

7. Caring for and supporting learners infected with HIV can be shown by:
- Only giving them attention.
 - Discriminating against them.
 - Calling the caregiver or social worker to establish the learner's wellbeing.
 - Only sympathizing with them.
 - Don't know.
8. HIV/AIDS will have impact on learners because of one of the following:
- Learners who are infected and affected by HIV/AIDS will attend school on a regular basis.
 - The illness disrupts teaching and learning.
 - Sick learners do well in their studies.
 - Teachers who are infected and affected by HIV/AIDS will always be present at school.
 - Don't know.
9. The South African Law Commission's Consultative paper on children infected and affected by HIV/AIDS specified that:
- Learners living with HIV/AIDS should be removed from the societies.
 - They should be denied access to schools.
 - They should be tested for HIV.
 - The learner's HIV status is confidential and may not be disclosed without the consent of the child or parents.
 - Don't know.
10. The window period occurs during:
- The first two months after being infected with HIV.
 - The first three years after being infected with HIV.
 - The first three months after being infected with HIV.
 - The first three weeks after being infected with HIV.
 - Don't know.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

OBSERVATION GUIDE

Name of the School:

Phase:

Grade:

Date:

Learning Area:

Topic:

Time:

Duration of the lesson:

Number of learners:

Method of observation:

Name of the observer:

PRESENTATION OF HIV AND AIDS LESSONS

Introduction:

Subject matter:

Method of teaching:

Conclusion:

Application:

Observer's remarks:

BIBLIOGRAPHY

Agency for Health Care Policy and Research (AHCPR). (2000). *Children infected and affected by HIV/AIDS*. Pretoria: Department of Health.

Bill of Rights for People living in South Africa, Equality Clause (Section 9 of the Bill of Rights). *People living with HIV/AIDS*. Pretoria.

Butterworth, J. & Pearsall, J. (2003). *Concise Oxford Dictionary*. New York: Oxford University Press.

Caesar, M. (2003). *The HIV/AIDS Emergency*. Department of Education Guidelines for Educators. Pretoria: Government Gazette.

Check, A. (2000). *HIV/AIDS: A Strategy for nursing care*. London: Edward Arnold Publishers.

Cohen, L. (2000). *Research Methods in Education*. Fourth Edition. London: Francis Group Publishers.

Creswell, J.W. (2002). *Research Design, Quantitative and Qualitative Approaches*. Thousand Oaks, London, New Delhi: SAGE Publishers.

Dalrymple, L. (2000). *Communicating beyond AIDS awareness*. Department of Health, South Africa.

Department of Education. (1996). National Education Policy Act 1996. (Act No. 27 of 1996). *National Policy on HIV/AIDS for learners and educators*.

Department of Education White Paper No. 6. (2001) *Special Needs Education: Building an inclusive education and training system*. July. Pretoria: Department of Education.

Department of Health (2000). *Living openly: HIV Positive South Africans tell their stories*. Pretoria: Beyond Awareness Campaign Publishers.

Department of Health. (2003) *Directorate HIV/AIDS and STIs Article*. Pretoria: Department of Health.

De Vos, A.S. (2002). *Research at grassroots for the social sciences and human sciences professions*. Second Edition. Pretoria: Van Schaik Publishers.

Edwards, A. (2002). *A guide to understanding the virus and its consequences*. Second Edition. United Kingdom: Cambridge University Press.

Evian, C. (2000). *Primary AIDS care*. Third Edition. Houghton: Jacana Education.

Fowler, H.W. and Fowler F.G. (2002). *The Concise Oxford Dictionary of Current English*. New York: Clarendon Press.

HIV/AIDS Emergency Guidelines for Educators (2000). *The epidemic, HIV/AIDS*. Government Gazette, pp. 2-39. Pretoria: Department of Education.

Hope, C. (2003). *International Dictionary of English*. Second Edition. Great Britain: Harper Collins Publishers.

Jackson, H. (2002). *AIDS: Africa, Continent in crisis*. Avondale, Harare, Zimbabwe: SAFAIDS Publishers.

Kelly, M.J. (2000). *The impact of HIV/AIDS schooling in Zambia*. Harare: SAFAIDS Publishers.

Louw, H. (2002). *Life Skills and HIV/AIDS education programme*. Teacher's resource guide. Pretoria. South Africa: Department of Health.

Lowveld Newspaper (14 December 2004). *The impact of HIV/AIDS on school learners*.

Makins, M. and Kathryn, K. (2003). *Oxford Advanced Dictionary*. New York: Oxford University Press.

Manaka, L. (2002). *HIV/AIDS and the Koinonian of the church: A theological and comparative study of the congregation of Harare, Zimbabwe and Nelspruit, South Africa*.

Manion, L. (2000). *European forum on HIV/AIDS: Children and Families*. Europe: European Publishers.

Maree, J.G. (2002). *Life skills and career counselling*. Cape Town: Heinemann Publishers (Pty) Ltd.

Mather, C. (2002). *AIDS in Africa*. Gallo Manor: South African Awareness Publishing cc.

Mbeki, T. (1998). Address by Thabo Mbeki, President of South Africa at a National Conference of HIV/AIDS. 9 October 1998. Pretoria.

McGeary, J. (2001). *HIV and AIDS*. Durban: Longman Publishers.

Mertens, D.M. (2002). *Research Methods in Education and psychology; integrating diversity with quantitative and qualitative approaches*. Thousand Oaks, London: SAGE Publishers.

Michele, T.D. (2000). *The pandemic, HIV/AIDS*. Cambridge: Cambridge University Press.

Morrison, K., Cohen, L. and Manion, L. (2000). *Research Methods in Education*. 5th Edition. London and New York: Routledge Falmer Publishers.

Mpumalanga Department of Correctional Services. Provincial Gazette Volume No 4. (March 2004). *Some Prisoners disclose their HIV status*. Nelspruit.

Mpumalanga Department of Education (2003). *HIV/AIDS: Care and Support of affected and infected Learners. A Guide for Educators. Supplementary Guide & Activity Book*. April. Nelspruit, South Africa: Mpumalanga Department of Education.

Mpumalanga Department of Education Report. (2000). *Life Skills and HIV/AIDS Education Programme*. Nelspruit: Department of Education.

Mpumalanga Department of Education Report. (2002). *Transmission and prevention of HIV and AIDS*. Nelspruit: Department of Education.

Mpumalanga Department of Education Report. (2004). *Life Skills and HIV/AIDS Education Programme*. Nelspruit: Department of Education.

Mpumalanga Department of Health Report. (2002). *Children infected and affected by HIV/AIDS*. Nelspruit: Department of Health.

Mpumalanga Department of Health Report. (2003). *The impact of HIV/AIDS on children*. Nelspruit: Department of Health.

Mpumalanga Department of Health Report. (2004). *People infected and affected by HIV/AIDS*. Nelspruit: Department of Health.

Mpumalanga Department of Health. Themba Hospital Report. (2003). *People living with HIV/AIDS*. Nelspruit: Department of Health.

Mpumalanga Department of Health. Embhuleni Hospital Report. (2004). *Some Patients disclose their HIV/AIDS status*. Nelspruit: Department of Health.

Mpumalanga Department of Safety and Security. Child Protection Unit Report. (January 2005). *The high rate of sexual abuse among children and women*. Nelspruit: Department of Safety and Security.

Mpumalanga Department of Social Services Report (13 June 2003). *Children orphaned as a result of HIV/AIDS*. Mpumalanga Province. Nelspruit: Department of Social Services.

Mpumalanga HIV/AIDS Unit Desk Report. (2004). *The transmission of HIV/AIDS*. Nelspruit: Department of Health.

Mpumalanga Provincial Population Unit Report. (2003). *The impact of HIV/AIDS on the population in Mpumalanga Province*. Nelspruit: Department of Environmental Affairs.

Mpumalanga Newspaper (22 May 2003). *The impact of HIV/AIDS on children*.

Mpumalanga Newspaper (13 June 2003). *The impact of HIV/AIDS on learners*.

Mpumalanga Newspaper. (26 June 2003). *Children Orphaned by HIV/AIDS*.

Neuman, L.W. (2002). *Social Research Methods: Quantitative and qualitative approaches*. Allyn and Bacon Publishers.

Nourse, S. (2000). *HIV/AIDS. A pocket book of diagnosis and management*. Second Edition. London, New York: Oxford University Press Inc.

Nursing Update (2003). *The impact of HIV/AIDS*. Volume 23, No.12, January. Pretoria: DENOSA Publishers.

Pick, S. (2003). *HIV/AIDS, our greatest challenge yet*. New York: Lux Verbi, B.M Publishers.

Protector, P. (2003). *Longman Dictionary of Contemporary English*. New York: Longman Publishers.

Punch, K.F. (2000). *Introduction to Social Research: Qualitative & quantitative approaches*. London: SAGE Publishers.

Stevens, R. (2002). *Palliative care for people with AIDS*. London, Sydney, Auckland: Edward Arnold Publishers.

Stewart, J. (2002). *The impact of HIV/AIDS on the Health Sector in KwaZulu Natal*. VIIth International Conference on AIDS in Africa. Marrakesh.

Sowetan Newspaper. (24 June 2003). *South African Medical and Dental Council Report, March 2003, on 'HIV/AIDS affects most the poor and the destitute'*.

Sowetan Newspaper. (05 August 2003). *South African Human Science Research Council Report on the impact of HIV/AIDS*.

The South African Law Commissions Consultative paper on *children infected and affected by HIV/AIDS* (Section 63).

UNAIDS (June 2000). *Report on the global HIV/AIDS epidemic*. Geneva: World Health Organization.

UNAIDS (2003). *Fact sheets on HIV/AIDS*. Geneva, Switzerland: World Health Organization.

UNAIDS: (2003). *Report on the global HIV/AIDS epidemic*. Geneva: UNAIDS.

Van der Merwe, S. (2002). *Lifeskills and HIV/AIDS education*. Pretoria: Department of Health.

Van Dyk, A. (2001). *AIDS care and counselling*. Cape Town: Maskew Miller Longman.

Van Rensburg, D. (2002). *Strengthening local government and civic responses to the HIV/AIDS epidemic in South Africa*. University of Free State, Bloemfontein: Centre for Health Systems and Development Publishers.

Van Zyl, B. (2002). *AIDS in South Africa*. Johannesburg: The Center for Health Policy.

Whiteside, A. and Sunter, C. (2000). *AIDS: The Challenge for South Africa*. Cape Town: Tafelberg Publishers.

Williams, G. (2000). *Work against AIDS: Workplace-based AIDS initiatives in Zimbabwe. Strategies for Hope*. London: Action Aid, Arnref.

World Bank Report. (2004). *The Impact of HIV/AIDS on children*. New York: World Bank.

World Health Organization. (2004). *The economic impact of HIV/AIDS in Sub-Saharan Africa*. (Workshop Report). University of Dar es Salaam.