

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.