CHAPTER 2

LITERATURE REVIEW

2.1 THE AIM OF THIS CHAPTER

In this chapter I outline the conceptual framework for my study. In order to achieve this, I undertook a thorough review of the literature on HIV & AIDS, on prevention campaigns and on the expectations and role of education with regard to HIV & AIDS programmes. In the onset of this chapter, I shall review existing literature on the HIV & AIDS pandemic, then follow with a discussion on the prevalence of HIV & AIDS in South Africa, and conclude with a discussion of current prevention campaigns and of responsibilities with regard to education. I shall also explore existing education responses in South Africa with regard to HIV & AIDS programmes and curriculum developments.

2.2 BACKGROUND AND PREVALENCE REGARDING HIV & AIDS

AIDS (Acquired Immune Deficiency Syndrome) has been compared to the holocaust and to the plague. Certain people view it as an allusion to God's anger towards mankind and as the leprosy of our time (Saayman & Kriel 1992:70). Despite the feelings and attitudes that this disease provokes in one, there is no doubt that since the first manifestation of this disease, the world has never been quite the same. The global HIV & AIDS pandemic has an impact on individuals, families, schools and communities on an unheard of scale. Although the HIV & AIDS pandemic is viewed as a global phenomenon, the prevalence thereof and the manner in which it manifests in different countries is quite diverse. In the following discussion I shall focus on the epidemic as it manifests in South Africa.

2.2.1 HIV & AIDS - An endemic, epidemic or a pandemic?

As a scientist I am dependent on specific concepts that form the tools or instruments of my particular field of study. These concepts facilitate my practising of science and afford me a better grip on my study field. If I express a thought or make a statement in vague terms it will cause confusion and result in misunderstanding and erroneous conclusions. It is for this reason that I delineate and refine the concepts below and elsewhere in my study – a prerequisite for the sound practising of science.

2.2.1.1 Endemic

The term "endemic" is derived from the Greek ***endēmos,*** which means "dwelling in a place, indigenous". With regard to disease, "endemic" means that the disease is peculiar to and recurring in a particular locality (Reader's Digest Universal Dictionary 1989:509).

2.2.1.2 Epidemic

The term "epidemic" is derived from the Greek ***epidēmia,*** which means "(illness) prevalent among people; common". With regard to disease, "epidemic" means that the disease is spreading rapidly and extensively among many individuals in an area (Reader's Digest Universal Dictionary 1989:518). The disease is prevalent in a community at a specific time. It breaks out in a place and lasts for a time only.

2.2.1.3 Pandemic

"Pandemic disease" refers to a widespread, general or universal prevalence of a disease. The disease is endemic over an exceptionally wide geographical area. The term "pandemic" is derived from the Greek word ***pandēmos,*** which means "of all the people" (Reader's Digest Universal Dictionary

1989:1118). Van Rooyen (2001:7) states that a pandemic has a slow onset, and then causes a serious disruption of the functioning of society, resulting in widespread human disaster, and material and environmental loss – a massive silent and slow developing catastrophe.

2.2.2 The nature of epidemics in general and the HIV & AIDS epidemic in South Africa in particular

The characteristics of epidemics vary between countries and can show variations with regard to the speed and extent of their development and growth. The geographical area or part of the world in which an epidemic occurs has a further determining influence on the epidemic's character (Van Rooyen 2001:12). The HIV & AIDS epidemic in Europe and America differs considerably from, for example, the South African epidemic. Two of the most obvious differences in this regard are, for example, the infection rate among the 14-49 year age group is much higher in South Africa than in Europe and America, while the infection rate among men who prefer to have sex with men is much higher in the USA than in Europe or South Africa (UNAIDS 2006:24).

2.2.2.1 Unique characteristics of the HIV & AIDS epidemic in South Africa

Regarding the above discussion, the HIV & AIDS epidemic in South Africa reveals its own unique characteristics, some of which are:

- an urban bias, with urban:rural figures of 5-10:1;
- gender differences – a male:female ratio of 0.7:1;
- regarding distribution among economic groups - a disproportionate effect on the middle class early in the epidemic, but an even distribution amongst economic groups as the epidemic progresses;
- the high infection rate with regard to people within the 14-49 year old age group;

- the increasing number of HIV & AIDS orphans (UNESCO 2003:13; UNAIDS 2006:27).

2.2.2.2 Stages of the HIV & AIDS epidemic

In general an epidemic progresses through three sequential stages. Although different epidemics might reveal the same progressing pattern, each epidemic remains unique with regard to the speed and extent of its development and progression (UNAIDS 2002b:13).

2.2.2.3 The HIV & AIDS epidemic

According to Van Rooyen (2001:5), the three stages of the HIV & AIDS epidemic, that occur roughly a decade apart, are as follows:

- STAGE 1 The silent, pre-epidemic stage: This initial stage is characterised by extensive viral transmission, but minimal progression to noticeable disease. Although no overt signs or symptoms of the disease are visible, the disease thrives as it spreads amongst the population.

- STAGE 2 The second stage of the AIDS epidemic is characterised by the visible and concrete signs of increasing numbers of infected persons and the rising levels of adult morbidity and mortality.

- STAGE 3 The third stage is characterised by a measurable demographic, social and economic impact. Institutions are closing down, public services are suffering, more and more children are orphaned and terminally ill themselves, and rural villages simply vanish.

2.2.2.4 The stage of the HIV & AIDS epidemic in South Africa

(a) South Africa as a Stage 3 country

In view of the above discussion South Africa is considered to be a Stage 3 country in terms of the stages of an epidemic as described above (UNAIDS 2002b:3). This is evident through research that indicates that the HIV & AIDS epidemic is currently spreading more rapidly in South Africa than ever before (Statistics South Africa 2006:3). Furthermore, research substantiates the facts that institutions are closing down, public services are suffering, the death rate is rising significantly, more and more children are orphaned and terminally ill (UNAIDS 2002a:8; Department of Health 2005:63), and some of the isolated villages in rural areas are in a process of vanishing (UNAIDS 2002b:3)(in this regard also refer to the general statistics in paragraph 2.3.1).

(b) Possible causes for South Africa being a Stage 3 country

The fact that South Africa, in a time span of about twenty years, has progressed to a Stage 3 country, may inter alia be ascribed to the unique socio-economic problems that prevail in this country, such as under-development, poverty, unhealthy life styles, high-risk behaviour patterns, social chaos, moral deterioration, natural disasters and violence (UNAIDS 2002b:3; Department of Education 2003d:4).

2.3 AN OVERVIEW OF THE PREVALENCE OF THE HIV & AIDS EPIDEMIC IN SOUTH AFRICA

I find it alarming that research done by UNAIDS (2006:17) classifies South Africa as a country in which the HIV & AIDS epidemic has already reached the stage of "generalised infection", which implies that more than one percent of the population is infected with HIV & AIDS, and the epidemic shows no signs of declining (UNAIDS 2006:17).

2.3.1 General prevalence

I find the statistics presented on HIV & AIDS infections and mortality overwhelming. Although I do not accept these as absolute figures, the statistics offer me an estimate on the scope of challenges that are facing prevention efforts in schools and communities. I am of the opinion that the impact of HIV & AIDS on South Africa is most severe, and the most critical in the world. I regard both the tremendous rate of the increase in infections and deaths, as well as the extraordinary scale of the epidemic in South Africa, as being significant.

The first two cases of AIDS in South Africa were recorded in 1982 and the first acknowledged AIDS-related death occurred in 1985 (Shell 2000:8). Over the period between 1982-1986 all the diagnosed cases, except two, had died. By 1995 the estimated number of HIV-positive people in South Africa had increased radically, and was in the region of 1,8 million people (Shell 2000:9). In 1996 in the region of 700 people were being infected daily. According to UNAIDS (2000:9), approximately 4,2 million people in South Africa were living with HIV & AIDS by the year 2000. By then South Africa was already the country in the world with the largest number of people living with HIV & AIDS.

Research done by the Nelson Mandela Foundation and the Human Siences research Council (hereafter referred to as HSRC) in 2002, indicated that about 11,4 % of the South African population, or between 4.5 and 4.8 million people, were infected with HIV & AIDS (HSRC 2002:73). A National HIV Survey that was conducted during 2004 projected that 11.6% of the total population were already living with HIV & AIDS (Department of Health 2005:16). By 2004, between 2.6 and 3.1 million men, between 3 and 3.6 million women, and more than 100 000 babies were estimated to be living with HIV – an estimated 12% of the South African population being infected with the virus. In 2005 an estimated 5.5 million people in South Africa were

living with HIV & AIDS, with no signs of a decline in the epidemic (UNAIDS 2006:7; Department of Health 2005:17; Marais 2005:9).

Statistics South Africa (2006:3) calculates that 311,000 people died because of AIDS in 2004 - comprising 44% of all deaths. Statistics such as these indicate the fact that South Africa has become one of the countries with the highest HIV & AIDS infection rates in the world.

More people are infected every three days in South Africa than the total number of deaths on 9/11 in New York. According to estimations, more than 900 people die of AIDS in South Africa daily, whilst more than 1 500 become infected. It is projected that 500 000 South Africans will die annually from AIDS-related causes by the year 2008 (Page, Louw & Pakkiri 2006:25; Brouard, Maritz, Pieterse, Van Wyk & Zuberi 2005:13; Department of Social Development 2002:29). Researchers expect that the pandemic will reach its peak in South Africa between 2010 and 2020. Therefore, it is predicted that South Africa will be one of the five countries experiencing a negative population growth as a result of AIDS mortality by 2010, with the growth rate estimated at -1.4% (Richter, Manegold & Pather 2004:8; Stanecki 2002:2).

2.3.2 Prevalence with regard to children and young adults

In Chapter 1 it was mentioned that by 2005 an estimated global number of 40.3 million people were living with HIV, of which 2.3 million were children under the age of 15 years. As already indicated the total number of children that were HIV infected in South Africa was estimated at 240 000 (Department of Health 2005:64).

In South Africa, it appears that the highest HIV infection rate emerges within the age group 15-24 years. As mentioned earlier, it is further estimated that 18.8% of people between the ages of 15-49 years are currently living with HIV & AIDS (Department of Health 2005:64; Statistics South Africa 2006:3),

while 70% of all deaths in this age group are ascribed to AIDS (Statistics South Africa 2007:2).

In 2002 UNAIDS (2002b:46) projected that in South Africa there will be more than 17 times as many deaths among 15-34 year old persons between the years 2010-2015, as there would have been without HIV & AIDS. Even if the risk of HIV & AIDS infection is decreased by 50%, still 47% of South Africa's 15-year-old adolescents of today would have died by 2015 (UNAIDS 2004a:2; Smart 2003b:11). It is estimated that more than five million South Africans are currently living with HIV & AIDS, and that 50% of South Africans within the age group 10 to 24 years will die of AIDS (UNAIDS 2006:18).

2.3.3 Number of orphans

Approximately 350 000 people are already terminally ill and are dying because of HIV & AIDS. Of the total of 14.4% of children aged 2–18 years, 2.6% are maternal orphans, 10.0% paternal orphans and 2.0% double orphans. This means an overall total of 2 531 810 orphans in South Africa in 2005, with 455 970 of them being maternal orphans, 1 745 715 paternal orphans and 330 125 double orphans (Shishana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste & Pillay 2005:36). Statistics according to the Department of Health (2005:64) indicate that 29.1-31.2% of antenatal clinic attendees (30.2% is the best estimate) are living with HIV & AIDS.

My perspective on the abundant sources on HIV & AIDS statistics is that research in the field of HIV & AIDS is ongoing and relevant. Yet, the fact, that the scale of the pandemic appears to be vaster than predicted, makes me suspicious regarding the success of research and intervention initiatives with regard to prevention. In addition to this, the high prevalence rate in South Africa will lead to an increase in the number of orphans in the near future, which implies that our country has not yet experienced the full impact of the orphan crisis. I am of the opinion that, because the impact of HIV & AIDS will

be experienced as even more devastating in the future, schools and communities will have to increase their efforts with regard to implementing HIV & AIDS programmes.

Even before entering the research field, statistics like the above resulted in my eagerness to determine what the schools in our country are undertaking in order to reduce statistics like these, and how they are going about it. I was aware that the continuous increase of HIV & AIDS affects and damages our society as a whole, and our education system forms part of this. It became evident that some schools deal with great difficulties, and school communities can often not depend on healthy learners, stable families, sufficient teachers or a strong economy (Department of Education 2005:64). In anticipation of an even further escalation of the infection rate (which is most likely to happen) and a consequent spiral in the projected mortality rates, especially among young people (adolescents), South Africa may be in store for devastating long term consequences. Seeking answers to a question (the primary question of this study[8]) might provide insight into the implementation of HIV & AIDS programmes in schools.

The current HIV & AIDS situation in South Africa, as discussed above, necessitates continuous research as well as attempts to inform and prepare our children and schools to cope with the challenges related to the pandemic. The efforts in schools and communities, to prevent our children from becoming HIV infected, have to be scrutinized and supported. Upon gaining insight into the extent of the pandemic, I contemplated the question as to whether schools in South Africa are seriously making an effort with the government-initiated programmes with regard to HIV & AIDS. In consideration of the specific nature and prevalence of HIV & AIDS, as I have discussed above, I assume that the current strategies, to prevent HIV & AIDS infection amongst the 15-24 year old age group, are not successful, or are

[8] The primary question of this study is: In what manner do contextual factors influence the implementation of HIV & AIDS programmes in South African schools?

not successfully being implemented as far as school programmes are concerned. The fact that the current HIV & AIDS programme has not, as yet, been scientifically evaluated or tested in respect of its desired outcomes can also be significant in this regard (no indication whatsoever in this regard was found in the literature). In the light of this, I anticipate that the findings of my study may make a significant contribution to the existing knowledge base regarding prevention and HIV & AIDS programme (curriculum) delivery.

2.4 THE IMPACT OF HIV & AIDS

In view of the above discussion on the distressing prevalence of HIV & AIDS, the Department of Social Development (2002:10) that regards HIV & AIDS as the *'most urgent health, welfare and socio-economic challenge in South Africa'*. I regard the pandemic as a cross-sectoral developmental issue, impacting and giving rise to challenges on several levels, such as health, economic, social, agricultural, policy level and various other areas (Brookes, Shisana & Richter 2004:17; Smart 2003a:38). In view of the fact that my study focuses on the education sector, I shall henceforth primarily direct my discussion on the impact that HIV & AIDS has on education.

2.4.1 HIV & AIDS: The binary impact on education

When examining the impact on education, it becomes clear that HIV & AIDS has affected the sector in various ways (UNAIDS 2000:29; Department of Education 2003d:5). My view is that the HIV & AIDS pandemic has a binary impact on education. Firstly, the education and training systems have been increasingly weakened by the HIV & AIDS pandemic. In addition to children being infected with and affected by HIV & AIDS, teachers are also infected and affected, consequently decreasing the workforce of the education sector. Factors like teacher absenteeism, a low morale, poor school attendance by learners, trauma, grief and mourning experienced in schools when people die, as well as insecurity and anxiety, further influence the quality of education

that is provided in schools (Marais 2005:22; Kelly 2001a:16; Kelly 2001b:8; World Bank 1999:23). In consideration of the fact that all the participants in my study were teachers, I was very alert to the potential impact of the pandemic on the education sector, as well as the manner in which this impact might influence their teaching practice regarding the implementation of the HIV & AIDS programme at their schools.

Furthermore, the impact of HIV & AIDS also requires extensive and immediate change of educational curricula, planning and delivery, in order to deliver much needed educational services to communities. Further aspects of the education system such as management styles, management of human resources, establishment of support services and resources, demand and supply are adversely affected by HIV & AIDS (Kelly 1999:3; Kelly 2000:32; Department of Education 2003d:9).

It is impossible to establish a definite role for education in reducing the spread of HIV & AIDS, without taking the impact of the disease on the demand, supply, resources and quality aspects of education into account. It appears that education will have to facilitate both pro-active strategies, such as prevention programmes, as well as re-active strategies, such as empowering infected and affected learners to care for themselves and to cope with living with HIV & AIDS (in this regard refer to Diagram 2.1).

Kelly (2000:45) mentions ten different aspects of education that may be affected by HIV & AIDS, such as:

- The demand for education;
- the potential consumers of education;
- the supply of education;
- the process of education;
- the organization of schools;
- the role of education;
- the availability of funds for education

- aid agency involvement in education;
- the planning of education systems;
- the effective management of education systems.

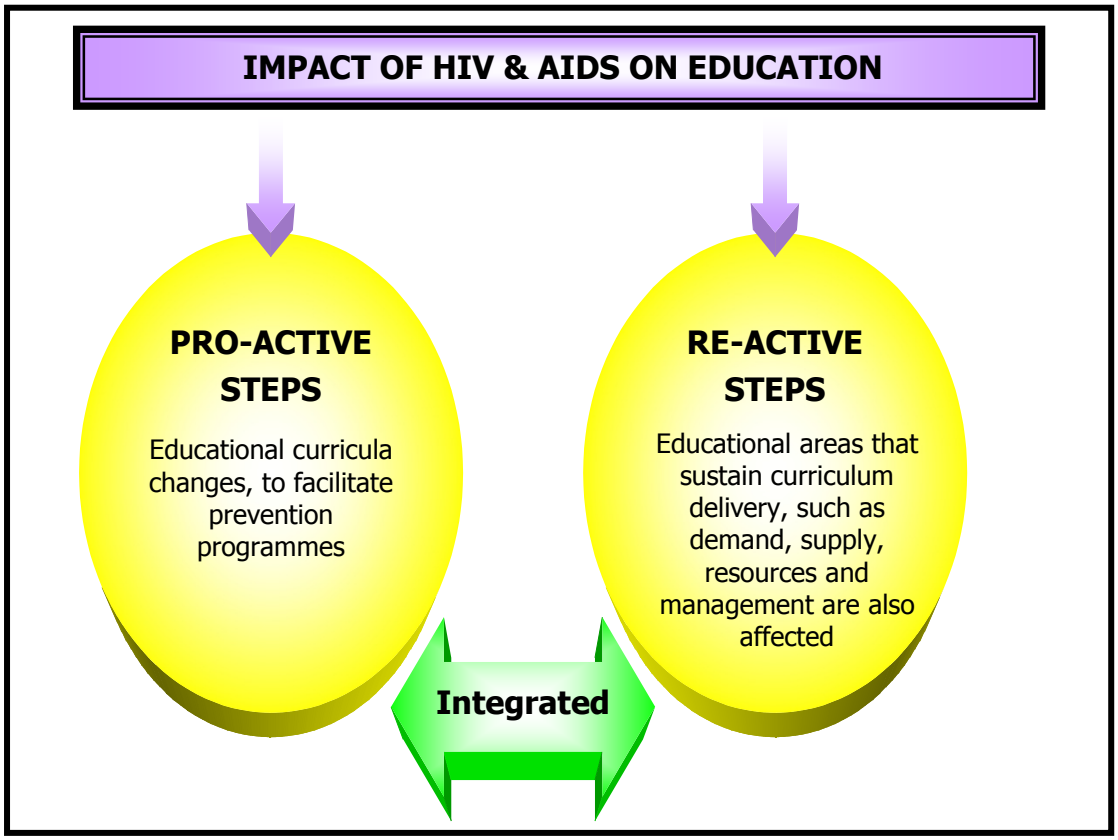

Diagram 2.1: The binary impact of HIV & AIDS on education

In a school's efforts to empower adolescents to become less vulnerable to HIV & AIDS infection, I find it obvious that several aspects of schooling, such as the curriculum, management, policy and organization will be implicated. Kelly (2000:32) states that the role of education in reducing the spread of HIV & AIDS infection is essentially a matter of curriculum issues, the content of educational programmes and the manner in which these programmes are organized and delivered.

The discussion that follows will firstly focus on the demographical impact of HIV & AIDS on teachers and learners within the school as educational institution (re-active). Then I shall discuss some implications that the impact

of HIV & AIDS may have for educational institutions, in consideration of the fact that adolescents are more vulnerable to HIV & AIDS infection. I regard adolescents to be in urgent need of empowerment by the school, to ensure the eradication of their vulnerability to HIV & AIDS infection (pro-active) by means of implementing educational programmes (UNESCO 2003:4).

2.4.2 The impact of HIV & AIDS on teachers and education supply

It is evident that HIV & AIDS affects the supply of education because of the loss of trained and experienced teachers through death, reduced productivity of ill teachers, and the passing away or frailty of education officers, finance officers, inspectors, planning officers and management personnel (Kelly 2000:63). In some countries the closure of classes or schools, as a result of population decline and the consequent decline in enrolments, or because of teacher shortages, also affects the supply of education.

Van Rooyen & Hartell (2001:22) and Kelly (2000:40) confirm that teachers are a high-risk group with regard to HIV infection. The apparent relationship between level of education and risk of HIV infection may be attributable to the association between higher levels of education and greater mobility that increases the possibility for sexual promiscuity. It is disturbing to note that in South Africa teachers form the largest occupational group that are infected with HIV & AIDS: 12% or 44 400 of the current 443 000 teachers are reported to be infected with HIV (Business Report 17 July 2000); 88 000 to 133 000 teachers will have died by 2010 (Kelly 2000:64). The immediate consequences of this fact may be as follows:

- An escalation of medical costs,
- an annual increase of the death rate amongst teachers who are HIV+ and have no access to appropriate treatment, and die within seven years of infection,
- the number of teachers in schools will be reduced, coupled with significant loss of specialization,

- increased absenteeism of teachers (bearing in mind that the absence of one teacher has an impact on a large number of children),
- general loss of teachers to other sectors of the workplace, due to the need for educated personnel to replace those lost to AIDS,
- reduction in the supply and quality of education,
- deterioration of school effectiveness,
- debilitation of the school's capacity to curb further HIV infection amongst adolescents.

In addition to the reality that some teachers could either be ill, absent or dying, colleagues would have to provide support to members of their families who succumb to the virus, as well as to the AIDS orphans within their extended family (Department of Education 2001a:29; Department of Education 2003:9). It is estimated that the equivalent of 2,6 teachers would have to be trained to replace every teacher that leaves the department. Furthermore, it was estimated that the teacher-pupil ratio would increase to 1:50 by 2007. This may also result in older and experienced teachers being replaced by younger personnel, and eventually having an impact on the quality and standard of education (Kelly 1999:6; Kelly 2001b:66; Department of Education 2001b:32).

2.4.3 The impact of HIV & AIDS on learners and education demand

HIV & AIDS has severe implications for education demand, as there will be fewer learners to educate, fewer learners wanting to be educated, fewer learners able to afford education, and fewer learners who complete their schooling (Kelly 2000:48). In this regard, I shall focus the following discussion on the impact that HIV & AIDS has on education in respect of learners and their demand on education.

2.4.3.1 The ebbing school enrolment

HIV & AIDS will affect the size of learner populations, as the increasing mortality rate among adults of reproductive age and declining fertility rates will result in fewer children being born. The increasing mortality rate of children infected with HIV around the time of birth (of whom the majority pass away before the age of five) results in fewer potential learners than there would have been without AIDS (Abt Associates 2001:4; Kelly 2000: 48).

In addition to this, the ebbing of school enrolment in South Africa may further increase if orphans and other vulnerable children do not enrol, delay enrolling, or leave school in large numbers (Van Rooyen & Hartell 2001:23). Orphans are more likely to be denied education, and children affected by HIV & AIDS often perform poorly at school, and their drop-out rates are high (Coombe 2001a:11).

I also consider the fact that, apart from the direct school fees that have to be paid, learners have indirect costs related to education with regard to educational materials, educational activities, school uniforms and transport. Many learners, and especially orphans who may live with HIV+ persons, may not have cash available for these purposes. The family cannot afford to send learners to school, with the result that learners stop attending school following the death of the parent (Kelly 2000:50).

2.4.3.2 Erratic school attendance of learners

I am convinced that erratic school attendance may occur as school enrolment rates decline and learners experience additional barriers to participation in educational programmes. In this regard Van Rooyen & Hartell (2001:23) state that traumatized learners, ill learners, care-givers and heads of households (in the case of child-headed households) may be absent from school for a considerable period of time. These learners may be referred to as "drop-outs"

and "drop-ins" who may have the additional responsibility to supplement the family's income, care for sick parents or family members, or are too discouraged to attend school. I believe this will have serious implications for educational managers and teachers, which implies that more flexible learning opportunities should be designed, as "drop-outs" and "drop-ins" might want to have a second chance to complete their education.

Kelly (2000:51) attributes possible erratic school attendance to some attitudinal barriers that learners may experience once HIV & AIDS has struck their families. Many learners may, for example, be absent because of fear of the stigma and ridicule they may encounter at school, or because of the trauma learners have experienced while watching a parent or beloved family member suffering a mortifying death. In many countries, parents experience a certain sense of fatalism. They question the value of sending learners to school amid the possibility that these learners may die before benefiting from any economic returns for what was spent on their education (UNESCO 2003:8). I also consider the fact that some parents may not want to send their children to school, in an effort to protect them from HIV infection (Human Rights Watch 2001:47). This parental attitude may stem from the apparent correlation between educational status and increased vulnerability to HIV infection that exists. "Parents may value education as opening the door to greater prosperity, but they do not want to expose their children to the risk of HIV infection" (Kelly 2000:52). It also appears that, in the midst of HIV & AIDS related trauma in the family, girls are more likely to be kept away from school than boys. Girls are expected to provide domestic care and service in an HIV & AIDS stricken household, to marry early and to bear as many children as possible, to ensure the continuity of the family and to qualify for the maximum subsidy provided for teenage mothers by the South African government (The Kaiser Family Foundation 2001:28).

In light of the above discussion, I am of the opinion that educational institutions, such as the school, will have to act proactively as well as

reactively as a result of the impact of HIV & AIDS on teachers and learners. Schools will have to adapt and implement educational programmes, curricula, policies and day-to-day administration and management (such as timetables) in order to provide sustained educational services to the learners and the community that the school serves. Hereafter, I shall focus my discussion on the educational programmes and curricula that exist in schools, as an effort of the educational sector to curb the spread of HIV & AIDS.

2.5 IMPLICATIONS FOR EDUCATIONAL PROGRAMMES AND CURRICULA

The most significant impact of HIV & AIDS on the education sector is the manner in which education authorities and schools had to adapt their programmes and curricula – to the benefit of the child. The role of the educational sector in curtailing the spread of HIV & AIDS infection essentially has to do with curriculum issues, the content of educational programmes and the manner in which these programmes are organized and delivered. The following discussion will focus on curriculum strategies and policy developments that are in place in order to facilitate the implementation of HIV & AIDS programmes in schools.

Kelly (2000:33) states that the objective of all control and preventative programmes since the 1980s and early 1990s was focused on the manner in which the further spread of HIV & AIDS could be prevented, and on promoting change in behaviour that would make HIV transmission less likely. In view of the fact that the majority of global HIV transmission occurs through sexual activity, behaviour-change programmes are directed towards empowering individuals with knowledge and skills to avoid sexual behaviour that would place them at risk of HIV infection. Therefore, Sexuality and Health Education as a fundamental part of the school curricula, has been introduced in both industrialised and developing countries to help disseminate

information regarding HIV & AIDS, reproduction, and human sexuality (UNAIDS 2001b:14; UNAIDS 2004b:6; Kelly 2000:13; Parker 2004:2).

I agree with the view that behaviour cannot be changed by knowledge alone, as adolescents need skills to put what they learn into action (WHO 2002:29; Parker 2004:4). Therefore I regard skills in negotiation, conflict resolution, critical thinking, decision-making and communication as vital for adolescents, to enable them to relate to each other as equals, working in groups, building self-esteem, resolving disagreements peacefully and resisting both peer and adult pressure to take unnecessary risks.

The teaching response to HIV & AIDS, known as HIV & AIDS Education, Reproductive Health and Sex Education, Life skills or Life Orientation, is generally defined as including the ability to distinguish between healthy lifestyles and risky behaviours, such as unsafe sex, substance abuse, and violence (Coombe 2001a:16; UNESCO 2003:4; Department of Education 2003d:12). HIV & AIDS education and teaching materials are generally supposed to communicate relevant knowledge, to inculcate gender appropriate values and attitudes, and to develop a personal capacity among learners to sustain or embrace behaviour that will minimize or eradicate the risk of becoming HIV infected. Sexuality education entails, *inter alia,* formal education about HIV & AIDS and other reproductive health matters, and it can be an effective way of providing information to help both adolescents and adults to protect themselves from sexually related illnesses such as HIV & AIDS (Department of Education 1998: Circular 485; UNAIDS 2001a:15).

Kelly (2000:41) is of the opinion that the minimum requirements with regard to curriculum content and delivery strategies should include:

- Reproductive health and sexuality education;
- HIV & AIDS in the community;
- psycho-social life skills;
- human rights, relationships and responsibilities;

- incorporation of reproductive health and sexuality education as part of the curriculum, as soon as children start school;
- enhanced reliance on peer education within the school and in the community;
- capitalizing on the resources inherent in persons living with HIV & AIDS;
- extensive involvement of communities, NGO's, businesses, churches and voluntary organizations;
- thorough re-orientation and re-training of teachers;
- establishing linkages with critical support services, especially in the health sector.

2.5.1 Implications for training and empowerment of teachers

According to Coombe (2001a:5), it is imperative for all teachers, students training to be teachers, and especially education managers, to understand the contextual circumstances under which HIV & AIDS infection increases. In my opinion, teachers are the first barricades, after medical professionals, in the fight against HIV & AIDS infection. Teachers' contact with HIV & AIDS infected persons may proliferate as they deal with an increasing number of HIV & AIDS infected learners in their classrooms, as well as in situations where they themselves or their colleagues may be HIV & AIDS infected (Department of Health 2001:1). It is therefore crucial that teachers and educational managers are well-informed and adequately trained with regard to curriculum, policy and programme requirements, in order to ensure the adequate implementation of HIV & AIDS programmes in the institutions for which they are responsible.

2.5.2 Current state of HIV & AIDS prevention programmes

The aims of authorities throughout the world, as well as in South Africa, is to establish policies and legislation, to educate, to prevent transmission and

discrimination, and to respect the rights of those affected by, or living with, HIV & AIDS. Some of the prominent programmes in South Africa are endorsed and funded by government and Non-Governmental organisations (refer to hereafter as NGOs) and are presented in schools, communities, clinics and other institutions on a national basis.

Limited studies are available that investigate the lived-experiences of teachers responsible to facilitate the implementation of HIV & AIDS programmes in schools were done in South Africa. In this regard quantitative research undertaken by Hartell & Maile (2004:198) identified challenging contextual factors that exist such as a distance between policy and practice; the absence of relevant guidelines on HIV & AIDS for learners and educators; uninformed School Governing Bodies (hereafter referred to as the SGB); the lack of an own school-based policy on HIV & AIDS; Departmental policy that is not clearly communicated to schools; and the lack of sufficient training and policy guidelines. Mathews, Boon, Flisher and Schaalma (2006:388) identified the existence of a school HIV & AIDS policy, a climate of equity and fairness, and good school community relations as factors that positively influence HIV & AIDS programme implementation.

HIV & AIDS programmes in South Africa are mainly grounded in a variety of theories such as the Social Cognitive Theory, Theory of Reasoned Action, Piagetian Cognitive Developmental Perspective combined with the Intuitive Theories' Approach, Third person perception and "optimistic bias" theory, AIDS Risk Reduction Theory and the Redefining Actions and Decisions Model (Dickson-Tetteh & Ladha 2000:393).

My view is that one or more of these theories should form the basis of the programmes[9] that are developed and implemented in South Africa. Although

[9] Such programmes are, for example, programmes that target children and young people in schools, and include life skills programmes and peer education programmes; programmes that aim at improving access for youths to services, and at the adaptation of services to the

not directly related to my primary question I nevertheless decided to study the essence of each these theories in order to improve my expertise and enhance my own mobility in the field of programme development. Account of this investigation into the theories is discussed in paragraphs 2.5.3 to 2.5.3.7 below.

2.5.3 Models of health behaviour

Several health behaviour models explain risk-taking behaviours in terms of the contextual interplay of factors such as attitudes, beliefs, self-efficacy, acquisition of behavioural skills and other extrinsic factors that may include peer, parental and media influence. Various theories and models corroborate different reasons why people knowingly engage in high-risk behaviour that may have life-threatening consequences.

2.5.3.1 The Social Cognitive Theory

In the Social Cognitive Theory, Bandura (1986:4) explains risk-taking behaviour on the principle that it is easier to alter people's beliefs about causes of their behaviour than to change the manner in which they behave. He further asserts that people engage in "unhealthy habits" because they do not know how to change their own behaviour. Bandura (1989:93) defines the term "self-efficacy" as not being concerned with the skills one has, but with the judgements of what one can do with whatever skills one possesses. He argues that a person's judgement of his/her self-efficacy will determine how much effort he/she will apply, even in the face of obstacles. Bandura notes numerous sources of developing self-efficacy, amongst others he lists: family, peers, and, most importantly, the school as an agency for imparting

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needs of youth; efforts to regulate conditions affecting youths' exposure to risk - at legislative, policy and rights levels, and to provide a social base of support and intervention within the school as well as in the community (Dickson-Tetteh & Ladha 2000:393; Department of Education 2003c:14).

knowledge, behavioural skills and beliefs with regard to capabilities. In HIV & AIDS education programmes it will be imperative to determine whether schools are directing their efforts to all these areas of developing a learner's sense of self-efficacy, or whether the focus is mostly on knowledge acquisition.

2.5.3.2 Health Belief Model

The Health Belief Model (hereafter referred to as HBM) focuses on two distinct elements with regard to health-related behaviour, namely the threat of illness, and the behavioural response to the perceived threat (Kirscht & Joseph 1989:114). In perceiving the threat, the individual considers his/her personal susceptibility to harm and/or illness, the perceived severity of the threat of the illness and the value of the behaviour or line of action to overcome the perceived threat, and barriers that he/she might experience with regard to problem-solving behaviour. In evaluating the cost and benefits of a particular behaviour, the individual must feel convinced that there is definite value in pursuing that particular behaviour.

The advocators of this theory argue that the belief elements build in an individual a sense of psychological readiness to act in the face of some perceived threat, in this case, to one's health. Several factors influence this psychological readiness, for example, peers as well as the environment. HIV & AIDS education programmes therefore ought to build a sense of personal susceptibility to harm when learners are being educated with regard to unsafe behaviours. In other words, these theorists are of the opinion that educational efforts must stimulate the recipients with the persuasive belief that it is in their best interest to change their way of behaving.

2.5.3.3 Theory of Reasoned Action

The theory of Reasoned Action is based on the premise that humans are reasonable creatures who systematically use information that is available to them in order to decide on their actions (Ajzen & Fishbein 1980:18). In other words, to change behaviour there is a need to change the underlying cognitive structure of the behaviour in question. The theory integrates beliefs, attitudes, intentions and behaviour, and is based on the argument that the individual has the skills and opportunities to engage in the desired action. However, the weakness of this argument lies in the fact that this is not necessarily true in all instances. The theory was therefore further expanded to incorporate the concept of control over the intended behaviour, known as the Theory of Planned Behaviour (Ajzen & Fishbein 1985:12). This refers to the individual's perceived ability to engage in the desired behaviour. If the individual believes that he/she has control over his/her own behaviour, together with the attitudes and societal norms that promote the desired behaviour, the right climate for effecting the desired behaviour is created.

In the application of the Theory of Reasoned Action, in order to understand and change HIV & AIDS related behaviours, Fishbein and Middlestadt (1989:97) cite several issues that may influence behaviour. One such factor is the identification of the behaviour. A person may define his/her own behaviour in terms of criteria such as context, time, action and target. Should one of the criteria change, the individual may not define the act he/she engages in as "undesirable". In addition to this, another important factor is the corresponding intention that complements a desired behaviour. The theorists argue that the reason why many educational programmes and interventions have been unsuccessful, is because they did not focus directly on the appropriate intentions in advocating a desired behaviour. This may elucidate, for example, the phenomenon that both teachers and learners have knowledge of the universal precautions with regard to HIV & AIDS prevention,

and yet are unsure of when to apply them, and whether a particular situation is appropriate or not.

2.5.3.4 Piagetian Cognitive Developmental Perspective combined with the Intuitive Theories Approach

Sigelman, Derenowski, Woods, Mukai, Alfred-Liro, Durazo and Maddock (1996:259) advocate the integration of intuitive theories with a theory that has dominated research and HIV & AIDS education responses, which is the Piagetian Cognitive Developmental Perspective. Piaget (Mussen, Conger, Kagan & Huston 1984:236) has indeed had a remarkable influence on the manner in which HIV & AIDS education has developed the world over. He theorized that cognitive development consisted of four stages, namely the sensori-motor, pre-operational, concrete operational and formal operational thinking.

A distinct aspect of Piagetian thinking is the premise that an individual actively constructs his/her world. Cognitive development depends on both maturation and active contact with the outside world (Mussen *et al.*, 1984:236). In the light thereof the main target age group of HIV & AIDS education has been early adolescence, in cognition of the theoretical assumption that the complexity of children's thinking increases with age. Therefore, the view that children need to be cognitively ready to gain understanding with regard to disease concepts. This resulted in HIV & AIDS education being targeted at the early adolescent. An intervention or educational programme that targeted younger children was seen as a waste of energy and resources, as young children were not matured and ready to assimilate these behaviours.

In challenging the view that children cannot benefit from instruction until they are cognitively ready to assimilate new information, and that their levels of conceptual understanding cannot be altered, Sigelman *et al.* (1996:255) state

that, although children may lack certain understanding due to age factors, this does not mean that they should not be exposed to age-appropriate instruction in HIV & AIDS education. They are of the opinion that the earlier HIV & AIDS education is introduced, the greater the benefits. They further contend that early education of elementary school children can prepare them to avoid high-risk behaviours, to make better sense of HIV & AIDS-related information, to increase their compassion for people living with HIV & AIDS, to correct misconceptions about transmission through casual contact, and reassure children.

Sigelman *et al.* (1996:263) therefore advocated the integration of Piagetian principles with those of the intuitive theories approach, as espoused by Carey (1985:17). The fundamental principles of this approach are based on the premise that children enter the teaching situation with organised knowledge bases, or intuitive theories of a domain, and, if provided with appropriate information, they have the capability to formulate new theories regarding that domain (Carey 1985:69).

Sigelman *et al.* (1996:263) point out that, whilst Piagetian theorists suggest that children's knowledge and understanding increase systematically with age, the intuitive theorists disagree and ascribe it to increased exposure to more and more information about HIV & AIDS each year. The younger the children are when exposed to HIV & AIDS-related information, the more they will learn. He indicates that even the youngest of children have their knowledge organized into a coherent whole, though not always correct. The child's immaturity may nevertheless result in certain misconceptions regarding the health messages he/she is exposed to.

However, there are still greater benefits in exposing children to HIV & AIDS education earlier rather than later. In essence Sigelman *et al.* (1996:263) state that health education for children can be effective if it rests on the assumption that even relatively young children have coherent ideas about

what causes a disease and they can learn more correct ideas if provided with appropriate instruction. Kistner *et al.* (1997:269) also support this point of view by stating that there should be an integration of the Piagetian approach with other methods when researching children's conceptions of HIV & AIDS.

2.5.3.5 Third person perception and "optimistic bias"

Other researchers cite several factors that may decrease the impact of HIV & AIDS education endeavours. Davison (1983:3) focusses on the concept of "third-person perception", which he defines as an individual's perception that others are more influenced by media messages than he/she is. The fundamental belief is that individuals expect communication to have a greater impact on others than on themselves. Carter (1999:296) states that, in terms of the notion of personal susceptibility to harm and the third-person perception, Australian research has shown that, although people are knowledgeable with regard to HIV & AIDS, they do not perceive themselves to be personally vulnerable to risk. In terms of Davison's theory teachers in schools may, because of their authoritarian roles and in general having a high self-esteem, perceive themselves as not personally at risk to HIV & AIDS infection.

According to Weinstein (1989:142), another important concept is that of "optimistic bias". This refers to the individual's perception that he/she is less vulnerable to risks than others. With regard to HIV & AIDS, the theories of third-person perception and optimistic bias indicate that, even if individuals are knowledgeable about transmission modes of HIV & AIDS, they tend to believe that others are more vulnerable than themselves to being influenced by negative factors outside themselves.

Chapin (2000:69) adds another interesting dimension to these two concepts of third-person perception and optimistic bias. His research established that HIV & AIDS-related knowledge reduced third-person perception, in other

words, the more learners knew about HIV & AIDS, the less likely were they to believe that they would be affected by HIV & AIDS messages. Chapin (2000:71) differs from the notion that there is a positive relationship between third-person perception and optimistic bias. He argues that there is actually an inverse relationship between these two concepts. He, however, found that a definite relationship exists between optimistic bias and self-esteem. Learners with high self-esteem tend to be self-assured and confident in their knowledge and choices, resulting in a false sense of security when faced with decisions about sexual risks.

Chapin's conclusions indicate that learners with high self-esteem are more likely to underrate their personal risk of health hazards than students with a lower self-esteem. It may be possible to extend this line of thought to teachers who are symbols of authority in the schools. In view of teachers' position of relative power in the context of the classroom, they would tend to have higher self-esteem than others, including learners. In terms of the research findings, this could have implications for teachers' behaviour. Teachers may also display a sense of complacency regarding their vulnerability to HIV & AIDS, and thereby decrease the impact of HIV & AIDS education.

Chapin (2000:76) advocates that AIDS-related education should commence at a young age, as optimistic bias increases with grade level. The most appropriate age for influencing learners' sex-risk perceptions is middle school or earlier.

Reitman, St. Lawrence, Jefferson, Alleyne, Brasfield and Shirley (1996:511) state that, to increase adolescents' risk recognition, risk-sensitization efforts must be increased. One way is to link HIV to other sexually transmitted infections (STIs) in order to achieve maximum impact with youths who do not perceive themselves to be at risk. These authors add that relative high levels

of knowledge with regard to HIV & AIDS, like for example in the United States, did not necessarily prove to be a good predictor of health behaviours.

2.5.3.6 AIDS Risk Reduction Model

Catania, Kegeles and Coates (1990:53) developed the AIDS Risk Reduction Model (ARRM). The basic principle of this theory is that social and psychological influences affect behaviour changes. They detail the three stages of behaviour change as follows:

- The labelling of problematic behaviours.
- Making a commitment to change these behaviours.
- Seeking and enacting behavioural change to reduce risk to HIV infection.

Faryna and Morales (2000:52) suggest that a forth stage should be introduced to this model, namely cultural diversity and ethnic identity. They argue that the forth stage, based on their research, is an important factor with regard to risk reduction, because ethnicity has a considerable effect on risk behaviour and risk sensitization. In their investigation of the concept of risk behaviour in the context of ethnicity, they found that ethnicity and cultural identity were the most powerful factors in risk prediction. As factors they were even stronger than gender, knowledge, self-efficacy, attitudes and beliefs. They therefore advocate the incorporation of the cultural dimension into the latest HIV & AIDS prevention theories.

2.5.3.7 Redefining Actions and Decisions Model

The Redefining Actions and Decisions Model (RAD), advocated by Schoeberlein, Woolston and Brett (2000:389), presents a model for school-based HIV & AIDS prevention, which appears to collaborate the various essences of the health behaviour theories. They root their theory on the premise that effective HIV & AIDS education must produce desirable

outcomes in the individual's knowledge, attitudes, skills and behaviour. They further state that such interventions must be culturally, socio-economically and developmentally appropriate to the target group, and to the facilitator, that is, the teacher who actually implements the RAD programme with learners. The comfort or discomfort level of the teacher appears to be an important factor, as it may impact positively or negatively on learners' attitudes, knowledge levels and levels of comfort when discussing HIV & AIDS-related issues (Schoeberlein *et al.*, 2000:403).

It is interesting to note that the implementation of the RAD model starts in the early years, and progresses from a content-based curriculum in the elementary years to a more applied and evaluative type of programme in the later years of schooling. According to Schoeberlein *et al.* (2000:399), risk elimination and risk reduction are optimal outcomes of the model, with the emphasis on risk elimination as the safest way to prevent HIV & AIDS.

2.5.3.8 Conclusion

In viewing the health behaviour theories and models, it appears that the focus is on the individual as well as on social influences, such as the influence of peers, family social norms and the media on health behaviours. Each theoretical school of thought places different emphasis on different issues. It is clear that, in planning HIV & AIDS prevention programmes cognizance must be taken of several critical factors, to ensure that programmes have the desired outcome. More recent studies have shown that knowledge of HIV & AIDS is not an accurate indicator of risk-sensitive behaviour, that is, a person may have a vast content knowledge of transmission modes and other relevant facts, but may still engage in high-risk behaviour (Parker 2004:2).

Parker (2004:4) is of the opinion that a range of conceptual and contextual factors limits the success of behaviour change theories and interventions. Airhihenbuwa, Makinwa, Firth and Obergon (1999:25) also argue that these

theories and models lack an adequate framework for bringing about behavioural change when applied to contexts in Africa, Asia, Latin America and the Caribbean. This view is supported by Melkote, Muppidi and Goswani (2000:17), who notes that cognitive theories, that are largely centred around volitional (making a conscious choice; a decision) control over behaviour, do not take into account the individual, cultural (including gender and race), and socio-economic contexts and relayed differentials of self-efficacy and power in sexual relations.

2.6 HISTORICAL DEVELOPMENT OF HIV & AIDS PROGRAMMES IN SCHOOLS

With HIV & AIDS being a relatively new and unidentified disease in the seventies, education authorities, if enlightened, did not even consider mentioning the disease on the school campus (Louw: interview 11 November 2006). After the disease became well-known and documented in the 1980s, it was at first considered a disease not to be mentioned in good company. History has shown that the then South African education authorities were hesitant to allow discussion of any sensitive issues regarding sexuality in the classroom[10]. During the late 1980s the Apartheid Government initiated ad hoc presentations with regard to HIV & AIDS prevention, although these efforts were discredited because of racial differentiation. Although Sexuality Education was made compulsory in all schools in 1991 (and the sporadic presentation thereof in selected schools, was supposed to terminate), nothing changed (Van Rooyen: interview 14 October 2006). A variety of reasons prohibited principals from implementing the programmes in their schools. Sexuality Education (in selected schools) served as the vehicle through which the HIV & AIDS message could be brought to learners. It formed part of, for

[10] The first research assignment in this regard was given by the Willem Nicol Commission to dr. Franklin Freed in 1933. His positive recommendations were discarded by the said Commission, based on the principle that discussion of private issues such as sexuality was, according to the Commission, confined to the parental home (Transvaalse Onderwys Departement 1986:44).

example, the Guidance curriculum of the previous Transvaal Education Department (Van Rooyen 1987:148; Department of Education 1998: Circular 485).

The new South African Government soon re-directed its HIV & AIDS Education activities and made Sexuality and AIDS Education programmes compulsory in all schools in the country. Education activities saw the introduction of the red ribbon logo, the promotion of the AIDS helpline for young people on billboards and posters (by NGOs), and messages to incorporate both prevention and care aspects. Finally, the current Revised Curriculum Statement of 2005 provides for Sexuality Education and HIV & AIDS Education within the Life Orientation Learning Area, not in isolation, but integrated throughout the whole curriculum (Department of Education 2003d:2; Department of Education 2005:9). These developments ran concurrently with the introduction of the Soul City Television and Radio Series, campaigns of the National Progressive Primary Health Care Network (NPPHCN), activities of the Society for Family Health that promoted condom use and low cost, socially marketed, condom brands, and the introduction of the loveLife campaign in schools (Kelly *et al.*, 2002:35). I find it remarkable and strange that the government, in their maintenance of the school programmes (as well as the introduction of other campaigns and activities), exhibited a lacking enthusiasm, rigour, consistency and systematic delivery, for which it was widely criticised.

Provincial governments, non-governmental organisations, and community-based and sectoral organisations have also been involved in HIV & AIDS education programmes to provide young people with perspectives which may assist them in adopting and maintaining HIV-preventative behaviours (Kelly *et al.*, 2002:44). At this stage in my research, I am battling with the fact that, in spite of all the efforts, young people still remain the most infected age-group. Can it be ascribed to personal and/or interpersonal causes reasons such as a lack of skills, for example self-assertiveness? Or are the young

people, in a world where they are heavily criticised, overcome by strong feelings of a need for approval, or can it be that they do not regard their own needs and thoughts as important?

According to UNAIDS (2002b:52), the initial reaction of many countries with regard to the prevention of HIV & AIDS infection was to try to persuade individuals to change their behaviour, by providing information about HIV & AIDS. In the absence of a cure to this date, the best mode of behaviour change appears to be education (Coombe 2000a:8; Simbayi 1999:150; Van Rooyen & Louw 1993:108; World Bank 2002:xv; Hope 1999:117; UNAIDS 2002a:52). Voices of disagreement with regard to this view were raised. Different opinions by institutions, for example the clinical sciences and the Department of Health, explained that education and behaviour change were so-called long term interventions, and, considering the seriousness of the AIDS disease, there wasn't sufficient time left. A quick-fix was regarded necessary (Department of Health 2001:4). In contrast the Department of Education confirms its viewpoint with regard to education, which entails abstinence, responsibility, respect, the maintenance of monogamous relationships, absolute loyalty to one sexual partner, safe sex practices, and precautionary measures for drug users (Department of Education 2003c:24; Department of Education 2003d:5).

As a teacher, I am convinced that education remains the most important strategy for the prevention of HIV & AIDS infection. People, especially young people, must have knowledge of HIV and realise their responsibility towards themselves and their partners not to become infected with HIV. Even if 11,6% of the South African population is living with HIV & AIDS (Dorrington, Johnson, Bradshaw & Daniel 2006:6), there still remains 88,4% that need to be protected from becoming infected.

2.6.1 The focus of HIV & AIDS education programmes

Education's focus on the prevention of HIV & AIDS infection has become the guidance of the child towards abstinence and towards practising sexual relationships only within a monogamous relationship (Van Rooyen & Louw 1993:110). This may seem to be a rather old-fashioned approach, but it is currently being promoted within the new National Curriculum Statements (NCS) for grades 10 - 12 in the Life Orientation Learning Area (discussed below) that has been implemented since 2006 (Department of Education 2005:5). This approach also encompasses the promotion of responsible sexual behaviour, improvement of children's socio-economic status and the reduction of their vulnerability to sexual and other forms of exploitation (Department of Education & Department of Health 2000:31-34; Department of Education 2003c:11; Department of Education 2005:26-27). The approach of the South African programme is followed by different school districts and programmes in the USA, for example The Montana HIV & AIDS Education Programme (Court 1999:36). It is the opinion of the World Bank (2002:xv; Department of Education 2003d:7) that the HIV & AIDS education of children and youth should enjoy the highest priority in a world that is afflicted by HIV & AIDS.

According to Hope (1999:118), HIV & AIDS education programmes in sub-Saharan Africa mainly focus on Behaviour Modification Models and Information Dissemination Strategies. These programmes seem to deviate from the HBM and are in absence of basic elements that have made the HBM a relatively successful mode of disseminating health education messages with regard to behaviour change.

I am convinced that HIV & AIDS programmes in South African schools may benefit from the focus of the HBM. These models focus on effective health education messages and can be translated as HIV & AIDS programmes that include explicit information that indicates the severity of the potential illness;

indications to the receiver of the message that he or she is susceptible to the illness; a convincing message to the receiver that behaviour change can reduce the likelihood of illness; a demonstration that the benefits of behaviour change are greater than the costs; information on specific behaviours needed to reduce risk as well as positive encouragement for behaviour change (Dwadwa 1997:9; Parker 1997:22; Hope 1999:118).

This discussion will be incomplete if I fail to mention that the HBM focuses on individual change and neglects the most important skills and dynamics of social interaction that inform and shape human behaviour (Hope 1999:19). Any model that views the behaviour of people within any given society as similar and undifferentiated, runs the risk of providing stereotypical explanations and typologies with regard to the sexual behaviour of people, which are totally untrue and therefore unsound. The relevance and efficacy of such a stereotypical model, that ignores the existence of existential realities and the loss of traditional restraints within the framework of HIV & AIDS education and prevention, might be doomed to failure.

According to the HSRC (2002:7), concerns are raised with regard to behavioural interventions. The concern is about the generalising of assumptions of risk, and the homogenising of target audiences in prevention programmes. The misconception, that risk with regard to HIV & AIDS infection and risk behaviour within the diverse target groups is perceived to be the same, is usually evident within behavioural interventions. Programmes that promote behaviour change, and which are driven by high intensity mass media interventions (such as loveLife), involve homogenising of the target audiences and seldom appreciate differences in language, culture and socio-economic contexts. These approaches also tend to be passionately orientated towards forceful communication messaging, often under the banner of "behaviour change", while little endorsement of already appropriate behaviour and practices is given (Parker 1997:12).

In view of the above discussion, it may be assumed that the school, as an institution in service of a specific community within a specific contextual milieu, is best positioned to address contextual factors that may predispose learners and the community as a whole to HIV & AIDS infection.

2.6.2 The advantages of school-based prevention programmes

I am of the opinion that the school as a community institution has the capability to reach the greatest majority of children and young people in South Africa, while the possibility also exists that the school can have a constructive impact on the community. HIV infection can be prevented. Educating the youth about health risk behaviour and social issues with regard to HIV & AIDS, is the shared responsibility of families, schools and communities (Basset & Kaim 2000:4; Michel 2000:2; UNAIDS 2002a:7; Parker 2005:15).

In rural and semi-rural communities schools have the unique advantage of supplying prevention programmes to adolescents, while simultaneously supporting family and community values. Education offered consistently and over time can assist youth in developing positive health behaviours associated with disease prevention (Patterson 1996:33; Court 1999:4; Department of Education 2003d:7).

I regard the school as the most advantageous preventative agent with regard to HIV & AIDS. The school has the capacity to introduce reproductive health programmes early, in order to reach children before they become sexually active or drop out of school because of early pregnancy, contracting an infection, caring for sick relatives, or become orphaned (World Bank 2002:30). A further advantage of the school lies in the fact that trained teachers can facilitate learning and serve as role models for adolescents while providing accurate information with regard to reproductive health (Michel 2000:4; World Bank 2002:30; Kelly *et al.*, 2002:13). Another advantage of the

school that I want to add is the possibility that the teacher, if trained to do so, can support and counsel the child who has been affected or infected by HIV & AIDS.

Research findings (World Bank 2002:30) indicate that the content of school-based reproductive health programmes within different countries varies greatly. These programmes can include components such as family life or life skills education; sex education; HIV & AIDS education; and/or school based health services. I find it distressing that there is a lack of sufficient evidence with regard to the success of such programmes in South African schools (World Bank 2002:31) (in this regard also refer to paragraph 2.3.3). This fact highlights the need for intensified monitoring and evaluation of the impact of intervention programmes in South African schools.

2.6.3 The state of HIV & AIDS programmes in South African schools

In other countries, such as the United States of America, teachers fulfil a meaningful role in HIV & AIDS programmes (Meeks & Heit 2001:31; Ainsa 2002:16). Professional preparation programmes are provided to teachers to assist them and improve their knowledge of and ability to effectively manage HIV & AIDS programmes. Despite the introduction of compulsory HIV & AIDS and Sexuality Education programmes, embedded in the Life Orientation Learning Area in South African schools (refer to paragraph 2.7), many schools fail to implement the policy or to deliver the prescribed programmes as required by the Ministry of Education. Research indicates that a mere 18% of schools are following a Sexuality Education programme with HIV & AIDS as focal point, despite the fact that 60% of the schools in the study acknowledge that learners are at serious risk of becoming HIV & AIDS infected (Rademeyer 2003:2; World Bank 2002:30; Kwazulu-Natal Department of Education and Culture 2002:2; Department of Education 2003d:22).

2.6.4 HIV & AIDS education as compulsory programme

At the launching of the macro plan for education in South Africa, called "Tirisano" (Working Together), the then Minister of Education, Professor Kader Asmal, highlighted nine priorities, amongst which HIV & AIDS was prominent (Department of Education 2001a:7; Department of Education 2003d:7). The Tirisano document outlines the education sector's strategy to deal with the HIV & AIDS epidemic in a three-pronged approach. The approach firstly embarks on an awareness, information and advocacy campaign; secondly, ensures the introduction of the HIV & AIDS issue into the curriculum, and; thirdly, plans for the inclusion of other HIV & AIDS related issues within the education system.

The education authorities have developed two policy documents on HIV & AIDS. These policies embody a management plan with the aim of addressing HIV & AIDS in the education sector. The first policy is titled: *The National Policy on HIV & AIDS for Teachers and Learners in public schools and students and teachers in further education and training institutions.* The second is *The HIV & AIDS emergency: Department of education guidelines for teachers* (Department of Education 1999:1).

The development and implementation of the above HIV & AIDS policies for Education falls within the government's strategic planning with regard to HIV & AIDS prevention that has been in place since 1994 (Coombe 2000b:21). The strategies include:

- The South African Strategy and Implementation Plan endorsed by the Cabinet in 1994. The plan was comprehensive and practical, designed with the aim to prevent the spread of HIV & AIDS, to reduce the impact of HIV & AIDS, and to harness existing and potential resources. The plan dealt with the epidemic as both a family-health and education issue. By 1998, administrative structures were in place at national and provincial levels. An HIV & AIDS coordinator was appointed in each of the nine provinces to

develop, implement and monitor national HIV & AIDS programmes (Coombe 2000a:26; Louw, Edwards & Orr 2001:5; Marais 2005:7).

- The *HIV/AIDS and STD strategic plan for South Africa, 2000-2005,* was announced by the then Minister of Health in 2000. The document sets out a broad strategic plan to guide and coordinate the country's responses as a whole.
- The *National Integrated Plan for Children Infected and Affected by HIV & AIDS*. This plan was also developed in 2000 (Coombe 2000a:22) with the aim to support the teaching of life-skills in primary and secondary schools, to develop strategies for the caring of orphans and for people living with HIV & AIDS, and to find ways of making voluntary testing and counselling available (Louw *et al*., 2001:8, Cohen 2002:14).

In addition to the above, government is currently translating a variety of informative publications that deal with HIV & AIDS issues, into nearly all the official languages of South Africa. The aim is to create an awareness of the seriousness of the disease amongst all people. Despite numerous prevention efforts, the number of infected people rises daily. Regardless of these strategies, it seems to me as if the government has thus far developed strategies that cannot be regarded as effective to fight the spread of HIV infection (Coombe 2000a:23; Crewe 2002:448; Bate 2003:x). I wonder what this means for the school and for relevant stakeholders within the school community? Are they doing what is expected of them? Do the policies seem ineffective because they are not being implemented or because they are not being implemented adequately?

2.6.5 The role of the school and a way forward

According to Coombe (2000b:1), education can no longer be "business as usual". Constructs at the heart of education such as 'curriculum development' and 'educational support services' have to change under the influence of political will and the prevailing effect of the HIV & AIDS pandemic. Prevention

programmes, as mentioned above, can only be effective if they reach the people most at risk to HIV & AIDS infection, such as adolescents. Van Rooyen (2001:15) emphasizes the fact that society expects the school to reduce the spread of the virus and to take up its responsibility in the fight for survival against the dreaded virus. Utilizing educational structures and institutions may be the most logical (and cost-effective) way of getting prevention strategies across to adolescents in an effort to promote responsible sexual behaviour - which appears to be amongst the best strategies for preventing HIV & AIDS infection (Kelly 2000:14; World Bank 2002:3; Van Rooyen & Louw 1994:113; Department of Education 2003d:5).

2.6.6 Expectations of the Department of Education

Teachers can no longer elude their responsibility to empower and inform learners with regard to comprehending, taking control of and being responsible for their own bodies and sexual health (Van Rooyen 2001:17). Teachers must acknowledge the dynamic sexual energy that forms part of each human being, together with the fact that the adolescent is overwhelmed by sexually provocative material.

The responsibilities and traditional role of the teacher, amid the challenges of a fast changing world and the immense impact that HIV & AIDS has within the educational sector, necessitate that the role of the teacher will have to be much more diverse. The National Education Policy Act, that outlines the norms and standards for teachers (Act 27 of 1996), points out the following seven roles of teachers. Teachers should be learning mediators; interpreters and designers of learning programmes and materials; leaders, administrators and managers; scholars, researchers and lifelong learners; community facilitators and pastoral care givers; assessors; and learning area/ subject/discipline/phase specialists (in this regard refer to Diagram 2.2 on the next page).

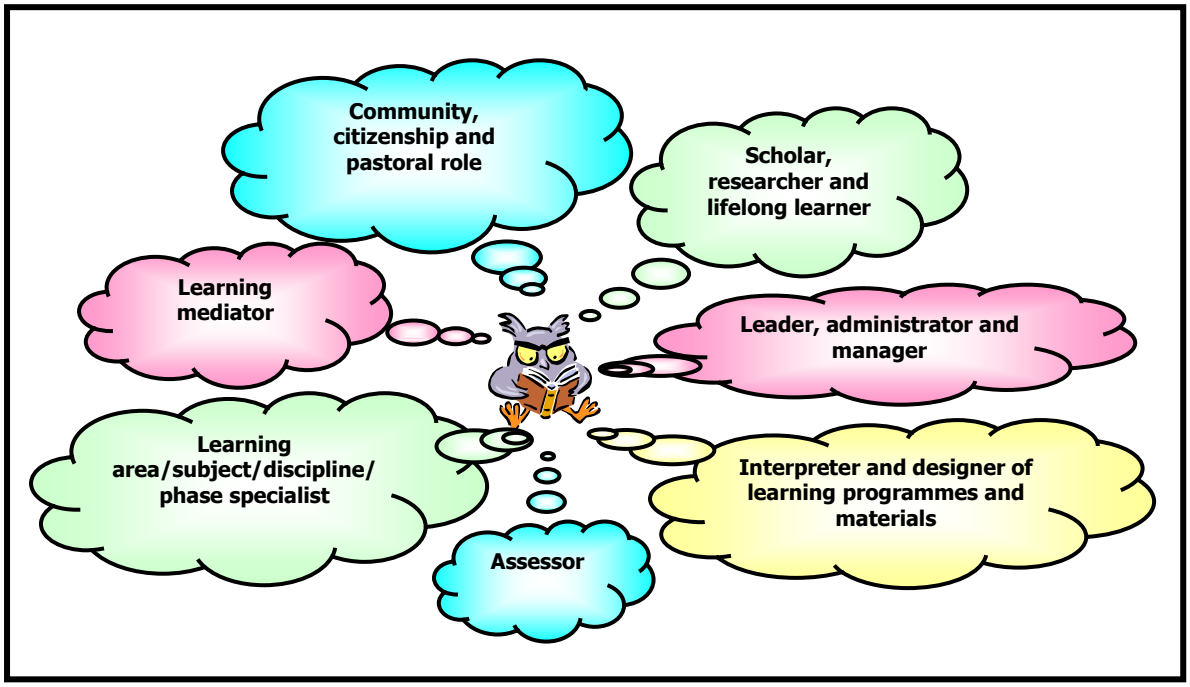

Diagram 2.2: Seven diverse roles of the teacher

Source: Adapted from The Department of Health (2001:6)

The primary responsibility of the teacher with regard to Sexuality or HIV & AIDS Education is to teach learners about safe sexual behaviour and the values consistent with healthy community life (Coombe 2001b:5). Furthermore, the National Education Policy Act (Act 27 of 1996) directs teachers to protect the rights of learners; provide education and opportunities to learners infected with HIV & AIDS; provide learners with care and counselling; create a safe and secure environment in institutions of learning; apply infection control measures universally, regardless of any learner's HIV status; employ adequate wound management in the classroom, in the laboratory and on the sports field or playground, when a learner sustains an open, bleeding wound. Teachers should assist in mitigating the impact of HIV & AIDS on those they teach and support; educate learners about their rights concerning their own bodies, to protect themselves against rape, violence, inappropriate sexual behaviour and contracting HIV & AIDS; and present Life-skills Education on an ongoing basis, that embraces HIV & AIDS education and promotes abstinence from sexual intercourse.

Fundamental practices should be evident in learning institutions to mitigate the long-term consequences of the HIV & AIDS epidemic for learners (Coombe 2001a:15). Teachers should be conversant with HIV & AIDS as a disease, the traumas associated with the HIV & AIDS epidemic, the socio-economic context in which the epidemic reveals itself, and their roles and responsibilities for guarding and guiding children and young people. It is expected that teachers will be equipped with basic knowledge and appropriate counselling and caring skills.

Teachers must be able to create a learning institution that serves as a safe haven for all those who learn and teach there (Coombe 2001a:17; Department of Education 2003d:6). This implies zero tolerance for discrimination, violence or abuse, but a guarantee for the safety and security of all learners and teachers (Act 84 of 1996).

More creative responses, to meet the complex learning needs of those who are affected by HIV & AIDS, in order not to lose young people with regard to learning, must be developed (Coombe 2001b:19). Schools and teachers may achieve this by reviewing and adapting the curricula to meet the needs of learners who are outside of the formal system; timetabling and setting calendars more flexibly in response to the needs of the community they serve; use teaching techniques like distance learning, peer group work, radio and television that do not require teachers or physical structures; and involve community members in learning situations (Kelly 2000:82).

Learners are in desperate need of the guidance of trained and understanding teachers with regard to sensitive issues such as sexual maturation and the development of the sex urge during puberty, sexual activity vs. abstinence, safer sex, masturbation, contraception, and the role of values in responsible decision-making (Van Rooyen & Hartell 2001:17). I hold the view that trained and motivated teachers, who aim at preventing learners to become HIV infected, and at minimizing the vulnerability and defencelessness which may

expose adolescents to HIV infection during risky circumstances, can positively contribute to addressing these issues.

In view of the above discussion, I am deeply under the impression of the numerous responsibilities that teachers have to deal with, in order to implement an HIV & AIDS programme in their schools. The teachers can, however, not fulfil these responsibilities in the absence of adequate opportunities. If programmes are not implemented and teachers are not enabled to create and establish learning opportunities, they cannot fulfil their responsibilities with regard to the implementation of HIV & AIDS programmes.

2.6.7 The responsibilities of school management and leadership

According to Coombe & Kelly (2001:3), the education system has to respond creatively in order to provide meaningful and relevant educational services of acceptable quality to learners. Such a creative response will also have to pay attention to the level of education management. Society as a whole and especially the school's direct community have a need for the school to curb the spreading of HIV & AIDS and to accept responsibility in the fight for survival against a dangerous, indistinct and obscured rival. Effective management and sturdy education on the part of the school may produce future citizens with the ability to prove themselves as norm-dependent and conscientious adults who can face a vigorous, changing world in which some of the values of the past may be inappropriate tomorrow and even today (Van Rooyen & Hartell 2001:16). More has to be done than *"wearing red ribbons and distributing condoms"*.

I am of the opinion that the responsibility of implementing educational programmes ultimately rests with the management of the school, therefore I shall direct my discussion towards the duties and functions of the school

management in respect of designing and implementing the school's HIV & AIDS policy and programmes.

2.6.7.1 Preventative orientated management

I am convinced that the implications of HIV & AIDS, with special reference to the impact thereof on the education sector, will have far-reaching implications for the management and implementation of HIV & AIDS programmes. According to Van Rooyen & Hartell (2001:5), many of the appalling implications may not be known yet, but one recognized implication that influences the school directly and demands the attention of educational leaders and principals, is that effective management and leadership with regard to HIV & AIDS prevention is of paramount importance in every school.

I suggest that successful preventative management in a school should start with a school-orientated strategic plan that is appropriate to manage HIV & AIDS-related crises (Coombe 2001b:34; Department of Education 2004:3). Van Rooyen & Hartell (2001:10) suggest a triangular management approach, based on the Policy of the Department of Education (Government Gazette, 410, 20372, August 10).

The focus of a triangular management approach (Diagram 2.3 below) may be on prevention with the aim of reducing HIV infection rates, on formulating coping strategies to mitigate the impact of the disease on learners and teachers, and on care that avails post-exposure knowledge and services to all infected and affected persons within the community of the school. The manager of the school or principal should face up to the attack on HIV & AIDS and manage it with the same responsibility and devotion as he or she manages other management areas in the school (Van Rooyen & Hartell 2001:17; Department of Education 2003d:24).

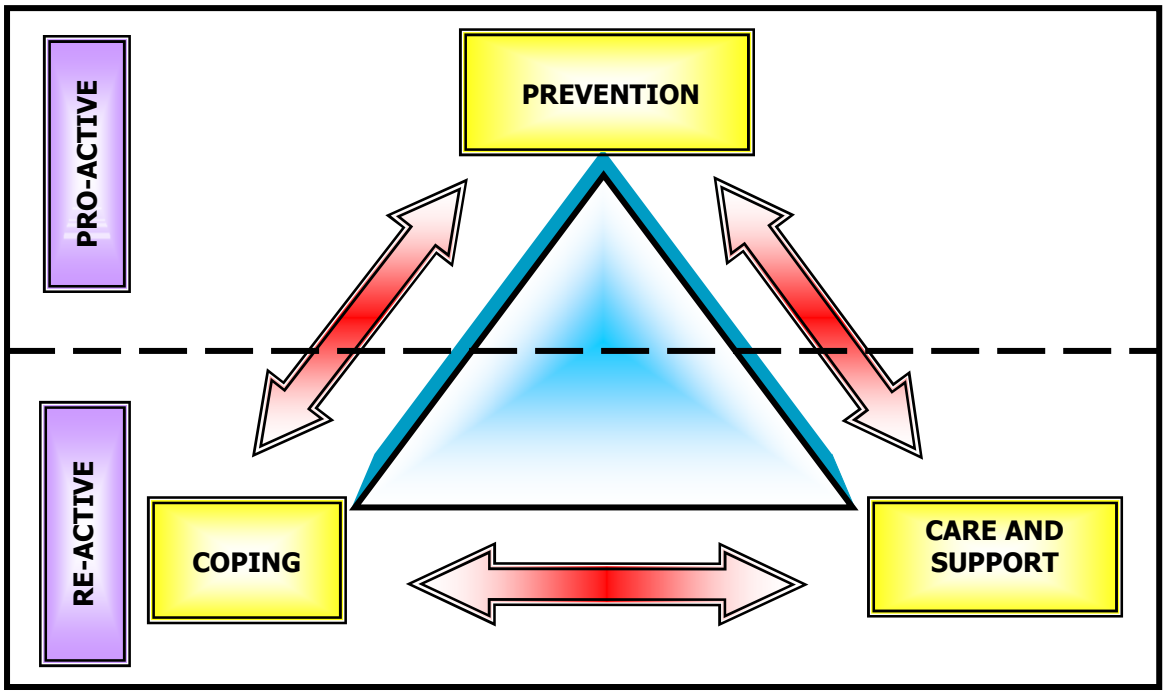

Diagram 2.3: A triangular approach to management of HIV & AIDS programmes

2.6.7.2 Implementing a health and HIV & AIDS information bank

I regard it as essential that Health information and knowledge within a school should form part of the Health Education that is presented to all learners. According to Larson & Narian (2001:32), learners should be educated with regard to sexuality, reproductive health and prevention of STIs and HIV before they become sexually active.

The many facets of the child as a human being, such as the physical, emotional, spiritual, social and intellectual, can be distinguished, but should be addressed as a whole and never be separated (Van Rooyen & Hartell 2001:26). This awareness of a person that functions as a whole "oneness" forms the basis for a healthy and balanced family life and lifestyle, and it should be kept in mind that a person can only be his or her best if he or she functions holistically. Therefore, I regard it as vitally important that teachers

and principals keep in mind that a child has to be addressed holistically when health and HIV & AIDS knowledge is presented.

Van Rooyen & Hartell (2001:10) state that with regard to health knowledge the child should acquire and internalise as much knowledge as possible, accompanied by relevant skills, as a condition for maintaining good health and a positive lifestyle. Adequate health knowledge may prevent the adolescent from risky, irresponsible and potentially harmful behaviour and may be beneficial with regard to maintaining the best health possible in the midst of an illness.

To begin with, the school principal should gather as much information with regard to HIV & AIDS as possible. The vast range of HIV & AIDS documentation includes extensive medical elucidations, extended user-friendly computerised databases, and general information available in almost all languages for readers from of all levels of society. Information exists to inform the illiterate, visually and hearing impaired, young children and isolated rural families who do not have access to media and other resources (Van Rooyen & Hartell 2001:27). I am of the opinion that the availability of resources, especially with regard to information on HIV & AIDS in a school, is of utter importance in order to succeed with the implementation of an HIV & AIDS programme.

2.6.7.3 Rationale for an HIV & AIDS school policy

I agree that the HIV & AIDS school policy ought be a written document, stating the institution's position and procedures and informing concerned stakeholders on what is expected of them (Van Rooyen & Hartell 2001:27). In this regard, I consider the school's HIV & AIDS policy as a valuable management tool that furthers and enriches the implementation of the HIV & AIDS programme in an integrated manner.

2.6.7.4 Function of an HIV & AIDS school policy

It should be kept in mind that it is not a requirement for the school's HIV & AIDS policy to provide for an entire HIV & AIDS programme. The policy should serve as a strong foundation on which to build a sound HIV & AIDS programme (Van Rooyen & Hartell 2001:28). It is suggested that an HIV & AIDS policy ought to set the framework for communication, debate and consultation on HIV & AIDS. The policy may serve as the cornerstone for the school's entire HIV & AIDS programme and therefore enhance consistency and stability within the school. An HIV & AIDS policy may establish principal standards with regard to the behaviour and conduct of all stakeholders in the school; identify the sources of available assistance and the procedures that have to be followed, and instruct and direct educational managers on how to address HIV & AIDS in their schools.

2.6.7.5 Discrepancy of an HIV & AIDS policy as to a "Rule Book"

An established "Rule Book" or code of conduct that may exist at schools usually contains established practices or rules that determine and direct behaviour within a school. I consider the fact that such established practices or rules are often laid down within a school's code of conduct after harmful and risky incidences have occurred, and they are usually not established in advance for guiding future behaviour and actions. With regard to the prevention of HIV & AIDS infection, I believe it may be detrimental and even fatal to postpone the establishment of a policy that guides future behaviour until harmful and risky incidences have occurred. Policy needs to be established in advance (Van Rooyen & Hartell 2001:28).

2.6.7.6 The National Policy as a guide for an HIV & AIDS school policy

The development of a unique HIV & AIDS policy within the school is directed by the South African Schools Act, Act 84 of 1996, as it must be kept in mind that the National Policy places on obligation on all parties and functions as the framework for the development of any school policy (South African Schools Act, Act 84 of 1996). The policy provides the framework for:

- Compulsory basic education for all learners from the age of seven (or grade 1) to the age of 15 (or grade 9).
- Banning unfair discrimination policies and discriminatory educational practices in public schools, even though School Governing Bodies (hereafter referred to as the SGB) determine admission policies for respective schools.
- Admitting learners with disabilities into mainstream schools, where reasonably practicable. Schools are encouraged to ensure that their facilities are accessible to learners with disabilities.
- The special education of learners (at special schools) that cannot be taught properly at mainstream schools.
- Ensuring that no learners are excluded from a school because of the non-payment of school fees. Although school fees are determined by majority resolution of the parent body, parents have the right to appeal if they cannot afford to pay school fees.
- Providing home schooling.

The National Education Policy Act, Act 27 of 1996, and the National Policy on HIV & AIDS for learners in Public Schools, keep to international standards, educational law and the constitutional guarantees of the right to a basic education, the right not to be unfairly discriminated against, the right to life and bodily integrity, the right to privacy, the right to freedom of access to information, the right to freedom of conscience, religion, thought, belief and

opinion, the right to freedom of association, the right to a safe environment, and the best interests of the learner.

I concur with Van Rooyen & Hartell (2001:12) that the SGB, under initiative of the principal, should, as part of their allocated functions (according to the South African Schools Act, Act 84 of 1996) develop a unique HIV & AIDS policy and implementation plan for the school, that reflects the needs, ethos and values of that specific school and its community. I am of the opinion that the school policy should address aspects such as a detailed plan on HIV & AIDS prevention, coping strategies with regard to care for the HIV & AIDS infected and affected learners and teachers, as well as particular attention to aspects such as:

- **Non-discrimination and equality**

  All learners and teachers with HIV & AIDS have the right not to be unfairly discriminated against in any way (Department of Health 2001:8). The school's policy with regard to HIV & AIDS should ensure that all learners and teachers within the school are treated in a just, humane and life-affirming way (Van Rooyen & Hartell 2001:14).

- **Admission to school and HIV & AIDS testing**

  No learner may be denied admission to a school or be deprived of his or her continued attendance at a school on account of his or her HIV status. Routine HIV testing of learners and teachers, to determine the prevalence of HIV & AIDS in a school, is regarded as illicit.

- **School attendance for learners with HIV & AIDS**

  The needs and rights of learners infected with HIV to basic education are enshrined within the National Education Policy, Act 27 of 1996. Learners infected with HIV are expected to attend

classes in accordance with statutory requirements for as long as they are able to function effectively. When learners with HIV become debilitated due to illness, or if they pose a significant medically recognised health risk to others at the school, they may be granted exemption from school attendance (South African Schools Act, Act 84 of 1996, Section 4(1)), or their parents may educate them with material made available for study at home.

- **Confidentiality, disclosure of HIV & AIDS-information and status**

  It is of paramount importance that confidentiality with regard to the HIV & AIDS status of any person be maintained under all circumstances. According to The National Education Policy, Act 27 of 1996, no learner, or his or her parent, or teacher, is compelled to disclose his or her HIV & AIDS status to any school authorities.

  Any learner (above the age of 14 years) with HIV & AIDS, or his or her parents, is free to voluntarily disclose the HIV & AIDS status of the learner. Sincere voluntary disclosure of a person's HIV & AIDS status should be welcomed and an enabling environment should be cultivated in which the confidentiality of such information is ensured and in which unfair discrimination is not tolerated.

  It is of vast importance for principals and educational managers to see to it that any person, to whom any information about the medical condition of a learner or teacher with HIV/AIDS has been divulged, shall keep this information confidential. Disclosure of a person's HIV/AIDS status to third parties may nevertheless be authorised by the informed consent of the learner (if the learner is above 14 years of age), or his or her parents; or be justified by statutory or other legal authorities. Unauthorised disclosure of HIV-related information could give rise to legal liability.

- **Ensuring a safe school and learning environment**

  In efforts to ensure a safe school and learning environment, universal precautions, to effectively eliminate the risk of transmission of all blood-borne pathogens, including HIV, should be implemented. The National Policy on HIV & AIDS for Learners and Teachers in Public Schools (Government Gazette, No. 20372, 10 August 1999) includes the following universal precautions (standard precautions):

  - All blood and blood-stained fluids must be regarded as potentially infectious. The body fluids to which universal precautions explicitly apply are blood, semen, vaginal secretions, pus, amniotic fluid, breast milk and any other body fluid containing visible blood. Universal precautions do not apply to faeces, nasal secretions, sputum, sweat, tears, urine and vomit unless these body fluids contain visible blood.

  - Injuries, eczema, dermatitis, or any break in the skin should always be covered with waterproof plasters or dressings so that there is no risk to exposure of blood. A supply of waterproof plasters should always be available for this purpose.

  - Direct contact with blood or blood-contaminated body fluids should be prevented through the use of waterproof gloves or other protective material such as plastic bags, a folded paper towel or clothing, to safeguard hands from contact with these fluids.

  - Hands should be thoroughly washed with soap and water in the case of contamination with body fluids, after the gloves have been removed, or after any accidental blood contact. Should the

eyes or mucous membranes of the mouth be splashed with blood or blood-stained body fluid, the area should be washed with water immediately.

- Blood-contaminated items such as toothbrushes and razors should never be shared. Extreme care should be taken in laboratories to prevent learners from becoming contaminated with blood by implements used for dissection, or by breakable items.

- Items that are contaminated with blood or body fluids such as sanitary towels or dressings should be carefully disposed of in a sturdily tied plastic bag, and soiled linen should be effectively laundered.

Van Rooyen & Hartell (2001:15) state that principals should bear in mind that the essence of promoting the continual application of universal precautions lies in the premise that in situations of potential exposure to HIV, all persons are potentially infected and all blood and body fluids should be treated as such.

- **Prevention of HIV transmission during sport and play**

The National Policy on HIV & AIDS for Learners and Teachers in Public Schools (Government Gazette, No. 20372, 10 August 1999) regards the risk of HIV transmission as a result of contact sport and play as generally insignificant, although Van Rooyen & Hartell (2001:15) regard the following precautions during sport and play as extremely important:

- Learners with open wounds, sores, breaks in the skin, abrasions, open skin lesions or mucous membranes that

are exposed to infected blood may not participate in contact sport or contact play.

- If bleeding occurs during contact play or sport, the injured player should be removed from the playground or sports field immediately and treated according to the universal precautions.
- Blood-stained clothes must be changed.
- A fully equipped first-aid kit should be readily available wherever contact sport and contact play take place.

- **Managing blood**

  Van Rooyen & Hartell (2001:16) advise that a school policy on the managing of blood should incorporate measures such as the following:

  - Extreme caution when handling any blood, whether it is small or large spills, old blood or blood stains.
  - The immediate cleansing of the skin with soap and water even if it had been accidentally exposed to blood.
  - All open wounds on the skin (including biting or scratching) should be cleaned immediately with running water and/or other antiseptics, dried, and covered with a waterproof dressing.
  - Disposable bags and incinerators must be available to dispose of sanitary wear.

- **Coping with the unforeseen**

As mentioned in paragraph 2.6.7.5 of this study, it is imperative that an HIV & AIDS policy be developed in advance of possible risky and harmful incidents that may facilitate HIV infection. The fact inevitably remains a reality that within a school unforeseen situations may occur which require immediate decisions and actions, for example: An teacher discloses that he or she has

HIV and this results in shock, discrimination and colleagues refusing to work with the relevant teacher (Van Rooyen & Hartell 2001:30). The following suggestions may serve as guidelines for the principal:

- Remain calm and act as a true leader. The leadership of the principal will influence his or her ability to command respect and foster confidence for action that has to be taken.
- Act immediately and take the needs of the institution, colleagues, learners and other individual stakeholders into consideration.
- Maintain confidentiality and privacy regardless of the steps that are to be taken.
- Prevent discrimination at all cost.
- Ensure that the universal precautionary measures with regard to first-aid and infection control are implemented.
- Utilize and access all relevant resources that may be available both inside and outside the school.
- Consult the official policy documents or get legal advice before any actions are taken. Decisions and actions during an emergency have to comply with departmental and state laws.
- Involve and consult other stakeholders before deciding on the best course of action.
- Assure fellow employees that everything is under control by means of open communication.
- Consult with other principals and other educational managers who might have had the same experience.
- Implement education programmes, as the teacher's reaction may be ascribed to ignorance.

2.6.7.7 Expectations of the Department of Health

According to the Department of Health (2001:6), the roles of community facilitator and pastoral care-giver may not have been seen as the task of an teacher, even though many teachers have historically fulfilled this task on

account of the need in their communities, and this may include one or more of the following tasks:

- The ability to respond to contemporary social and educational problems such as violence, drug abuse, poverty, child and women abuse, HIV & AIDS and environmental degradation;
- Gaining access and working in partnership with professional services to deal with these issues (multi-disciplines working together);
- Rendering counselling and/or tutoring to learners in need of assistance regarding social or learning problems;
- Demonstrating caring, committed and ethical professional behaviour and a conception of education as dealing with the safety and security of learners and the development of the person in totality.

2.7 THE HIV & AIDS PROGRAMME AS PART OF LIFE ORIENTATION

In the following discussion, I shall briefly highlight the background, origin, purpose and outline of Life Orientation as a subject within the National Curriculum Statement. I believe that this will enhance the conceptual framework of my study and illustrate the manner in which the HIV & AIDS programme for schools is integrated within Life Orientation (in this regard also refer to paragraph 2.6.1 and 2.6.2).

2.7.1 The National Curriculum Statement as framework for Life Orientation

The South African government began the process of developing a new curriculum for the school system in 1995. The changes to the curriculum were firstly necessitated by the scale of change in the world. The growth and development of knowledge and technology, coupled with the demands of the 21st Century, required learners to be exposed to diverse and higher skills and knowledge. Secondly, South Africa as a country has changed. This change

required the revision of the curriculum in order to reflect new values and principles, in particular those of the Constitution of South Africa (Department of Education 2007:2).

The adoption of the Constitution of the Republic of South Africa therefore provided a basis for curriculum transformation and development (Farhangpour, Pretorius & Smith 2007:vi). The National Curriculum Statement (hereafter referred to as NCS) is the policy document for the new curriculum and replaces all previous syllabi and curricula. The NCS is the primary tool created to bring about social and economic changes that are needed to transform South African society into that envisaged in the South African Constitution. The NCS Grade 10-12 (General) lays a foundation for the achievement of the aims of the Constitution (Department of Education 2007:3).

All formal qualifications in South Africa are regulated by the National Qualifications Framework (hereafter referred to as NQF). The NQF divides formal education in South Africa into three bands, namely the General Education and Training (hereafter referred to as GET) band, Further Education and Training (hereafter referred to as FET) band, and Higher Education and Training (hereafter referred to as HET) band.

The NCS is the National Curriculum for the FET band in South Africa's schooling system. The Minister of Education, Naledi Pandor, describes the curriculum as follows: *"At its broadest level, our education system and its curriculum express our idea of ourselves as a society and our vision as to how we see the new form of society being realized through our children and learners. Through its selection of what is to be in the curriculum, it represents our priorities and assumptions of what constitutes a 'good education' at its deepest level. It encapsulates our vision of teachers and learners who are knowledgeable and multi-faceted, sensitive to environmental issues and able*

to respond to and act upon many challenges that will still confront South Africa in this twenty first century" (Department of Education 2002:1).

The purpose of the NCS is to determine the policy framework for the implementation of a curriculum for the FET band (Department of Education 2003a:viii). It does so by presenting the principles of the NCS; summarizing the main issues related to inclusive education, the FET certificate, and assessment; introducing the subject statements that form the foundation of the NCS (Department of Education 2003a:5).

The Learning Outcomes (LOs) and the Assessment Standards (ASs) are the fundamental features of the curriculum. A Learning Outcome (LO) describes knowledge, skills and values that learners should acquire by the end of the FET band, while the Assessment Standards (ASs) explain the minimum level of performance expected from an outcome.

Since the NCS is based on the theoretical foundation of outcome-based education (OBE), the three levels of outcomes are:

- Critical and developmental outcomes (the broad, exit, capping, ultimate outcomes),
- Subject learning outcomes (learning outcomes specific to particular subjects), and
- Lesson learning outcomes (learning outcomes specific to particular lessons).

The NCS Grades 10-12 (Department of Education 2003b:2) explains that education within the new curriculum aims to develop the whole person, therefore the following seven critical outcomes have the intention to ensure mature, well developed learners who are able to:

- Identify and solve problems and make decisions using critical and creative thinking.

- Work effectively with others as members of a team, group, organisation and community.
- Organise and manage themselves and their activities responsibly and effectively.
- Collect, analyse, organise and critically evaluate information.
- Communicate effectively using visual, symbolic and/or language skills in various modes.
- Use science and technology effectively and critically, showing responsibility towards the environment and the health of others.
- Demonstrate an understanding of the world as a set of related systems by recognising that problem-solving contexts do not exist in isolation.

I addition to the seven critical outcomes, there are a further five developmental outcomes. The developmental outcomes envisage learners who are able to:

- Reflect on and explore a variety of strategies to learn more effectively.
- Participate as responsible citizens in the life of local, national, and global communities.
- Be culturally and aesthetically sensitive across a range of social contexts.
- Explore education and career opportunities
- Develop entrepreneurial opportunities. (Department of Education 2003a:7-8).

The critical and developmental outcomes form the basis for all learning outcomes specific to all subjects. The subject specific learning outcomes, in turn, are the basis for all learning outcomes that are to be achieved in all learning programmes and lessons. I regard it as critical that teachers are familiar with the critical and developmental outcomes, because during the development of each lesson these outcomes ought to reconcile with the specific lesson outcomes.

In summary, I consider the aims of the NCS Grades 10-12 to develop a high level of knowledge and skills in learners. The curriculum sets up high expectations of what all South African learners can achieve. The NCS specifies the minimum standards of knowledge and skills to be achieved at each grade and sets high, but achievable standards in all subjects by promoting the integration of learning theory, practice and reflection. The curriculum is designed to develop progressively more advanced and complex knowledge and skills as the learner moves from one grade to the next (Department of Education 2005:2-4; Department of Education 2007:3-5; Monteith 2006:6-7).

2.7.2 The nature of the subject Life Orientation

The "new" subject Life Orientation has been introduced as part of the Further Education and Training (FET) band. My intention is not to discuss the content of the subject in full, as a complete content analysis of the subject is available in the Life Orientation Subject Statement (Department of Education 2007:1-44). In the following discussion, I shall briefly refer to the definition, purpose, focus areas and scope of the subject to provide a clear understanding as to how the HIV & AIDS programme integrates with Life Orientation.

2.7.2.1 A definition of Life Orientation

Life Orientation is defined as a study of "the self in relation to others and to society. It is a unique subject in the Further Education and Training Band in that it applies a holistic approach to the personal, social, intellectual, emotional, spiritual, motor and physical growth and development of learners. This encourages the development of a balanced and confident learner who can contribute to a just and democratic society, a productive economy and an improved quality of life for all" (Department of Education 2007:7).

In addition to this, the Subject Statement (Department of Education 2003b:9) defines Life Orientation as a subject that guides and prepares learners for life, and for its responsibilities and possibilities. This subject addresses knowledge, values, attitudes and skills with regard to the self, the environment, responsible citizenship, a healthy and productive life, social engagement, recreation and physical activity, and career choices. Furthermore, the subject equips learners to solve problems, make informed decisions, and take appropriate actions to enable them to live meaningfully and successfully in a rapidly changing society.

Life Orientation is an inter-disciplinary subject that draws on and integrates knowledge, values, skills and processes embedded in various disciplines such as Sociology, Psychology, Political Science, Labour Studies and Industrial Studies (Department of Education 2003b:9). Although Life Orientation is regarded as a "new" subject in the Grade 10-12 South African school curriculum, it draws on the core of then non-examinable subjects previously known as Guidance, Family Guidance, Vocational Guidance, Religious or Bible Education, Civic Education, Health Education and Physical Education in *Report 550* (Department of Education 2007:7). I find it exciting that in the NCS Life Orientation is one of the four fundamental subjects required for the National Senior Certificate, which means that it is compulsory for all learners in Grades 10-12. I am of the opinion that this positive change will enhance the importance of the subject and cause teachers and learners to view the subject more seriously, and therefore ensure the implementation of the HIV & AIDS programme embedded within Life Orientation.

In view of the above definitions, I regard Life Orientation as a unique subject with regard to the demands which it may place on teachers and learners as learners are encouraged to confront the challenges and difficulties in their lives (Haddon & Moore 2006:v). I am of the opinion that Life Orientation teachers may find themselves confronting issues which are highly emotive to themselves and to learners. The sensitive nature of the subject itself may

therefore pose challenges to teachers, who may not be trained or willing to cope with sensitive issues such as sexuality and HIV & AIDS. This may have an influence on the implementation the HIV & AIDS programme in the school.

2.7.2.2 The purpose and philosophy of Life Orientation

Life Orientation aims to equip *"learners to engage on personal, psychological, neuro-cognitive, motor, physical, moral, spiritual, cultural, socio-economic and constitutional levels, to respond positively to the demands of the world, to assume responsibilities, and to make the most of life's opportunities. It enables learners to know how to exercise their constitutional rights and responsibilities, to respect the rights of others, and to value diversity, health and well-being. Life Orientation promotes knowledge, values, attitudes and skills that prepare learners to respond effectively to the challenges that confront them as well as the challenges they will have to deal with as adults, and to play a meaningful role in society and the economy"* (Department of Education 2003b:9).

2.7.2.3 Focus areas and scope of Life Orientation

Life Orientation appreciates the multi-faceted nature of the human-being, as well as issues like human rights, gender, the environment, all forms of violence, abuse, sexuality and HIV & AIDS. In order to organise the issues effectively and to avoid duplication, these issues are located in one of four focus areas, although integrated across the Assessment Standards. The four focus areas are:

- personal well-being;
- citizenship education;
- recreation and physical activity; and
- career and career choices.

Each of the four focus areas for Life Orientation translates into the four Learning Outcomes for the subject (refer to Table 2.1 below). They are the following:

Table 2.1: Learning Outcomes for Life Orientation

LO 1: Personal Well-Being	The learner is able to achieve and maintain personal well-being.
LO 2: Citizenship Education	The learner is able to demonstrate an understanding and appreciation of the values and rights that underpin the Constitution in order to practise responsible citizenship, and enhance social justice and sustainable living.
LO 3: Recreational and Physical Well-being	The learner is able to explore and engage in recreation and physical activities, to promote well-being.
LO 4: Careers and Career Choices	The learner is able to demonstrate self-knowledge and the ability to make informed decisions regarding further study, career fields and career planning.

Although only Personal Well-being (LO 1), Citizenship Education (LO 2) and Recreational and Physical Well-being (LO 3) are relevant to my study (as the HIV & AIDS programme is integrated within these Learning Outcomes), I shall briefly refer to all four outcomes (Gauteng Department of Education 2004:207-214; Department of Education 2003b:13).

- **Learning Outcome 1: Personal well-being**

  In this phase, learners are expected to consolidate their own identities. The emphasis is on building self-esteem and confidence, and applying various life-skills in everyday life. Learners are made aware of their own development, a variety of risks (especially sexual risks), and substance use and abuse. Because learners of this age are vulnerable, these issues are explored in greater depth than in the General Education and training phase. Other influences in society and the environment, that impact on

well-being, are also studied. As learners in this phase are becoming more independent, preparation for effective life management becomes essential. Other influences in society that impact on well-being – such as indigenous knowledge systems, religion and the environment – are also studied.

- **Learning Outcome 2: Citizenship education**

In this phase, learners are prepared for the role of informed, active participants in community life, and as responsible citizens. Competencies and abilities in addressing discrimination, awareness of economic and social justice, and environmentally sustainable living (thinking globally and acting locally) are further developed. Learners are also exposed to diverse religions in order to foster peaceful co-existence in a multi-religious society. They are required to clarify their own values and beliefs, as these will influence their decisions throughout life.

- **Learning Outcome 3: Recreation and Physical Well-being**

In this phase, learners are in transition to adulthood. The importance of nutrition, physical activity and recreation and their contribution to personal health and fitness are emphasized. Opportunities are created for the expression of creativity and initiative. Learners will be encouraged to participate continuously in recreational activities, physical exercise and sport for lifelong well-being.

- **Learning Outcome 4: Career and Career Choices**

In this phase, learners are expected to reflect continuously on their own interests and abilities, as well as on career and entrepreneurial options, as they move towards finalizing their choice of a career. They have to critically evaluate socio-economic factors, additional and higher

education options, and access to financial assistance to finalize a career choice. As learners at this stage are about to enter the world of work, relevant employment legislation, how to access it, and dealing with unemployment, are studied.

2.7.2.4 The importance of Life Orientation

It is certain that with the introduction of Life Orientation in schools, the field of education has been further extended, to such an extent that the sensitive aspects concerning inter alia the learner's personal and sexual life, are included, therefore ranking Life Orientation as one of the most important subjects in the school. I am of the opinion this will make even greater demands on the teacher, requiring greater sensitivity, tact, understanding, insight, empathy and especially expertise.

The overall aim of education towards morally independent, responsible and purposeful adulthood is endorsed and stressed by Life Orientation. The fact that this aim is also directed towards promoting the child's personal life and his or her contribution to society (Department of Education 2007:8), contributes to my expectation that teachers will make serious efforts with regard to the implementation thereof, and consequently provide learners with a sound HIV & AIDS programme.

The aim of Life Orientation in schools is realized in the interaction between the teacher and the child (Gauteng Department of Education 2004:2; UNAIDS 1997:2; Van Rooyen 1997:83). I believe that in this unique didactic-educational situation a complex, interdependent relationship between teacher and child will develop. Therefore I regard the following as of the utmost importance: the extent to which the child exposes himself or herself to the content and participates in the learning opportunity, and the example that is set by the teacher, and his or her intention to educate. But equally important, if not the most important, is the teacher's intention regarding his message,

his educative actions and his or her motivation to fulfil his or her calling and his or her task with exceptional skill and devotion. Therefore I regard the teacher as indispensable and of vital importance in the development of the child – the role of the teacher is paramount with regard to the implementation of the HIV & AIDS programme in the school.

Because of the complex and sensitive nature of the content, I am of the opinion that Life Orientation has to be the responsibility of a specially selected and trained teacher. In addition to this, I regard it as important that Life Orientation has to be recognized and acknowledged as a special and very important subject, and that the aims of Life Orientation should be considered and fulfilled in whatever other endeavour is undertaken in the school, should it be in other classrooms, in other subjects, and during other learning opportunities. This means that every educative task that is undertaken in the school should be aimed at guiding the learner towards a healthy, fulfilled and well-balanced adulthood. The ultimate aims of Life Orientation should therefore be contained implicitly in everything that is undertaken in the school as a whole – this means the implementation of the HIV & AIDS programme within every aspect of the school.

I am convinced that the aims of Life Orientation, and consequently the outcomes of implementing the HIV & AIDS programme, can further be achieved if every teacher, by way of his or her example and behaviour, is a true and worthy example of adulthood.

2.8 ANALYSIS OF CONCEPTS

The title of this study is derived from the problem experienced in society and as stated in paragraph 1.4 of Chapter 1, namely: "In what manner do contextual factors influence the implementation of HIV & AIDS programmes in South African schools?". I shall now provide an elucidation of the concepts within the title and how it relate to the purpose of my study.

2.8.1 The concept "contextual"

According to the Readers' Digest Universal Dictionary (1989:343), the concept "context" refers to "circumstances in which a particular event occurs, a background". The Macmillan English Dictionary (2005:300) states that "context" is "the general situation in which something happens, which helps explain it". The word is derived from the Latin word "***contextus***", and means "to join together". For the purposes of my study I shall use "contextual" in order to refer to the circumstances or general situation in schools that exercise an influence on the implementation of HIV & AIDS programmes. In other words, I shall describe the manner in which the general situation or circumstances in schools influence the implementation of the HIV & AIDS programme.

2.8.2 The concept "factor"

The Macmillan English Dictionary (2005:495) explains the concept "factor" as "one of the things that influence whether an event happens or the way that it happens". The Reader's Digest Universal Dictionary (1989:548) also states that the noun "factor" refers to "an element that actively contributes to an accomplishment, result or process; a cause". For the purposes of my study the concept "factor" will refer to the elements in the school that actively contribute to (cause) the implementation (or non-implementation) of the HIV & AIDS programme.

2.8.3 The concept "influence"

I understand the concept "influence" to mean "the effect that a person or thing has on someone's decisions, opinions, or behaviour or the way something happens" (Macmillan English Dictionary 2005:735). The concept "influence" is also described as "a power indirectly or intangibly affecting a person or a course of events" (Reader's Digest Universal Dictionary

1989:790). I shall therefore use the concept "influence" in my study to refer to the manner in which the contexts (circumstances or powers) of schools affect the implementation (or non-implementation) of the HIV & AIDS programme.

2.8.4 The concept "implement"

The concept "implement" means "to make something such as an idea, plan, system or law start to work and be used"; and "implementation" refers to "the process of implementing something" (Macmillan English Dictionary 2005:718). In the Collins Cobuild Dictionary (1998:844), "implement" means "to ensure that what has been planned is done". I shall therefore use the concept "implementation" to refer to the processes and/or measures that schools follow in order to ensure that what has been planned with regard to the HIV & AIDS programme is done.

2.8.5 The concept "HIV"

The concept "HIV" is an acronym for "***H***uman ***I***mmunodeficiency ***V***irus" (Collins Cobuild English Dictionary 1998:800). In this acronym, four concepts are identified and will be discussed briefly.

a) "Human" is defined in Reader's Digest Universal Dictionary (1989:750) as:

i) "showing qualities characteristic of man as distinguished from machines, such as sympathy or fallibility (making errors)".

ii) "pertaining to or being a man as distinguished from a lower animal; reasoning; moral".

iii) "pertaining to or being a man as distinguished from a divine entity or infinite intelligence; mortal; earthly".

iv) "a human being; a person", a member of the genus *Homo*, and especially of the species *Homo sapiens*.

v) "a human" from the Latin "***hūmānus",*** meaning "man" (not referring to gender, rather mankind).

b) "Immuno-" indicates "immune response" or "immunity". "Immune" means "having immunity to infection"; it relates to or confers the body's immune system. If a person is immune he is "not affected or responsive" to infection and "protected from danger". The person has "immunity": an inherited, acquired, or induced resistance to a specific pathogen, especially by the production of antibodies or by inoculation (Reader's Digest Universal Dictionary 1989:770).

c) "deficiency" refers to "the quality or condition of being deficient"; "a lack; a shortage; an insufficiency". "Deficient" is used to refer to "insufficiency or incompleteness, and is basically a quantitative term" (Reader's Digest Universal Dictionary 1989:409).

The use of "deficiency" with regard to "immuno" thus implies that the immune system of the human body is lacking in quality as the antibodies are lacking in quantity and causing the immune system to be deficient in protecting the body against illness and infection.

d) "Virus" is derived from the Latin "***vīrus",*** meaning "poison, slime". A "virus" is described as "any of various submicroscopic pathogens consisting essentially of a core of a single nucleic acid surrounded by a protein coat, having the ability to replicate only inside a living cell."

It is interesting to note that the terms "germ" and "virus" are not interchangeable and must be carefully used. "Germ" is a non-scientific term relating to micro-organisms that are invisible to the unaided human eye, and

refers to disease producing bodies. "Virus" is the technical term for any of a group of extremely small agents capable of producing diseases in human, animal and plant life.

"HIV" reduces people's resistance to illness by destroying the immune system in humans (Van Rooyen & Louw 1993:109) and can cause "AIDS". If someone is "HIV positive", they are infected with HIV, and may develop "AIDS". If someone is "HIV negative", they have been tested for the virus and are not infected.

2.8.6 The concept "AIDS"

"AIDS" is the acronym for "***A***cquired ***I***mmune ***D***eficiency ***S***yndrome". The concepts will be discussed briefly:

a) "Acquired" is described in Reader's Digest Universal Dictionary (1989:24) as "to gain possession of" and "to get, especially by one's own efforts or qualities". The description of "an acquired characteristic" is very significant as it is "a nonhereditary change in an organ caused by use or disuse or by environmental factors".

   In Collins Cobuild English Dictionary (1998:17) the use of "acquired" is stated as "you buy, or obtain something for yourself, or someone gives it to you". It is important to note that "acquired" means "not inborn, passed from person to person, including from mother to baby" (World Health Organisation 1994:21).

b) "Immune" refers to the immune system of the human body. The "immune system" defends the body and creates "resistance to a disease" and to be "not affected by or responsive to" disease.

c) "Deficiency", as already mentioned, refers to the "insufficient" or ineffective condition or quality of the immune system to protect the body from disease.

d) "Syndrome" is from the Greek "***sundromē***", meaning "running together", a concurrence (of symptoms).

The Reader's Digest Universal Dictionary (1989:1535) describes a "syndrome" as:

i) "a group of signs and symptoms that collectively indicate or characterise a disease, psychological disorder, or other abnormal condition".

ii) "a set of signs or symptoms indicating the existence of an undesirable condition, problem, or quality".

2.8.7 The concept "programme"

I understand the concept "programme" to mean "a plan of activities for achieving something", or "a plan of activities for an event or series of events". In the United Kingdom, "a programme" usually refers to a "set of plans to develop or improve something" (Macmillan English Dictionary 2005:1127).

In addition to this, The Reader's Digest Universal Dictionary (1989:1230) explains "programme" as "any organised list or schedule of procedures or activities", and "a syllabus". For the purpose of my study the concept "programme" will refer to the organised list of activities within the syllabus (curriculum) that are planned with regard to the implementation of the HIV & AIDS programme.

2.8.8 The concept "HIV & AIDS programme"

Although HIV & AIDS programmes are being presented by a number of organisers (in this regard refer to paragraph 2.7), for the purposes of this study, when referring to *HIV & AIDS programme*, it will refer to the official HIV & AIDS programme of the Department of Education.

2.9 SUMMARY

In this chapter, I outlined my study within the framework of relevant literature. I introduced the chapter by deliberating on the context of HIV & AIDS, with regard to the extent of the pandemic, its impact, and demands on the education sector. Thereafter, I continued with a discussion on prevention programmes and curricula within education, followed by an investigation of the framework for the National Curriculum Statement, with specific attention to Life Orientation. I concluded the chapter with definitions of the concepts that constitute the problem and title of my study.

In the next chapter, I shall present an account of the empirical study that I conducted in the light of the theoretical backdrop that was described in this chapter. I shall clarify the methodological selections that I preferred in relation to the background of my study and, in terms of my research questions, as formulated in Chapter 1.