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CONTEXTUAL FACTORS INFLUENCING THE IMPLEMENTATION OF AN HIV & AIDS PROGRAMME

Dirk Nicolaas van den Berg

2008

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CONTEXTUAL FACTORS INFLUENCING THE IMPLEMENTATION OF AN HIV & AIDS PROGRAMME

by

DIRK NICOLAAS VAN DEN BERG

Submitted in partial fulfilment of the requirements for the degree

PHILOSOPHIAE DOCTOR

in

CURRICULUM AND INSTRUCTIONAL DESIGN

in the

DEPARTMENT OF CURRICULUM STUDIES
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PROMOTER: PROFESSOR DOCTOR LINDA VAN ROOYEN

2008

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DECLARATION

I, Dirk Nicolaas van den Berg, declare that this thesis which I hereby submit for the degree

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at the University of Pretoria, is my own work and has not previously been submitted by me for a degree at this or any other tertiary institution.

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Dirk Nicolaas van den Berg

2008-07-31

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DEDICATION

This study is dedicated to my wife Helga van den Berg, my two children, Marianné and Dirk and my parents Dirk and Beryl van den Berg. Your encouragement, sacrifice and love made the completion of this study possible.

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- Professor J.W.M. Pretorius for his meticulous language editing of this thesis.
- The Gauteng Department of Education and especially the participants of this study for their support and participation.

"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."

Kelly, M.J (2000)

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LANGUAGE EDITING

Herewith I, Dirk Nicolaas van den Berg, declare that the language usage in this thesis which I hereby submit for the degree

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Dirk Nicolaas van den Berg

2008-07-31

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ABSTRACT

CONTEXTUAL FACTORS INFLUENCING THE IMPLEMENTATION OF AN HIV & AIDS PROGRAMME

by

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DEPARTMENT: **DEPARTMENT OF CURRICULUM STUDIES**
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The primary aim of this study was to explore the manner in which contextual factors influence the implementation of HIV & AIDS programmes in schools, by investigating the lived-experiences of teachers who were responsible for the implementation of such programmes. The findings of this study mainly add to the vast body of knowledge on the implementation of the school's curriculum. In addition to this, the study highlights the manner in which educational policy can become a workable instrument by setting parameters for the development of an HIV & AIDS school policy, and for effective implementation of an HIV & AIDS programmes in schools. Furthermore, this study will contribute to addressing the barriers that negatively influence HIV & AIDS programme delivery in schools. Another outcome of this study could be the possible improvement of the training of teachers and curriculum developers.

The conceptual framework of the study dealt with the following: a description of the HIV & AIDS pandemic (as a background), the impact of the pandemic in the South African context, expectations and responsibilities of schools and teachers with regard to the implementation of HIV & AIDS programmes, and theories that underpin behaviour change, and form the basis of HIV & AIDS

prevention programmes. The important role of the school as a societal agent, and its important role in the prevention of HIV & AIDS infection, emerged clearly in this study. The study was conducted according to a qualitative research approach, guided by the interpretivist and constructivist epistemologies. An instrumental case study design was utilised, during which semi-structured interviews, as the main data collection strategy, were conducted with purposively selected participants from three schools (cases). The individual semi-structured interviews were supplemented with observations, a reflective journal and visual data collection and documentation strategies.

Four prominent themes emerged subsequent to an inductive data analysis that was done, namely: teachers' perceptions and experiences of the HIV & AIDS programme, managerial factors in the school, societal and community influences, and HIV & AIDS as a topic in the school subject Life Orientation. These identified and structured themes broadly categorised the empirical findings that were related to the primary and secondary questions of this study. Although the implementation of HIV & AIDS programmes in schools was made compulsory, the study indicated that schools were not adhering to this requirement, due to factors such as a lack of sound management practices in schools, insufficient training of teachers and school managers, uninvolved stakeholders, and the lived-experiences of teachers with regard to the HIV & AIDS programme.

Based on the findings of this study, recommendations were made with regard to the role that the Department of Education, school management, teachers and the community can fulfil, in order to improve the implementation of HIV & AIDS programmes in schools. This study also provides a suggested framework for developing and implementing an HIV & AIDS policy for schools, in an effort to prevent HIV & AIDS infection.

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LIST OF KEY WORDS

- HIV & AIDS
- PROGRAMME
- IMPLEMENTATION
- SCHOOLS
- CONTEXTUAL
- FACTORS
- MANAGEMENT
- CURRICULUM
- PREVENTION
- INTERPRETIVISM

SLEUTELTERME

- MIV & VIGS
- PROGRAM
- IMPLEMENTERING
- SKOLE
- KONTEKSTUELE
- FAKTORE
- BESTUUR
- KURRIKULUM
- VOORKOMING
- INTERPRETIVISME

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION AND ORIENTATION

1.1 THE AIM OF THIS CHAPTER 1

1.2 INTRODUCTION AND ORIENTATION 1

1.3 RELEVANCE OF THIS STUDY 4

1.4 STATING OF THE RESEARCH PROBLEM 5

1.5 THE PURPOSE OF THIS STUDY 7

1.6 DELIMITATION OF THIS STUDY 8

1.7 EPISTEMOLOGICAL COMMITMENT AND PARADIGMATIC PERSPECTIVE 8
- 1.7.1 Knowledge claim 8
- 1.7.2 Paradigmatic perspective 9

1.8 METHODOLOGICAL APPROACH 11
- 1.8.1 Qualitative research approach 11

1.9 RESEARCH METHODOLOGY AND DESIGN 12
- 1.9.1 Instrumental case study design 12
- 1.9.2 Selection of participants 14
- 1.9.3 Convenience sampling 14
- 1.9.4 Data collection 15
  - 1.9.4.1 Conceptual analysis 16
  - 1.9.4.2 Analysis of primary sources 16
  - 1.9.4.3 Analysis of secondary sources 16
  - 1.9.4.4 Semi-structured interviews 17
  - 1.9.4.5 Field Observation 18
  - 1.9.4.6 Visual data collection 18
  - 1.9.4.7 Reflective journal 18
- 1.9.5 Data analysis and interpretation 19
- 1.9.6 Quality criteria 20
  - 1.9.6.1 Credibility 20
  - 1.9.6.2 Transferability 21
  - 1.9.6.3 Dependability 21

1.9.6.4 Confirmability 22
1.9.6.5 Authenticity 23
1.9.7 Ethical considerations 23
1.9.7.1 Informed consent 23
1.9.7.2 Privacy, confidentiality and anonymity 24
1.9.7.3 Protection from harm 24

1.10 SIGNIFICANCE OF THE STUDY 25

1.11 CHALLENGES OF THE STUDY 25

1.12 OUTLINE OF THE STUDY 26

1.13 SUMMARY 27

CHAPTER 2

LITERATURE REVIEW

2.1 THE AIM OF THIS CHAPTER 29

2.2 BACKGROUND AND PREVALENCE REGARDING HIV & AIDS 29
2.2.1 HIV & AIDS - An endemic, epidemic or a pandemic? 30
2.2.1.1 Endemic 30
2.2.1.2 Epidemic 30
2.2.1.3 Pandemic 30

2.2.2 The nature of epidemics in general and the HIV & AIDS epidemic in South Africa in particular 31
2.2.2.1 Unique characteristics of the HIV & AIDS epidemic in South Africa 31
2.2.2.2 Stages of the HIV & AIDS epidemic 32
2.2.2.3 The HIV & AIDS epidemic 32
2.2.2.4 The stage of the HIV & AIDS epidemic in South Africa 33
(a) South Africa as a Stage 3 country 33
(b) Possible causes for South Africa being a Stage 3 Country 33

2.3 AN OVERVIEW OF THE PREVALENCE OF THE HIV & AIDS EPIDEMIC IN SOUTH AFRICA 33
2.3.1 General prevalence 34
2.3.2 Prevalence with regard to children and young adults 35

2.3.3 Number of orphans 36

2.4 THE IMPACT OF HIV & AIDS 38
2.4.1 HIV & AIDS: The binary impact on education 38
2.4.2 The impact of HIV & AIDS on teachers and education supply 41
2.4.3 The impact of HIV & AIDS on learners and education demand 42
2.4.3.1 The ebbing school enrolment 43
2.4.3.2 Erratic school attendance of learners 43

2.5 IMPLICATIONS FOR EDUCATIONAL PROGRAMMES AND CURRICULA 45
2.5.1 Implications for training and empowerment of teachers 47
2.5.2 Current state of HIV & AIDS prevention programmes 47
2.5.3 Models of health behaviour 49
2.5.3.1 The Social Cognitive Theory 49
2.5.3.2 Health Belief Model 50
2.5.3.3 Theory of Reasoned Action 51
2.5.3.4 Piagetian Cognitive Developmental Perspective combined with the Intuitive Theories Approach 52
2.5.3.5 Third person perception and "optimistic bias" 54
2.5.3.6 AIDS Risk Reduction Model 56
2.5.3.7 Redefining Actions and Decisions Model 56
2.5.3.8 Conclusion 57

2.6 HISTORICAL DEVELOPMENT OF HIV & AIDS PROGRAMMES IN SCHOOLS 58
2.6.1 The focus of HIV & AIDS education programmes 61
2.6.2 The advantages of school-based prevention programmes 63
2.6.3 The state of HIV & AIDS programmes in South African schools 64
2.6.4 HIV & AIDS education as compulsory programme 65
2.6.5 The role of the school and a way forward 66
2.6.6 Expectations of the Department of Education 67
2.6.7 The responsibilities of school management and leadership 70
2.6.7.1 Preventative orientated management 71
2.6.7.2 Implementing a health and HIV & AIDS information bank 72
2.6.7.3 Rationale for an HIV & AIDS school policy 73
2.6.7.4 Function of an HIV & AIDS school policy 74
2.6.7.5 Discrepancy of an HIV & AIDS policy as to a "Rule Book" 74
2.6.7.6 The National Policy as a guide for an HIV & AIDS school policy 75
2.6.7.7 Expectations of the Department of Health 81

2.7 THE HIV & AIDS PROGRAMME AS PART OF LIFE ORIENTATION 82
2.7.1 The National Curriculum Statement as framework for Life Orientation 82
2.7.2 The nature of the subject Life Orientation 86
2.7.2.1 A definition of Life Orientation 86
2.7.2.2 The purpose and philosophy of Life Orientation 88
2.7.2.3 Focus areas and scope of Life Orientation 88
2.7.2.4 The importance of Life Orientation 91

2.8 ANALYSIS OF CONCEPTS 92
2.8.1 The concept "contextual" 93
2.8.2 The concept "factor" 93
2.8.3 The concept "influence" 93
2.8.4 The concept "implement" 94
2.8.5 The concept "HIV" 94
2.8.6 The concept "AIDS" 96
2.8.7 The concept "programme" 97
2.8.8 The concept "HIV & AIDS programme" 98

2.9 SUMMARY 98

CHAPTER 3

DESIGNING AND CONDUCTING THE EMPIRICAL RESEARCH

3.1 THE AIM OF THIS CHAPTER 99

3.2 INTRODUCTION 99

3.3 PARADIGMATIC APPROACH 100
3.3.1 An interpretivist and constructivist epistemology 100
3.3.2 A qualitative methodological approach 105

3.4 RESEARCH DESIGN AND METHODOLOGY 109
3.4.1 Instrumental case study design 109
3.4.2 Selection of participants 111
3.4.3 Convenience and purposive sampling 112
3.4.4 Data collection and documentation 115
3.4.4.1 Conceptual analysis 115
3.4.4.2 Analysis of primary and secondary sources 116
3.4.4.3 Semi-structured interviews 116
3.4.4.4 Field Observation 119
3.4.4.5 Visual data collection 120

3.4.4.6 Reflective journal 120
3.4.5 Data analysis and interpretation 122

3.6 QUALITY CRITERIA 124
3.6.1 Credibility 124
3.6.2 Transferability 126
3.6.3 Dependability 127
3.6.4 Confirmability 127
3.6.5 Authenticity 128

3.7 ETHICAL CONSIDERATIONS 129
3.7.1 Informed consent 129
3.7.2 Privacy, confidentiality and anonymity 130
3.7.3 Protection from harm 131

3.8 SIGNIFICANCE OF THE METHODOLOGICAL CHOICES FOR MY STUDY 131

3.9 METHODOLOGICAL CHALLENGES OF MY STUDY 132

3.10 SUMMARY 134

CHAPTER 4

REPORTING THE RESULTS OF THE STUDY

4.1 THE AIM OF THIS CHAPTER 136

4.2 QUESTION 1: WHAT IS YOUR POSITION AT THE SCHOOL? 137
4.2.1 The aim of Question 1 137
4.2.2 Interpretation of Table 4.1 138
4.2.3 Assumption regarding Question 1 139

4.3 QUESTION 2: WHAT IS YOUR HIGHEST QUALIFICATION? 140
4.3.1 The aim of Question 2 140
4.3.2 Interpretation of Table 4.2 140
4.3.3 Conclusions regarding Question 2 141

4.4 QUESTION 3: HOW LONG HAVE YOU BEEN A TEACHER? 141
4.4.1 The aim of Question 3 141
4.4.2 Interpretation of Table 4.3 142
4.4.3 Conclusions regarding Question 3 143

4.5 QUESTION 4: TO WHAT EXTENT ARE YOU INVOLVED IN HIV & AIDS PROGRAMMES IN YOUR SCHOOL? 144
4.5.1 The aim of Question 4 144
4.5.2 Interpretation of Table 4.4 145
4.5.3 Conclusions regarding Question 4 145

4.6 QUESTION 5: HAVE YOU ATTENDED ANY TRAINING SESSIONS, WORKSHOPS OR INFORMATION SESSIONS WITH REGARD TO HIV & AIDS? IF SO, WHERE, WHEN AND BY WHOM WERE THESE SERVICES RENDERED? 146
4.6.1 The aim of Question 5 146
4.6.2 Interpretation of Table 4.5.1 147
4.6.3 Interpretation of Table 4.5.2 148
4.6.4 Interpretation of Table 4.5.3 149
4.6.5 Interpretation of Table 4.5.4 150
4.6.6 Conclusions regarding Question 5 150

4.7 QUESTION 6: ON A SCALE OF 1 TO 5, HOW HIGH WOULD YOU RATE YOUR KNOWLEDGE WITH REGARD TO HIV & AIDS? 151
4.7.1 The aim of Question 6 151
4.7.2 Interpretation of Table 4.6 152
4.7.3 Additional information 153
4.7.4 Conclusions regarding Question 6 154

4.8 QUESTION 7: DO YOU AGREE OR DISAGREE WITH THE STATEMENT THAT HIV & AIDS CAN BE PREVENTED. IF YES, HOW? 155
4.8.1 The aim of Question 7 155
4.8.2 Interpretation of Table 4.7 157
4.8.3 Additional information 158
4.8.4 Conclusions regarding Question 7 158

4.9 QUESTION 8: WHAT IS YOUR VIEW WITH REGARD TO THE ROLE OF EDUCATION IN THE PREVENTION OF HIV & AIDS INFECTION? DOES EDUCATION HAVE A ROLE TO FULFIL IN PREVENTION? 159
4.9.1 The aim of Question 8 159
4.9.2 Interpretation of Table 4.8 161
4.9.3 Additional information 161
4.9.4 Conclusions regarding Question 8 162

4.10 QUESTION 9: WHICH ASPECTS DO YOU REGARD AS IMPORTANT WHEN DEALING WITH HIV & AIDS PREVENTION? 162
4.10.1 The aim of Question 9 162

4.10.2 Interpretation of Table 4.9 163
4.10.3 Additional information 164
4.10.4 Conclusions regarding Question 9 165

4.11 QUESTION 10: DOES YOUR SCHOOL PRESENT AN HIV & AIDS PROGRAMME TO THE LEARNERS? IF NOT, IGNORE QUESTION 10 AND PLEASE ANSWER QUESTIONS 11A TO 11D. 166
4.11.1 The aim of Question 10 166
4.11.2 Interpretation of Table 4.10 167
4.11.3 Conclusions regarding Question 10 167

4.12 QUESTION 11a: WITH REFERENCE TO QUESTION 10, WHY IS YOUR SCHOOL NOT IMPLEMENTING THE HIV & AIDS PROGRAMME? 168
4.12.1 The aim of Question 11a 168
4.12.2 Interpretation of Table 4.11 169
4.12.3 Additional information 169

4.13 QUESTION 11b: DO YOU REGARD THE IMPLEMENTATION OF THE HIV & AIDS PROGRAMME AS IMPORTANT? IF NOT, WHY? 170
4.13.1 The aim of Question 11b 170
4.13.2 Interpretation of Table 4.12 170
4.13.3 Additional information 171

4.14 QUESTION 11c: DO YOU THINK THE IMPLEMENTATION OF SUCH A PROGRAMME CAN MAKE A DIFFERENCE? 171
4.14.1 The aim of Question 11c 171
4.14.2 Interpretation of Table 4.13 172

4.15 QUESTION 11d: HOW CAN THESE CHALLENGES BE ADDRESSED IN ORDER TO FACILITATE THE IMPLEMENTATION OF SUCH A PROGRAMME IN YOUR SCHOOL? 172
4.15.1 The aim of Question 11d 173
4.15.2 Interpretation of Table 4.14 174

4.16 QUESTION 12: ARE YOU AWARE OF THE FACT THAT THE IMPLEMENTATION OF THE HIV & AIDS PROGRAMME IS COMPULSORY? 174
4.16.1 The aim of Question 12 174
4.16.2 Interpretation of Table 4.15 175
4.16.3 Conclusions regarding Question 12 175

4.17 QUESTION 13: REGARDING YOUR SCHOOL'S HIV & AIDS PROGRAMME, ANSWER THE FOLLOWING QUESTIONS: 176
4.17.1 The aim of Question 13 176
4.17.2 Interpretation of Table 4.16.1 177

4.17.3 Interpretation of Table 4.16.2 179
4.17.4 Interpretation of Table 4.16.3 181
4.17.5 Conclusions regarding Question 13 181

4.18 QUESTION 14: IN YOUR OPINION, WHAT IS THE IMPACT OF YOUR SCHOOL'S HIV & AIDS PROGRAMME? 182
4.18.1 The aim of Question 14 182
4.18.2 Interpretation of Table 4.17 184
4.18.3 Additional information 184
4.18.4 Conclusions regarding Question 14 186

4.19 QUESTION 15: WHICH RESOURCES FOR FACILITATING THE IMPLEMENTATION OF THE HIV & AIDS PROGRAMME ARE AVAILABLE IN YOUR SCHOOL? 186
4.19.1 The aim of Question 15 187
4.19.2 Interpretation of Table 4.18 189
4.19.3 Conclusions regarding Question 15 191

4.20 QUESTION 16: HOW IS THE HIV & AIDS PROGRAMME ACCOMMODATED WITHIN THE SCHOOL'S TIMETABLE? 191
4.20.1 The aim of Question 16 191
4.20.2 Interpretation of Table 4.19 192
4.20.3 Conclusions regarding Question 16 193

4.21 QUESTION 17: DOES YOUR SCHOOL HAVE AN OWN, UNIQUE SCHOOL POLICY ON HOW TO DEAL WITH HIV & AIDS RELATED ISSUES IN THE SCHOOL AND ON THE PLAYGROUND? 193
4.21.1 The aim of Question 17 193
4.21.2 Interpretation of Table 4.20 194
4.21.3 Conclusions regarding Question 17 195

4.22 QUESTION 18: CAN YOU DESCRIBE THE PROCESS THAT WAS FOLLOWED FOR DEVELOPING THE SCHOOL'S HIV & AIDS POLICY? 195
4.22.1 The aim of Question 18 195
4.22.2 Interpretation of Table 4.21 196
4.22.3 Conclusions regarding Question 18 196

4.23 QUESTION 19: ARE YOU AWARE OF OTHER SOURCES THAT WERE CONSULTED DURING THE DEVELOPMENT OF YOUR SCHOOL'S HIV & AIDS POLICY, FOR EXAMPLE EXPERTS, DEPARTMENTAL REQUIREMENTS, THE INTERNET OR BOOKS? 197
4.23.1 The aim of Question 19 197
4.23.2 Interpretation of Table 4.22 198
4.23.3 Conclusions regarding Question 19 198

4.24 QUESTION 20: WHO WERE THE STAKEHOLDERS THAT WERE INVOLVED IN DRAFTING YOUR SCHOOL'S HIV & AIDS POLICY? 199
4.24.1 The aim of Question 20 199
4.24.2 Interpretation of Table 4.23 200
4.24.3 Conclusions regarding Question 20 200

4.25 QUESTION 21: DOES YOUR SCHOOL'S HIV & AIDS POLICY DEAL WITH UNFORESEEN INCIDENCES THAT MAY OCCUR ON THE CAMPUS OF THE SCHOOL (ACCIDENTS WHICH COULD LEAD TO BLEEDING)? 200
4.25.1 The aim of Question 21 200
4.25.2 Interpretation of Table 4.24 201
4.25.3 Conclusions regarding Question 21 201

4.26 QUESTION 22: DOES YOUR SCHOOL MAKE PROVISION FOR/ALLOW OUTSIDERS SUCH AS LOVELIFE, SOUL BUDDYZ, THE DEPARTMENT OF HEALTH, COMMUNITY INSTITUTIONS, NGOs OR THE CLERGY TO PARTICIPATE IN OR PRESENT HIV & AIDS PROGRAMMES IN YOUR SCHOOL? 202
4.26.1 The aim of Question 22 202
4.26.2 Interpretation of Table 4.25 203
4.26.3 Additional information 203
4.26.4 Conclusions regarding Question 22 204

4.27 QUESTION 23: ARE YOU COMFORTABLE OR UNCOMFORTABLE ABOUT TALKING TO LEARNERS ABOUT SENSITIVE TOPICS SUCH AS. . . 205
4.27.1 The aim of Question 23 206
4.27.2 Interpretation of Table 4.26 208
4.27.3 Additional information 209
4.27.4 Conclusions regarding Question 23 210

4.28 QUESTION 24: ACCORDING TO YOU, WHAT ARE THE STRENGTHS AND WEAKNESSES OF THE IMPLEMENTATION PROCESS FOLLOWED BY YOUR SCHOOL? 211
4.28.1 The aim of Question 24 211
4.28.2 Interpretation of Table 4.27 213
4.28.3 Conclusions regarding Question 24 214

4.29 QUESTION 25: IF YOU WOULD BE ASKED TO ADVISE THE SCHOOLS IN SOSHANGUVE WITH REGARD TO IMPROVEMENT OF THE PROCESS OF HIV & AIDS PROGRAMME IMPLEMENTATION, WHAT WOULD YOUR ADVICE BE? 214
4.29.1 The aim of Question 25 214
4.29.2 Interpretation of Table 4.28 216
4.29.3 Conclusions regarding Question 25 217

4.30 CONCLUSIVE SUMMARY 217
4.30.1 Reflections on the findings of the study 217

CHAPTER 5

SYNTHESIS, FINDINGS AND RECOMMENDATIONS

5.1 THE AIM OF THIS CHAPTER 223

5.2 SYNTHESIS 223

5.3 FINDINGS REGARDING MY RESEARCH QUESTIONS 226
5.3.1 Secondary Question 1: What are the expectations of the Department of Education (as stipulated in the relevant policy) with regard to the HIV & AIDS programme and the implementation thereof in secondary schools? 227
5.3.2 Secondary Question 2: What significance do the School Governing Body, the school management team and the teachers attach to the HIV & AIDS programme and the extent to what opportunities are created and resources made available in order to adequately implement the programmes? 228
5.3.3 Secondary Question 3: How do school management teams and teachers perceive their respective responsibilities with regard to the implementation of an HIV & AIDS programme in their schools? 230
5.3.4 Secondary Question 4: What are the attitudes and lived-experiences of teachers with regard to the practical implications of the HIV & AIDS programme in the classroom? 231
5.3.5 Findings: a final conclusion 232

5.4 RECOMMENDATIONS 235
5.4.1 Recommendations for rectifying problems addressed in this study 235
5.4.2 Recommendations for further research 237

5.5 POSSIBLE CONTRIBUTIONS OF MY STUDY 237

5.6 POSSIBLE LIMITATIONS OF MY STUDY 238

5.7 A FINAL WORD (OR TWO) 239

5.8 REFERENCES 241

LIST OF DIAGRAMS

Diagram 2.1	The binary impact of HIV & AIDS on education	40
Diagram 2.2	Seven diverse roles of the teacher	68
Diagram 2.3	A triangular approach to management of HIV & AIDS programmes	72
Diagram 3.1	A schematic presentation of the research approach and design	102
Diagram 3.2	Epistemological perspective with regard to interpretivism and constructivism	108
Diagram 4.1	Key to abbreviations	137
Diagram 4.2	Summary: number of participants	139
Diagram 4.3	Visual presentation of the participants' years of experience	143
Diagram 4.4	Visual presentation of the involvement of the participants in the HIV & AIDS programmes in their schools	145
Diagram 4.5	Visual presentation of the participants' perceived level of knowledge with regard to HIV & AIDS	153

Diagram 4.6	Important aspects mentioned with regard to HIV & AIDS prevention	164
Diagram 4.7	Visual presentation of participants' opinions on the limited or no impact of HIV & AIDS programmes	185
Diagram 4.8	Reasons for feeling uncomfortable when dealing with sensitive topics	210
Diagram 4.9	Conclusive summary of the findings in Chapter 4	222
Diagram 5.1	A final conclusion on the relation between the findings and answering of the primary and secondary research questions	234
Diagram 5.2	Recommendations for improving HIV & AIDS programme implementation	236

LIST OF TABLES

Table 2.1	Learning outcomes for Life Orientation	89
Table 3.1	A summary of the participants in the sample	114
Table 3.2	The schedule for interviews conducted	119
Table 4.1	Number and positions of participants	138
Table 4.2	Participants' qualifications	140
Table 4.3	Participants' teaching experience	142
Table 4.4	A summary of the involvement of all the participants	144
Table 4.5.1	Training that participants in Case Study 1 had received	147
Table 4.5.2	Training that participants in Case Study 2 had received	148
Table 4.5.3	Training that participants in Case Study 3 had received	148
Table 4.5.4	Summary of participants' training	149
Table 4.6	Participants' self-perceived level of knowledge with regard to HIV & AIDS	151

Table 4.7	Participants' opinions on HIV & AIDS prevention	156
Table 4.8	Participants' opinion on the role of education in the prevention of HIV & AIDS	160
Table 4.9	Important aspects with regard to HIV & AIDS prevention in Case Studies 1, 2 and 3	163
Table 4.10	Implementation of an HIV & AIDS programme at school	166
Table 4.11	Reasons for not implementing the HIV & AIDS programme	168
Table 4.12	Participants' views on the importance or unimportance of the HIV & AIDS programme	170
Table 4.13	The difference that an HIV & AIDS programme makes	172
Table 4.14	Addressing challenges to the implementation of the HIV & AIDS programme in schools	173
Table 4.15	Compulsory development of an HIV & AIDS programme	175
Table 4.16.1	The HIV & AIDS programme in Case Study 1	177
Table 4.16.2	The HIV & AIDS programme in Case Study 2	178

Table 4.16.3	The HIV & AIDS programme in Case Study 3	180
Table 4.17	The impact of the schools' HIV & AIDS programmes	183
Table 4.18	Availability or unavailability of resources in Case Studies 1, 2 and 3	188
Table 4.19	Facilitation of the HIV & AIDS programme within the school's timetable	192
Table 4.20	Existence of a school policy on HIV & AIDS	194
Table 4.21	Process followed during the development of the school's HIV & AIDS policy	196
Table 4.22	Sources utilised for HIV & AIDS policy development in schools	197
Table 4.23	Involvement of stakeholders in drafting the HIV & AIDS school policy	199
Table 4.24	Provision made for unforeseen incidences in the school's HIV & AIDS policy	201
Table 4.25	Other stakeholders that were involved in the implementation of the school's HIV & AIDS programme	202
Table 4.26	Feeling comfortable or uncomfortable when dealing with sensitive topics	207

Table 4.27	Strengths and weaknesses in the schools' implementation of the HIV & AIDS programme	212
Table 4.28	Advice on how to improve the implementation of an HIV & AIDS programme in schools	215

LIST OF FIGURES

Figure 1:	Examples of unutilised Life Orientation resources	292
Figure 2:	Example of a Life Orientation classroom	293
Figure 3:	Examples of painted HIV & AIDS murals	293
Figure 4:	Examples of love Life involvement in the schools and community	294
Figure 5:	Library utilised as a staffroom	294
Figure 6:	An example of a school's HIV & AIDS policy	295
Figure 7:	Examples of the surroundings in Case Study 1	295

LIST OF ADDENDA

ADDENDUM A:	QUESTIONS FOR SEMI-STRUCTURED INTERVIEWS	261
ADDENDUM B:	ETHICAL CLEARANCE CERTIFICATE FROM THE RESEARCH ETHICS COMMITTEE OF THE UNIVERSITY OF PRETORIA	273
ADDENDUM C:	PERMISSION FROM THE GAUTENG DEPARTMENT OF EDUCATION TO CONDUCT RESEARCH IN SCHOOLS	274
ADDENDUM D:	REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT THE SCHOOL	276
ADDENDUM E:	PARTICIPANT'S INFORMATION LETTER AND INFORMED CONSENT FORM	278
ADDENDUM F:	FIELD OBSERVATIONS AND REFLECTIVE JOURNAL	279
ADDENDUM G:	COLLECTED VISUAL DATA	292

CHAPTER 1

INTRODUCTION AND ORIENTATION

1.1 THE AIM OF THIS CHAPTER

The aim of this chapter is to outline the intended study in which an attempt will be made to identify contextual[1] factors within secondary schools that influence the implementation of HIV & AIDS prevention programmes[2]. A more detailed investigation with regard to aspects such as the views and experiences of, for example, principals, members of school management teams and teachers[3], will also be undertaken.

1.2 INTRODUCTION AND ORIENTATION

In order to provide a clear exposition against which this study must be read, the following discussion aims at informing the reader with regard to the background and status quo that gave rise to the necessity to investigate the issue of the implementation (or lack) of HIV & AIDS prevention programmes in schools.

Epidemics differ from one another and can reveal unique characteristics with regard to the speed and extent of their development and growth (Van Rooyen 2001:12). The HIV & AIDS epidemic[4] in Europe and America differs greatly from, for example, the South African epidemic. A typical difference in this regard is, for example, the infection rate among the 14-29 year age group

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[1] The term 'contextual' refers to the specific circumstances or background in which a particular event occurs (Reader's Digest Universal Dictionary 1989:343). For the purposes of this study the term 'contextual' will refer to the specific circumstances or background in a school that influence the implementation of HIV & AIDS prevention programmes.
[2] Refer to paragraph 2.8 in Chapter 2 for an analysis of the concepts used in this study.
[3] For the purposes of this study the term 'teachers' will refer specifically to teachers who teach Life-Orientation as a subject.
[4] Regarding the use of the words 'pandemic', 'epidemic', and 'endemic' refer to paragraph 2.2.1.

that is much higher in South Africa than in Europe and America (UNAIDS 2006:7). Other unique characteristics with regard to the South African situation are an urban bias, with urban:rural figures of 5-10:1; gender differences – a male:female ratio of 0.7:1; a disproportionate effect on the middle class early in the epidemic, but an even distribution amongst economic groups as the epidemic progresses; and an increasing number of HIV & AIDS orphans (UNAIDS 2006:7-12). Having taken cognisance of these characteristics, and especially the fact that the above-mentioned age group represents learners in South African secondary schools (grades 8 – 12), I continuously asked myself the following question: *What are secondary schools*[5] *doing to address the situation?*

South Africa is regarded as a Stage 3 country[6] with regard to the stages of an epidemic (UNAIDS 2002b:3). The HIV & AIDS epidemic is currently spreading more rapidly in South Africa than ever before (Statistics South Africa 2006:3), institutions are closing down, public services are suffering, the death rate is rising significantly, an increasing number of children are orphaned and terminally ill (UNAIDS 2002a:8; Department of Health 2005:62), and some of the isolated villages in rural areas are in a process of vanishing (UNAIDS 2002a:7). These findings can be ascribed to the unique socio-economic problems that prevail in this part of Africa, such as under-development, poverty, unhealthy life styles, high-risk behaviour patterns, social chaos, moral deterioration, natural disasters and violence (UNAIDS 2002b:3).

Having interpreted the above facts and statistics, I am of the opinion that the following factors may further contribute to the disastrous level of the HIV & AIDS epidemic in South Africa:

[5] For the purposes of this study any reference to "schools" in the text will mean "secondary schools".

[6] In general an epidemic progresses through three sequential stages. Although different epidemics might reveal the same progressive pattern, each epidemic remains unique with regard to the speed and extent of its development and progression (UNAIDS 2002b:3).

- A lack of government commitment, infrastructure and resources.
- A hesitancy and often overt refusal of School Governing Bodies (hereafter referred to as SGB's), school principals, managerial teams and/or teachers to implement or become involved in the prescribed and compulsory governmental HIV & AIDS programmes, regarding the epidemic as "someone else's problem".
- Insufficient teacher training.
- Opportunistic fly-by-night "experts" on, and presenters of HIV & AIDS programmes to young learners, often without any norms and values.
- Presenters who do not know the difference between moralistic (judgemental) presentations on the one hand, and on the other hand values and ethics education that is based on the Manifesto on Values, Education and Democracy (Department of Education 2001c:1), and on other relevant universal values such as the value of privacy, the value for life, and self-control.
- Personal resentment towards presentation of prescribed content in schools.
- Lack of the necessary understanding of the seriousness of the disease.
- Lack of a personal commitment to change individual behaviour.

In South Africa, 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 that the epidemic shows no signs of declining (UNAIDS 2006:17; Statistics South Africa 2006:4). In this regard a National HIV Survey revealed that approximately 11,1 % of the total population (5.5 million people) were already living with HIV & AIDS (Statistics South Africa 2007:2; UNAIDS 2007:9). More people are infected every three days in South Africa than the total number of deaths on 9/11 in New York (UNAIDS 2007:9).

The total number of children that are HIV infected in South Africa is estimated at 240 000 (Department of Health 2005:64). The highest HIV infection rate in

South Africa occurs among the age group 15-24 years. An estimated 18.8% of people between the ages of 15-49 years are currently living with HIV & AIDS, while 70% of all deaths in this age group are ascribed to AIDS. In South Africa HIV & AIDS will have killed two thirds of the adolescents that are currently 15 years old, by the year 2015 (Statistics South Africa 2007:2).

1.3 RELEVANCE OF THIS STUDY

Keeping the above facts in mind, it appears that the rate of infection is increasing and that the HIV & AIDS epidemic, with no evident cure in the near future, is mounting its impact.

Experts commonly hold the view that HIV infection can be prevented through education and positive changes in sexual behaviour (Department of Education 2000:39; Kelly, Parker & Oyosi 2002:20; Badcock-Walters & Whiteside 2003:3; Department of Education 2003d:13). Even though a significant number of education programmes are being presented to young children and adults in schools and society in South Africa (in this regard refer to paragraph 2.2), research indicates that the HIV infection rate is increasing. Although prevention strategies have been in place since 2001 (UNAIDS 2002b:47), the prevalence rate remains unacceptably high in South Africa, while research indicates that a mere 18% of schools are following a Sexuality Education programme with HIV & AIDS as a core component (Rademeyer 2003:2; Mathews, Boon, Flisher & Schaalma 2006:389).

I find it unacceptable that schools are not following the prescribed programmes and I am convinced that this fact is an outcome of one or more significant causes. Do SGB's, management teams and parents not consider the programme to be important? Don't they realise that it is a matter of life and death? Or can it be that the teachers do not feel competent and sufficiently trained to deal with such sensitive matters in the classrooms? Can it be that they do not feel comfortable with their own sexuality or perhaps

have unsolved issues that could prevent them from being open and honest with the learners? What are the contextual factors that influence the implementation of HIV & AIDS programmes in schools? Considering the state of affairs, isn't it high time that research be undertaken to identify, explore and explain the contextual factors that negatively influence the implementation of HIV & AIDS programmes in schools? I am convinced that such a study can contribute to the alleviation of this negative state of events!

The spread and the rising incidence of HIV & AIDS are damaging our society and our education system. Many schools are already experiencing great difficulties, and school communities no longer depend on healthy learners, stable families, competent teachers or a strong economy (Department of Education 2005:64). If the infection rate continues to escalate and the projected mortality rates, especially among young people (adolescents), become a reality, it may have further devastating long term consequences for South Africa.

In view of the specific nature and prevalence of the disease, as I have discussed above, I make the assumption that the current strategies for preventing the high rate of HIV & AIDS infection amongst the 15-24 year old age group are not successful, or are not successfully being implemented as far as school programmes are concerned.

1.4 STATING OF THE RESEARCH PROBLEM

It is within this framework that teachers are confronted with the escalating threat of HIV & AIDS. I am convinced that for HIV & AIDS education to be effective, the curriculum must include more than knowledge and information. In their study, Palmer, Boardman and Bauchner (1996:301) found that even though children seemed to have a considerable amount of knowledge with regard to HIV & AIDS, they were unable to apply this knowledge by displaying appropriate behaviour when presented with hypothetical situations

in class. These authors propose that HIV & AIDS educational programmes should encourage children to think and to discuss issues, thereby enabling them to incorporate knowledge into future behaviours.

According to Kistner, Eberstein, Quandnago, Sly, Sittig, Balthozor, Castro and Osborne (1997:294), HIV & AIDS education programmes need to be carefully designed to ensure that the programmes are tailored to meet the needs of children in respect of their ages, races and communities. They found that these variables also influence children's attitudes toward persons living with HIV & AIDS. They further state that another potential influence on children's beliefs with regard to HIV & AIDS is their parents' beliefs and attitudes with regard to HIV & AIDS and people living with the disease.

Although prevention strategies have been in place for several years, the prevalence rate remains unacceptably high in South Africa. What can be done? Why are schools not implementing the prescribed programmes and policies? What is hindering the actual implementation of programmes and policies?

With these questions in mind, the research problem of this study can be formulated as follows: **In what manner do contextual factors influence the implementation of HIV & AIDS programmes in South African schools?**

The primary research question, as stated in the previous paragraph, can inter alia be differentiated into the following secondary questions:

- What are the expectations of the Department of Education (as stipulated in the relevant policy) with regard to the HIV & AIDS programme and the implementation thereof in secondary schools?
- What significance do the School Governing Body, the school management team and the teachers attach to the implementation of the HIV & AIDS

programme and to what extent are opportunities created and resources made available in order to adequately implement the programme?

- How do school management teams and teachers perceive their respective responsibilities with regard to the implementation of the HIV & AIDS programme in their schools?
- What are the attitudes and lived-experiences of teachers with regard to the practical implications of the HIV & AIDS programme in the classroom?

1.5 THE PURPOSE OF THIS STUDY

In the light of the primary and secondary research questions formulated above, the primary aim of this study will be to identify and investigate contextual factors within secondary schools[7] that might influence the implementation of HIV & AIDS programmes, by inquiring into the experiences of teachers that are responsible for implementing HIV & AIDS programmes in schools.

In order to conduct this research and to achieve the primary aim of this study as formulated above, it is necessary to answer secondary questions. These questions can be translated into the following secondary aims of this study:

- To determine what the expectations of the Department of Education are with regard to the implementation of HIV & AIDS programmes in schools.
- To determine the significance that the SGB, school management team and teachers attach to the implementation of an HIV & AIDS programme.
- To determine to what extent opportunities are created, and resources made available, in order to implement an HIV & AIDS programme in the school.
- To ascertain the manner in which school management and teachers perceive their respective responsibilities with regard to the implementation of an HIV & AIDS programme in their schools.

[7] For the purposes of this study, certain secondary schools in a demarcated semi-urban area (Soshanguve) will be selected. (In this regard also refer to paragraph 1.6).

- To determine the attitudes and lived-experiences of teachers with regard to the practical implications of the HIV & AIDS programme in the classroom.

1.6 DELIMITATION OF THIS STUDY

This study will focus on the identification and investigation of the contextual factors that influence the implementation of the HIV & AIDS programme (as part of the Life Orientation Learning Area) in Soshanguve.

1.7 EPISTEMOLOGICAL COMMITMENT AND PARADIGMATIC PERSPECTIVE

In order to provide a general orientation and essential background with regard to the rest of my study, I shall now provide a brief delineation of my selected paradigm, methodological choices and methodological process. An elaboration on these aspects is done in Chapter 3.

1.7.1 Knowledge claim

I regard science as a search with a view to understanding a phenomenon and believe that there is no single truth to be discovered (Mouton 2001:138). People ascribe meaning to 'own truth' in their quest to understand phenomena. I therefore regard knowledge to be based on two epistemological theories, namely interpretivism and constructivism (Donald, Lazarus & Lolwana 2002:173; Sexton 1997:3).

Although epistemological research has the comprehensive goal of searching for knowledge that is truthful, I agree with Mouton (2001:138) who warns that it is impossible to produce scientific results that are absolutely true for all times and contexts. I am also of the opinion that all knowledge and "truths" are relative to the contexts of their application. I shall therefore focus on

generating knowledge that is truthful to the contextual realities within the social realm of education that influence the implementation of HIV & AIDS programmes in secondary schools.

1.7.2 Paradigmatic perspective

I shall conduct this study within the constructivist and interpretivist paradigms and therefore construct my own understanding from the understanding with which the participants construct their reality. According to McMillan and Schumacher (2001:396), the constructivist philosophy assumes "reality as multilayered, interactive, and a shared social experience interpreted by individuals". With regard to this study, the school in society and the manner in which it succeeds in the implementation of HIV & AIDS prevention programmes, will be viewed as an important role-player within the multilayered reality of society. Donald *et al.* (2002:174) state that constructivism is a view that sees knowledge as actively constructed by individuals, groups and societies, and not merely as something that is simply transferred.

Constructivism means to interpret or analyse in a manner that places emphasis on a person's active creation and building of meaning and significance (Sexton 1997:4). In view of the aim of identifying, exploring, describing and explaining contextual factors that influence the implementation of HIV & AIDS programmes, constructivism may provide a framework for interpreting and analysing the manner in which the teachers respond to the consequences of contextual factors that negatively impact on implementation efforts in schools. According to Schwandt (1998:223), interpretivists emphasize the permanence and priority of the real world of first-person, subjective experience. In this study this refers to the experiences of teachers that are responsible for implementing HIV & AIDS programmes in secondary schools.

Schwandt (1998:222) further clarifies the manner in which research is integrated within the constructivist and interpretivist paradigms. The constructivists and interpretivists presume that, to understand this world of meaning, it must be interpreted. The researcher must clarify the process of meaning construction and shed light on what and how meanings are embodied in the language and actions of social actors. To prepare an interpretation is to construct a reading of these meanings; it is to offer the inquirer's construction of the constructions of the actors one studies (Schwandt 1998:223).

In view of the above it is presumed that teachers and school management teams construct their own meaning with regard to the implementation of HIV & AIDS programmes in their school's context, based on their interpretations of what it entails to implement such a programme, which then relates to whether the programme is implemented or not. The teachers' interpretations of what the implementation of an HIV & AIDS programme entails are, in turn, constructed through their active participation in a social world filled with its own meanings and constructions of an HIV & AIDS programme.

Hayes and Oppenheim (1997:21) formulate the following common principles for a constructivist approach, such as that development is contextual, individuals are producers of their own development, cognition is an active relating of events, and that meaning-making is self-evolution. As a constructivist researcher, I shall engage in a search for the deep structure that underlies the construction of meaning as expressed in specific societal phenomena and actions, that is I will engage in a deep search for contextual factors within schools that influence the implementation of HIV & AIDS programmes (Hayes & Oppenheim 1997:33). These statements support my idea that teachers who are responsible for the implementation of the HIV & AIDS programme will construct their own understanding of what the implementation entails (in their particular contexts), which is then related to contextual factors that are present in the contexts of their schools.

1.8 METHODOLOGICAL APPROACH

I shall now highlight my methodological approach in order to orientate the reader with regard to the expectations and methodology of this study. This study aims at exploring a phenomenon, namely the contextual factors that influence the implementation of the HIV & AIDS programme in schools. However, various secondary aims will guide the inquiry (in this regard refer to paragraph 1.4 above).

1.8.1 Qualitative research approach

In the light of the primary aim of this study, that is to identify and investigate the experiences of teachers with regard to the implementation of the HIV & AIDS programme in schools, I prefer to follow a qualitative research approach. According to Ericson (1986:125), qualitative research design aims at gaining greater insight into man's situation. The qualitative approach may provide me with an opportunity to gain insight into the subjective experiences of individuals or groups with sensitivity regarding the contexts in which they interact with each other. Garbers (1996:15) adds that the qualitative approach places an emphasis on better understanding of human behaviour and experiences. Within the qualitative framework, the influence of relative factors on social relationships is also considered. I am convinced that a qualitative research approach will provide me with an understanding of the manner in which contextual factors influence the implementation of an HIV & AIDS programme from the participants' points of view (MacMillan & Schumacher 2001:16).

Parker, Dalrymple and Durden (2000:82) also state that qualitative research is concerned with trying to understand meaning and influence in a more multifaceted way. I believe that I might identify unanticipated information by means of my qualitative research approach, since the discussion is not limited by predetermined closed questions. A qualitative approach may therefore

provide me with vivid information with regard to the manner in which the teachers feel, think and act, as well as what they believe regarding the implementation of an HIV & AIDS programme in their schools. I concur with Willig (2001:15) as he points out that qualitative research provides the researcher with an opportunity to study meanings.

1.9 RESEARCH METHODOLOGY AND DESIGN

I shall now focus the discussion on the research methodology and design in order to orientate the reader with regard to the methodological expectations of my study.

1.9.1 Instrumental case study design

For the purpose of this study, I prefer to follow an instrumental case study design. An instrumental case study design with regard to scientific research will allow me to obtain an in-depth description of the lived-experiences of my research participants. According to Stake (2000:437), such a design type aims at providing insight into a specific issue or phenomenon.

I foresee that the data in my case studies will be hybrid by nature, consisting of new and existing information. There is, however, a low degree of structure in the design itself (Mouton 2001:149). I prefer this design, as it complements the exploratory and inductive approach and is consistent with the aim of identifying and investigating the experiences of school management teams and teachers that influence the implementation of the HIV & AIDS programme.

An instrumental case study design is selected with the main purpose of answering my research question, and in order to gain insight into the underlying issue, rather than the cases themselves (Bergen & While 2000:45; Stake 2000:438; Berg 2001:68; Cohen, Manion & Morrison 2003:183). This

may provide me with a clear understanding of the manner in which contextual factors influence the implementation of HIV & AIDS programmes. I assert that the purpose of this instrumental case study design is to support me in order to obtain a deeper understanding of any possible external theoretical questions or problems (Berg 2001:225). Although I shall investigate the selected cases, analyse their contexts, and describe their regular implementation activities in detail (Stake 2000:439), these activities will merely serve a supportive role during which the actual research interest (primary question) can be explored. I further believe that, by applying an instrumental case study design, I might obtain elaborate descriptions of the experiences of school management teams and teachers who implement HIV & AIDS programmes.

In choosing an instrumental case study design, I can rely on the advantage of not only understanding the important issues about my particular research, but also highlighting other critical issues at hand (Stake 2000:439). Further characteristics of an instrumental case study design that I find advantageous are that it will force me to constantly reflect on and revise meanings and impressions that I gain. Although I acknowledge that generalization will be limited, I shall be able to provide detailed, in-depth information and material for readers to discover on their own that which even I may not know, as well as refine theory and encourage hypotheses and successive studies (Stake 2000:440; Berg 2001:231).

Some of the challenges and limitations of an instrumental case study design that I have to keep in mind are as follows: generalizations cannot be made from a single or a few case studies; causal links are difficult to test as they are prone to problems of observer bias and they may be subjective, personal, selective and biased (Terre Blance & Durrheim 2002:133; Cohen *et al.*, 2003:184). Having taken cognisance of these challenges, it is important for me to keep in mind that the purpose of the proposed study is to present the case, which is the contextual factors that influence implementation of HIV &

AIDS programmes in secondary schools in Soshanguve, and not anywhere else in the world.

1.9.2 Selection of participants

McMillan and Schumacher (2001:39) state that data collection techniques refer to the specific skills and actions that are performed in order to gain information on the problem that is being investigated. Several practical skills are required for collecting data when conducting scientific research. The most important will be selecting a reliable sample of literature and participants for this study, in order to ensure that it is directly, or as closely as possible, related to the reality of contextual factors that influence the implementation of HIV & AIDS programmes in secondary schools.

In the light of the fact that it will be difficult to interview every teacher that is responsible for implementing HIV & AIDS programmes, a sample population will be selected by means of a convenience sampling technique.

1.9.3 Convenience sampling

Convenience sampling (also referred to as accidental or opportunity sampling) requires of me to choose the nearest individuals to serve as participants, and to continue the process until the required sample size has been obtained (Cohen *et al.*, 2003:102).

McMillan and Schumacher (2001:176) declare that in research on effective programme implementation, it may be most informative to select expert or master teachers rather than a sample of all teachers. Patton (2002:230) states that convenience sampling is the selection of information-rich cases for obtaining an in-depth understanding.

Three Soshanguve schools will be conveniently selected for the purpose of this research, as the researcher is currently a teacher at a secondary school in Soshanguve. The choice of schools within the vicinity will enhance accessibility to the research participants, as well as to suitable facilities to complete semi-structured interviews.

A number of twelve participants will further be purposively selected from the conveniently selected schools. Two identified teachers in each school that have been trained as "Master Trainers" by the Gauteng Department of Education, with reference to the implementation of HIV & AIDS programmes, will form part of the sample population for this study. These "Master Trainers" are nominated teachers from secondary schools that had been trained by their respective School Districts with regard to HIV & AIDS education. These teachers had attended a four-day training course in order to enable them to implement the HIV & AIDS education programme. It was expected that these teachers (Master Trainers) would then provide the same training to colleagues of their own schools as well as neighbouring schools in their cluster. The remaining participants will be the respective principal and members of the school management team (head of department for Human and Social Sciences) of each selected school.

These teachers are selected because of their special interest in the HIV & AIDS programme in schools and the specialised training that they have received from the Gauteng Department of Education. These participants are chosen because they are likely to have specialised knowledge and information with regard to the implementation of HIV & AIDS prevention programmes.

1.9.4 Data collection

In order to add depth and richness to the proposed study, I shall use multiple data collection methods. Janesick (2000:288) refers to the use of multiple methods of data collection as the process of crystallization that is used to add

and reflect different nuances to the gathered data. In the light of the qualitative paradigm and instrumental case study design, as discussed in paragraphs 1.8 and 19.1, the following data collection methods may provide the most reliable responses and contribute to the quality of the data:

1.9.4.1 Conceptual analysis

For the purposes of my study, the aim of the conceptual analysis as a non-interactive qualitative mode of inquiry is to describe the meanings, use and application of concepts in the study. It will be a process of separating the combined units of something (terms or concepts) in order to examine and describe them. When applying conceptual analysis as a method, I shall make an effort to "take apart, revisit, reconsider, study and describe" the different meanings of concepts, in order to provide clear perspectives on the problem that I am investigating (McMillan & Schumacher 2001:39).

1.9.4.2 Analysis of primary sources

In this study, I shall analyse primary sources, which to me will refer to original documentation or the remains thereof, such as report from persons that have participated in events relevant to this study, or were eyewitnesses to such events. In my study, "remains" will refer to sources that have been preserved intentionally to supply information, for example official minutes, articles and correspondence.

1.9.4.3 Analysis of secondary sources

The secondary sources that I shall utilize in this study, will for example consist of reports from people that were not eyewitness to, or part of, an event – but only reported what the person, who was physically part of an event, had said or wrote. I also regard textbooks, encyclopaedias, dissertations and theses as secondary sources.

1.9.4.4 Semi-structured interviews

Merriam (1998:74) states that semi-structured interviews ensure flowing discussions and in-depth knowledge with regard to the researched phenomenon. I shall therefore conduct semi-structured interviews with teachers responsible for Life-orientation and/or HIV & AIDS programmes, as well as the principal and head of department for Human and Social Sciences in the three selected schools. Semi-structured interviews will allow for flowing discussions, and will enable me to gain in-depth insight with regard to the participants' lived-experiences during the implementation and presentation of HIV & AIDS education programmes. The personal experiences and perceptions of the teachers will provide me with valuable information with regard to the phenomenon under investigation (O'Donoghue & Punch 2003:57).

From an interpretivist perspective, the interviews will provide me with the teachers' perspectives and experiences. I base this on the assumption that the research participants are able to provide me with clear perspectives that are knowable and significant. Through the interviews, I should therefore be able to determine the participants' knowledge, values and preferences, as well as their attitudes and beliefs (Patton 2002:306; Cohen *et al.*, 2003:268).

I concur with Babbie and Mouton (2001:278) as well as McMillan and Schumacher (2001:269), that a qualitative interview is an interaction between the researcher and a research participant, during which the researcher has a general plan of inquiry for the interview, but not a detailed set of questions that must be asked in particular words or in a particular order. I view a qualitative interview as a conversation during which topics may be raised by the participant while I (as the interviewer) can determine a general direction, to obtain research-relevant information. For the purpose of this study, I shall use open-ended questions with the intention of providing opportunities for the participants to share their personal experiences, opinions and beliefs (Cohen

et al., 2003:271; Schurink 1998:300). With their permission I shall tape-record and then transcribe the interviews with the aim of performing the first level of analysis. Using recorded data will give me of the advantage of being able to correct possible limitations regarding intuition and recollection (Silverman 1994:119).

1.9.4.5 Field Observation

Field observation is regarded as fundamental to most qualitative research (McMillan & Schumacher 2001:41). During the interviews, I shall note down detailed descriptions of events, people, actions, and objects in the setting (school). I shall record these observations in detail during and as soon as possible after an interview, to paint a vivid picture that also includes non-verbal signals during verbal conversations.

1.9.4.6 Visual data collection

I want to include the use of visual data as part of my data collection process, mainly as a means of data capturing. This method of qualitative research will provide me with records of the activities of the participants, and might enable the collection of information that could be difficult to obtain otherwise (Cohen *et al.*, 2003:279; Creswell 2003:187), regarding non-verbal communication, that could be missed during interviews. The use of visual data in addition to interviews may contribute to the richness of my data. By applying a visual data collection method, the potential partiality regarding observations of a single event can also be surmounted, as well as the possible tendency towards only recording frequently occurring events (Cohen *et al.*, 2003:313).

1.9.4.7 Reflective journal

In addition to the methods discussed above, I shall keep a reflective journal in order to capture and reflect on my experiences, perceptions and

interpretations. Bogdan and Biklen (1992:122) identify aspects that could be included in such a journal. These aspects include reflection on the methods used during the process of data collection and analysis; the researcher's own reactions to observations and recordings; as well as ethical issues, tensions and challenges experienced during the inquiry.

I am certain that a thorough and meticulously kept journal will also contribute to the richness of my data. The use of a journal will also enable me to reflect on the practicalities of my fieldwork and on emergent interpretations of the significance of the collected data. My journal will be a systematic attempt to facilitate the interpretative process that is at the heart of qualitative research (Ezzy 2002:72).

1.9.5 Data analysis and interpretation

According to Mouton (2001:108-109), data analysis is done with the intention to understand the different constitutive elements of the data by means of an inspection of the relationship between concepts, constructs and variables, to uncover any possible patterns or trends that can be isolated, and to establish themes in the data. The interpretation of the collected data entails the synthesis of data into larger coherent wholes.

Hatch (2002:148) states that data analysis is a systematic search for meaning, a way to process qualitative data so that what has been learned can be communicated to others. I shall analyse my data systematically by means of thematic analysis (refer to Diagram 4.9 in Chapter 4). The data will be inductively analysed in order for me to identify recurring patterns or common themes that are evident across the data (Merriam 1998:7). Most importantly, I shall aim to gain insight into the fundamental nature of the lived-experiences of my participants with regard to the implementation of HIV & AIDS programmes (O'Donoghue & Punch 2003:47). I shall commence with data analysis after the interviews have been transcribed verbatim. I envisage

that the data will initially present themselves in a confusing and illogic manner. I shall proactively identify a controllable index of categories (themes) in order to identify contextual factors that might influence the implementation of HIV & AIDS programmes (Mouton 2001:109).

Thereafter, I shall consult the participants in order to verify the accuracy of the collected data. I trust that this will enhance the authenticity and dependability of the findings (Cohen *et al.*, 2003:164), based on the assumptions of interpretivism and constructivism. Participant evaluation (or member checking) is significant and valuable, as the participants may wish to include additional information or even propose an alternative way of conveying the issue at hand. According to McMillan and Schumacher (2001:410), member checking can also be done during an interview, as topics are rephrased and explored to gain more comprehensive and accurate meanings.

1.9.6 Quality criteria

According to Babbie and Mouton (2001:271), the basic argument of trustworthiness is that of how researchers can convince their audiences that the findings of the study are worth paying attention to, or worth talking about. In relation to this, Denzin and Lincoln (2000:21) explain that terms such as 'credibility', 'transferability', 'dependability' and 'confirmability' replace the customary positivist criteria of internal and external validity, reliability and objectivity. Cohen *et al.* (2003:108) include 'authenticity' as a strategy to increase the trustworthiness of research.

1.9.6.1 Credibility

The aim with regard to credibility is to provide a true picture of the phenomenon under scrutiny (Poggenpoel 1998:351; Babbie & Mouton 2001:276)

I shall ensure credibility by means of the data analysis that I apply. I shall consider multiple perspectives, including member checking. I shall supplement this by making use of crystallization, as well as through thorough literature control. Frequent debriefing sessions with my study supervisor will further add to the richness and credibility of the findings (Babbie & Mouton 2001:277).

1.9.6.2 Transferability

According to Babbie and Mouton (2001:277), transferability is the extent to which the findings of a study can be applied to other respondents in other contexts. Due to the fact that meanings fluctuate across different contexts of human interaction, I shall aim at transferability rather than to generalising findings, by providing sufficiently rich, descriptive information with regard to the phenomenon under investigation, as well as about the meanings that develop during the investigation.

In the light of the interpretivist stance in this study, I shall aim to obtain the different inferences of each data source, therefore presenting a rich description of the data collected. Each piece of obtained information will render its own interpretation of what has been discovered.

1.9.6.3 Dependability

Dependability in research provides an indication of whether or not the findings would be the same if the study was replicated in the same (or a similar) context or with the same participants (Babbie & Mouton 2001:278). According to Guba and Lincoln (in Babbie & Mouton 2001:278), a display of credibility seems to be sufficient to establish the existence of dependability.

As mentioned earlier, the aim of my study is not to generalise, but rather to gain an in-depth understanding of contextual factors that influence the implementation of HIV & AIDS programmes in schools. The fact, that I shall obtain contributions from other persons during the data analysis, namely the supervisor of my study as well as through the participants involved, strengthens the possibility of the findings being fairly dependable and probably comparable to findings about similar groups of people and contexts. In addition, I shall provide a highly detailed methodological description to facilitate repetition of the study in similar contexts (Shenton 2004:71).

1.9.6.4 Confirmability

According to Babbie and Mouton (2001:278), confirmability is the degree to which the findings are the product of the focus of research, and not of the biases of the researcher. Freedom from bias in research is contradictory to the underlying assumptions of the interpretivist and constructivist approaches, according to which the values and motives of the researcher do play an essential part in the research process.

Scientific research, especially on sensitive issues such as HIV & AIDS, gender and sexuality requires strict self-control from the researcher. I shall regard confirmability as more important than being dispassionate or unbiased in the collection and interpretation of facts, and be careful not to tailor personal conceptions to fit my own preconceived notions or preferences. Research integrity will necessitate that I overcome personal and prejudicial attitudes, personal preconceptions and value judgements, and not be subject to traditional or "received systems" of thinking (Cohen *et al.*, 2003:129). I shall take care not to pursue only the apparent and obvious ideas and discoveries, but I shall also consider the inexplicable or complex ones according to the significance they have for answering the primary question of this study.

1.9.6.5 Authenticity

I regard authenticity as the ability of research to report a situation through the eyes of the participants (Cohen *et al.*, 2003:108). In my attempt to ensure authenticity, I shall make use of member checking and multiple data collection methods, in order to ensure fairness and provide a comprehensive and balanced representation of multiple realities with regard to the implementation of HIV & AIDS programmes in schools. I aim to ensure ontological authenticity by providing a fresh and more sophisticated understanding of the implementation of HIV & AIDS programmes in schools. I shall attempt to provide a clearer understanding of the challenges (contextual factors) that teachers experience, aiming at eventually improving the implementation of HIV & AIDS programmes in schools, and thereby ensuring catalytic authenticity in my research.

1.9.7 Ethical considerations

Due to the social nature of this research, I am aware that I not only have a responsibility towards my profession in the search for knowledge and truth, but also towards the research participants (Strydom 1998:25; Cohen *et al.*, 2003:292). The manner in which I conduct my research will at all times aim to preserve the dignity of the participants. This implies that I shall meticulously follow the ethical procedures of the University of Pretoria.

1.9.7.1 Informed consent

In the light of the sensitive nature of gathered information and discussions that might occur, I shall obtain permission from the relevant authorities, such as the Gauteng Department of Education, the relevant school principals, and teachers (in this regard refer to Addenda C and D regarding permission to conduct research, and Addendum E for the various letters of informed consent). This implies that the research participants will have the right to

choose whether, or not, to participate in the research study after being informed of facts that might influence their decisions (McMillan & Schumacher 2001:421; Cohen *et al.*, 2003:292). I shall provide the research participants with adequate information on the purpose of the study, the procedures I shall follow, as well as the possible advantages of the outcomes of the study. The right of participants to withdraw from the study at any time will also be emphasised.

1.9.7.2 Privacy, confidentiality and anonymity

I shall apply the principle of privacy, meaning that I shall ensure and protect the confidentiality and anonymity of the participants at all times (Strydom 1998:28; McMillan & Schumacher 2001:422; Cohen *et al.*, 2003:292). An advantage of protecting the privacy of participants is that it will ensure the attainment of maximum response during interviews. I shall not disclose the identities of the research participants during the study and shall deal with all information obtained during the research process in a confidential manner. I plan to preserve all field notes, visual material, transcripts and other data in a safe environment, and to destroy them only after the stipulated time has expired.

1.9.7.3 Protection from harm

In order to protect participants from harm, I shall try to avoid or at least recognise and communicate probable risk to the participants, such as exposure to psychological, physical or social harm (Strydom 1998:33; Berg 2001:232). I shall adhere to the principles of caring and fairness, as mentioned by McMillan and Schumacher (2001:422), with the intention of protecting participants from harm. At this stage of my research, I anticipate that the participants may be afraid of being labelled as informants who divulge sensitive information with regard to the implementation of HIV &

AIDS programmes in their schools. In order to avoid possible social harm, I shall assure the participants of their privacy and anonymity.

1.10 SIGNIFICANCE OF THIS STUDY

I am convinced that the identification of contextual factors and a description of the manner in which they influence the implementation of HIV & AIDS programmes may contribute to the improvement of curriculum delivery to learners. I anticipate that my study will contribute new knowledge with regard to contextual factors that influence the implementation and management of curricula in schools. In addition, this study could inform policy developers with regard to shortcomings in the current HIV & AIDS school policy and eventually result in the improvement of the programmes in schools. This study could also have significance regarding the improvement of teacher training in respect of the Life Orientation Learning Area. I anticipate that this study will inform policy makers with regard to the challenges that schools experience during the implementation of HIV & AIDS programmes.

1.11 CHALLENGES OF THE STUDY

Language differences may be regarded as a serious challenge regarding the study. I shall enter the field as a person with a cultural and linguistic background that differs from that of the research participants. According to Berg (2001:58), the interviewer's language should be understandable to the research participants and the interview should (ideally) be conducted on their level and/or in their preferred language. Although none of the participants speak English as a first language, all interviews will be conducted in English, due to the fact that English is used as a medium of instruction in all the participating schools in Soshanguve. This challenge may be overcome by using an interpreter if necessary in order to ensure that possible suspicions and uncertainties are clarified. Being a white South African male with my own personality and life-history implies a degree of subjectivity and prejudices.

This fact necessitates that I constantly will have to self reflect and seek clarity from participants when uncertainties arise.

1.12 OUTLINE OF THE STUDY

In the light of the fact that this study diverges into different sections, the proposed outline of the chapters is as follows:

- **Chapter 1: Introduction and Orientation**

Chapter 1 provides an overview that commences with an introductory orientation that is followed by the purpose and rationale of the study, the paradigmatic perspective and the conceptualisation. The research design and methodology are outlined and discussed and the chapter is concluded with a discussion on the quality criteria, significance, and possible challenges of the study.

- **Chapter 2: Literature review**

Chapter 2 will outline the conceptual framework of the study, based on relevant, authoritative literature on HIV & AIDS programmes and their implementation.

- **Chapter 3: Designing and conducting the empirical research**

The research process, with detailed attention to research design and methodology, will be outlined in Chapter 3. The proposed methods of data collection, data analysis and data interpretation will be outlined and justified.

- **Chapter 4: Reporting the results of the study**

The fourth chapter will include the presentation and discussion of the data obtained and analysed. This will be followed by a detailed discussion of the findings and interpretation of the results. The findings of the study will be compared with findings reported in relevant literature (where applicable), as discussed in Chapter 2.

- **Chapter 5: Synthesis, findings and recommendations**

The final chapter will include a synthesis and conclusions of the study. Findings will be linked to the research questions posed in Chapter 1. The possible contribution (new knowledge) of the study, as well as the challenges encountered, will be indicated. Recommendations for further research, practice and training will be suggested.

1.13 SUMMARY

This chapter presents an introduction and general orientation regarding the study, and provides a background against which the rest of the thesis can be read. I outlined the aim and relevance of the study with regard to various choices that I made during the planning phase. The main research question, that is formulated against the background of these choices and considerations, reads as follows: In what manner do contextual factors influence the implementation of HIV & AIDS programmes in South African schools?

I indicated what the contribution of my study will be, and briefly discussed the selected paradigm, methodological choices and process of the empirical part of the study. Furthermore, I indicated what attention I shall give to ethical issues and quality criteria during my study. These aspects are dealt with in more detail in Chapter 3.

In Chapter 2, I shall elucidate the conceptual framework of the study, by exploring literature on the HIV & AIDS pandemic and HIV & AIDS programmes. The discussions in Chapter 2 will then represent the background to the empirical study, which is described in Chapter 3.

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.

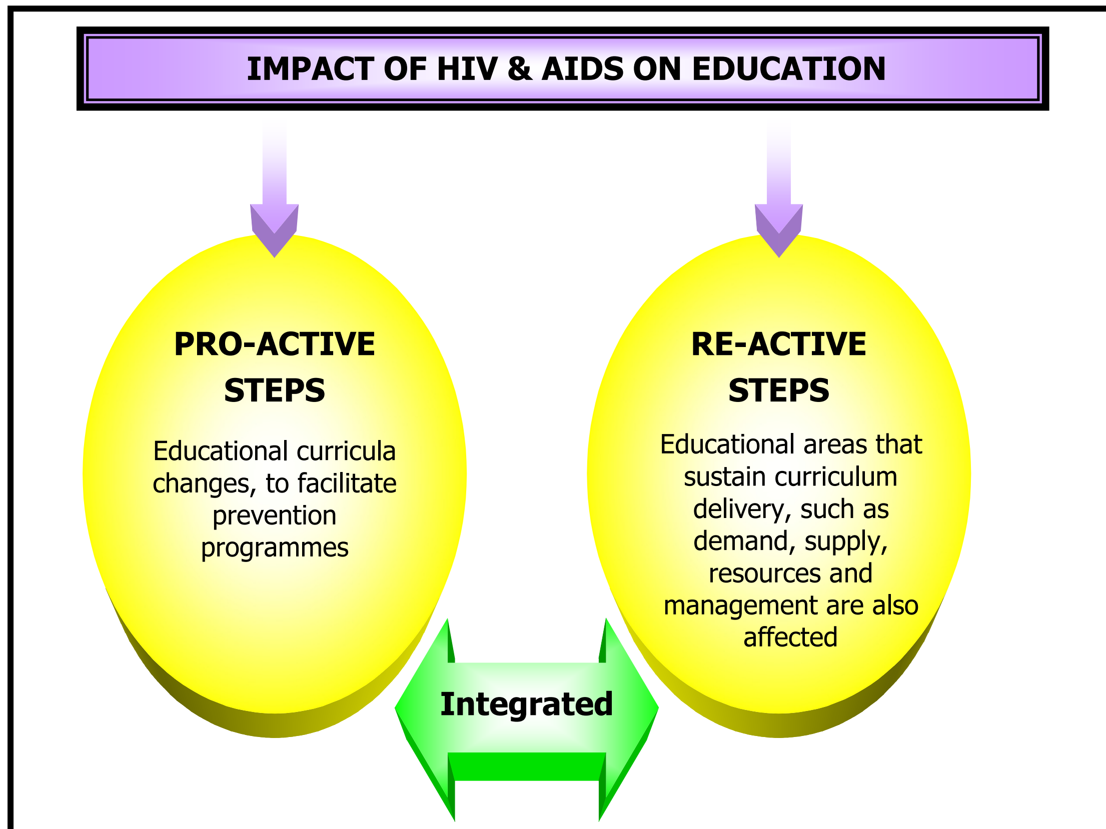

Diagram 2.1: The binary impact of HIV & AIDS on education

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).

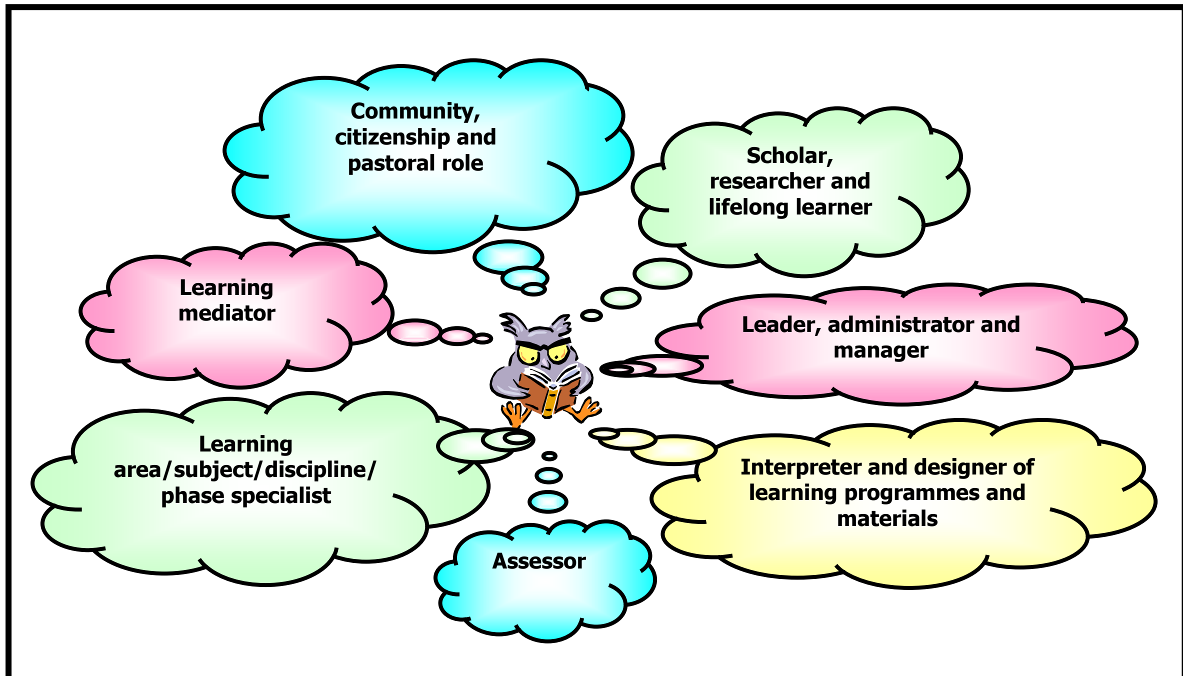

Diagram 2.2: Seven diverse roles of the teacher

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).

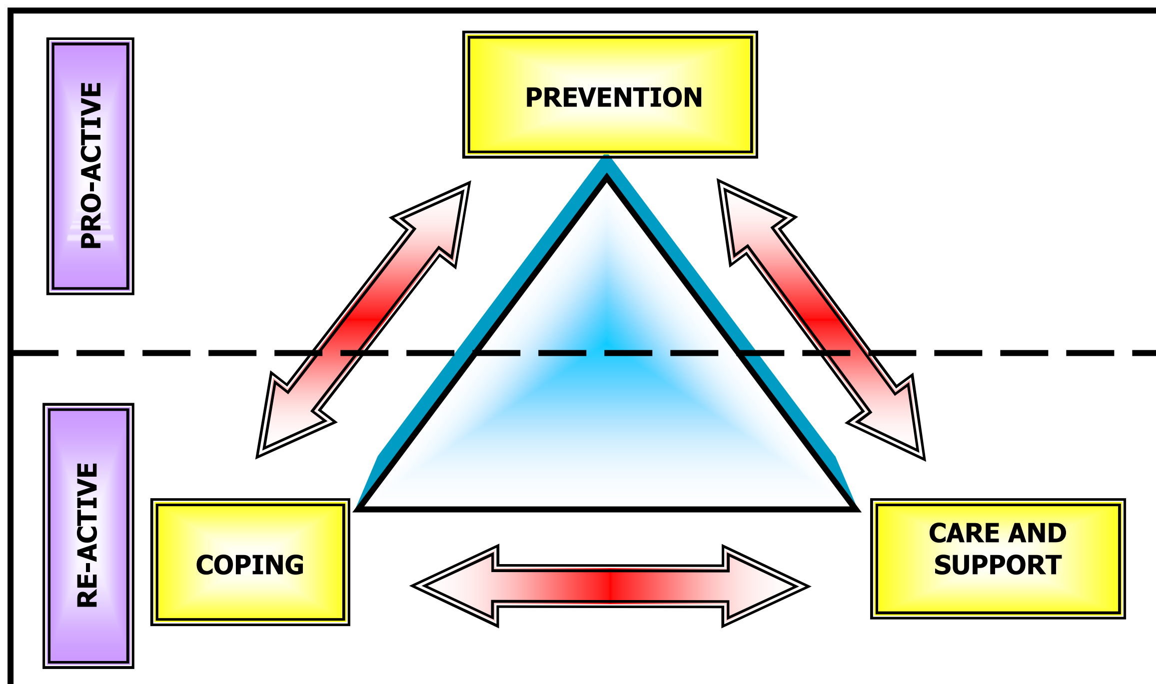

Diagram 2.3: A triangular approach to management of HIV & AIDS programmes

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.

CHAPTER 3

DESIGNING AND CONDUCTING THE EMPIRICAL RESEARCH

3.1 THE AIM OF THIS CHAPTER

The aim of this chapter is to provide a comprehensive description of the direction and processes that I followed during the empirical study, in order to obtain potential answers to my primary research question, namely: In which manner do contextual factors influence the implementation of HIV & AIDS programmes in schools?

3.2 INTRODUCTION

In Chapter 2, I undertook an extensive literature investigation into *inter alia* the impact that HIV & AIDS has on the education sector, and the consequent responses of education authorities in South Africa with regard to the HIV & AIDS programme and curricula that were to be implemented in schools. The investigation in Chapter 2 provided the conceptual framework and background for my study, against which I planned and conducted an empirical study, in order to identify and investigate the manner in which contextual factors influence the implementation of the HIV & AIDS programme in schools.

In this chapter I shall present the methodological choices and procedures that formed the empirical part of my research endeavour. I shall aim to justify the choices that I made with regard to the research questions and the purpose of my study. This chapter will serve to inform the reader on the research philosophy, research design, methodology, research instruments, data collection strategies and data analysis procedures. Furthermore, I present a discussion on the strengths of my methodological choices as well as the challenges that I encountered. I conclude this chapter with a reflection on the

ethical guidelines and quality criteria that I pursued during my study (refer to Diagram 3.1 for a schematic overview of the research methodology and design).

3.3 PARADIGMATIC APPROACH

Research paradigms consist of philosophical assumptions that provide guidance to the researcher's perspective with regard to the phenomenon that is being researched, as well as the actions employed (Creswell 2003:6; Patton 2002:17; Mertens 1998:3). In other words, the researcher states a knowledge claim with which he enters the research field. In this regard I (as the researcher) entered the research field with my own collection of concepts, values and methods, that I derived from a distinctive history, background, gender, class and race as determinative factors that influence and form my unique view on reality. Therefore I preferred to conduct my study from the interpretivist and constructivist paradigms (my selected meta-theories), ensuing a qualitative research approach (methodological paradigm) in order to best address the purpose of my study.

3.3.1 An interpretivist and constructivist epistemology

The Greek word ***episteme*** means "truthful knowledge", and relates to the concept "epistemic". Therefore, from an epistemological point of view, research has the comprehensive goal of searching for knowledge that is truthful. I concur with Mouton (2001:138), that it is impossible to construct fastidious answers to research that are authentic for all times and contexts. I view science as a search towards understanding phenomena, and I believe that there is no single truth which can be identified or researched objectively. Knowledge and "truths" are relative to the context of their application.

Furthermore, I view knowledge and "truths" as subjective and spiritual, based on personal experiences, insights, and beliefs (subjective). I adhere to the

universal law of cause and effect as the substantiation of events and phenomena that occur in society and ground the generation of knowledge. This subjective (or anti-positivist) approach to my research is grounded on my belief that individuals create their own reality as they interpret and understand their environment. In other words, unique persons create their own reality through their own minds (Cohen *et al.*, 2003:22). I concur with the view that human beings do not respond mechanically to their environment, but are initiators of their own actions. The reality that people perceive can never be fully explained, or understood as an undiscovered phenomenon, therefore, research can only provide a specific perspective on the truth, rather than claiming to expose the truth (Merriam 1998:46). Truth is not static, but rather a dynamic phenomenon interpreted through the meaning and understanding of people. In this study, I shall seek to generate knowledge that is truthful to the contextual realities within the social realm of education that influence the implementation of HIV & AIDS programmes in secondary schools.

I preferred to conduct this study within the constructivist and interpretivist paradigms. The constructivist philosophy assumes "reality as multilayered, interactive, and a shared social experience interpreted by individuals" (McMillan & Schumacher 2001:396). In this study, I observed the school in society, and the manner in which it succeeds in the implementation of HIV & AIDS prevention programmes, as an important element within the multilayered reality of society. In addition to this, Donald *et al.* (2002:174) argue that constructivism is a perspective that views knowledge as actively constructed by individuals, groups and societies, and not merely as something that is simply conveyed. Furthermore, constructivism implies interpretation or analysis on peoples' active creation and building of meaning and significance (Sexton 1997:4).

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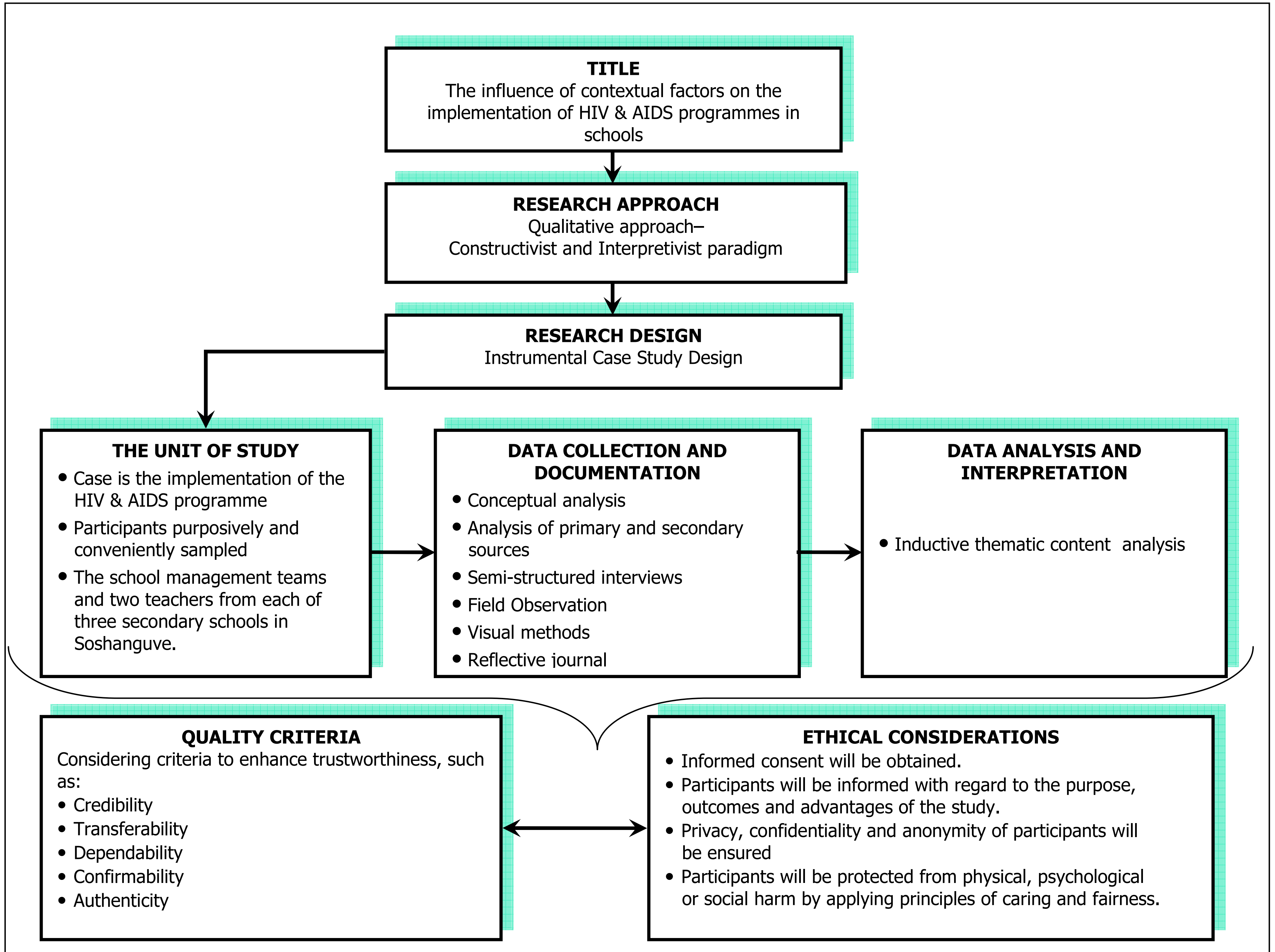
Diagram 3.1: A schematic presentation of the research approach and design



Therefore, I considered constructivism to provide a framework for the interpretation and analysis of the manner in which teachers respond to the consequences of the contextual factors that influence the implementation efforts of schools with regard to the HIV & AIDS programme.

I also considered the fact that interpretivism emphasizes the permanence and priority of the real world of first-person, subjective experiences of people (Schwandt 1998:223). In my study, I (from an interpretivist view) therefore investigate the first-person and subjective lived-experiences[11] of teachers and school management that are responsible for implementing HIV & AIDS programmes in secondary schools. Furthermore, interpretivism implies the interpretation of human behaviour and experiences on both a verbal and a non-verbal level, with cognisance of the context of the participants' life-worlds, as well as their past experiences and existing understandings thereof (Terre Blanche & Durrheim 2002:105). Assigning meaning constantly occurs within a particular context, meaning that human behaviour, feelings and experiences can only be understood within a particular context (which in my study refers to the implementation efforts and experiences of teachers with regard to the HIV & AIDS programme). In consideration of this, the experiences are interpreted in a personal, unique manner, which implies that reality, within the context of my study, is structured on different interpretations, namely mine, and those of the participants.

In view of Schwandt's (1998:222) elucidation that constructivists and interpretivists presume that, to understand this world of meaning, it must be interpreted. I aimed to gain understanding (*Verstehen*) with regard to the lived-experiences and personal worlds of the participants, in terms of their perceptions and interpretations, but by taking into *account* that I am a co-creator of meaning (Terre Blanche & Kelly 2002:125). As such, I aimed to clarify the process of meaning construction and attempted to explain what

[11] The person **lives** or **gives meaning to** his/her experiences.

and how meanings are embodied in the language and actions of the participants. I aim to report on experiences and perspectives as understood in a particular context, thereby working with data in context, and constructing meaning. I believe that the presentation of an interpretation is in itself the construction of meanings and experiences; it is to present the researcher's (my) construction of the constructions of the actors (participants) in the study (Schwandt 1998:223).

My decision, to conduct this study within the interpretivist and constructivist paradigms, can be related to the aim of my study, which focuses on an in-depth understanding of the personal perceptions and views of the teachers who are expected to implement an HIV & AIDS programme in the context of their schools. Conducting my study from an interpretivist and constructivist approach concurs with the following common principles for a constructivist and interpretivist approach, such as that development is contextual, individuals are producers of their own development, cognition is an active relating of events, and that meaning-making is self-evolution (Hayes & Oppenheim 1997:21). In consideration of this, I aimed to engage in a search for the deep structure that underlies the construction of meaning as expressed in specific societal phenomena and actions, that is I engaged in a deep search for contextual factors within schools that influence the implementation of HIV & AIDS programmes (Hayes & Oppenheim 1997:33). Therefore, I engaged in this study with the assumption that school management teams and teachers who are responsible for the implementation of an HIV & AIDS programme will construct their own understanding of what the implementation entails (in their particular contexts), which is then related to contextual factors that are present in the context of their schools.

De Vos (2000:240) states that interpretative research aims to understand and interpret the meanings and intentions that underlie everyday human action. In addition to this, I adhere to Trauth's (2001:219) stance of interpretivism

and believe that nearly all knowledge is attained, or at least filtered, through social constructions such as language, consciousness, shared meanings, documents and other artefacts. As an interpretivist researcher, I attempted to understand phenomena through the meanings that people assigned to them. Therefore, an interpretative paradigm suited the focus of my research, as its purpose is to gain an in-depth understanding of contextual factors that influence the implementation of HIV & AIDS programmes.

In view of the interpretative and constructivist paradigms, that reflect the belief that humans construct reality individually and collectively, I entered the research field with the assumption that school management teams and teachers construct their own meaning with regard to the implementation of HIV & AIDS programmes in their school's contexts. I accepted that their constructs will be based on their interpretations of what it entails to implement such a programme. I then created my own reality, by interpreting their constructions of reality, considering that the school management teams' and teachers' interpretations of what the implementation of an HIV & AIDS programme entails, were in turn constructed through their active participation in contexts that are filled with their own meanings and constructions of an HIV & AIDS programme (in this regard please refer to Diagram 3.2).

3.3.2 A qualitative methodological approach

Accepting that a variety of ways exists to make sense of the world, I consider a qualitative approach as suitable for addressing the primary aim of this study. My intention is to explore, describe and interpret the experiences of teachers with regard to the implementation of HIV & AIDS programmes in schools, and through a qualitative approach, it would be possible to construct the "reality" as perceived from the participants' point of view. A qualitative research approach and design aim at gaining greater insight into man's situation (Ericson 1986:125). I expect a qualitative approach to provide me

with the opportunity to gain access into the subjective experiences of individuals or groups (the participants), with focus on the contexts in which they interact with each other, and the efforts they make regarding their tasks. Furthermore, a qualitative approach to research places an emphasis on enhanced comprehension of human behaviour and experiences (Garbers 1996:15; Neuman 1997:37). Therefore, by approaching my study within the qualitative framework, I may be able to consider the influence of relevant factors on social relationships, and consequently this may grant me access to an understanding of the way in which contextual factors influence the implementation of an HIV & AIDS programme, from the participants' points of view (MacMillan & Schumacher 2001:16).

In assuming that multiple realities are socially constructed by individuals and society, I believe a qualitative approach will be valuable to determine teachers' experiences and understanding with regard to the implementation of the HIV & AIDS programme in their schools. In consideration of my intention to reflect on the experiences of teachers from various perspectives, I consider a qualitative research approach most appropriate, as it may enable me to understand meaning and influence in a more multifaceted way (Parker, Dalrymple & Durden 2000:82). Furthermore, I took into account that my research may identify information that I did not anticipate and, in following a qualitative research approach, I would be able to continue discussions that are not limited by predetermined closed questions. As such, a qualitative approach would present me with an opportunity to acquire vivid information with regard to the teachers' feelings, thoughts and actions, as well as their believes in respect of the implementation of an HIV & AIDS programme in their schools. In view of my intention to interpret and create my own construction of the views and experiences of teachers, qualitative research would enable me to study meanings that the participants ascribed to their experiences (Willig 2001:15). I therefore cannot claim that I am rigidly

objective, as I shall be subjectively involved in reporting or narrating my research (Adler & Adler 1994:110).

Therefore, by undertaking qualitative research, I aim to develop an understanding of the manner in which reality (the world) is constructed by individuals in a specific social setting, in terms of symbols, structures and social roles familiar to them (Denzin & Lincoln 2000:112; Henning, Van Rensburg & Smit 2004:48) . Qualitative techniques may therefore enable me to share in the views and understandings of other people and to explore the manner in which they give meaning to their life-worlds, to themselves and to others (Leedy 1997:107; Glesne & Peshkin 1992:6).

My decision, to approach the study within a qualitative paradigm, was firstly guided by the nature of my study, in terms of the research question and research aim. Secondly, I was of the opinion that the qualitative approach corresponds with my belief that the world consists of multiple realities which differ according to context and time (Mertens 1998:26; Creswell 2003:10). I aimed to explore and focus on the processes, meaning-giving patterns, and structural characteristics of schools' and teachers' programme implementation efforts in order to address my research questions. This qualitative research process is described by Flick, Von Kardorff and Steinke (2004:4) as the "*use of the unusual or the deviant and unexpected as a source of insight and a mirror whose reflection makes the unknown perceptible in the known, and the known perceptible in the unknown, thereby opening up further possibilities for recognition*".

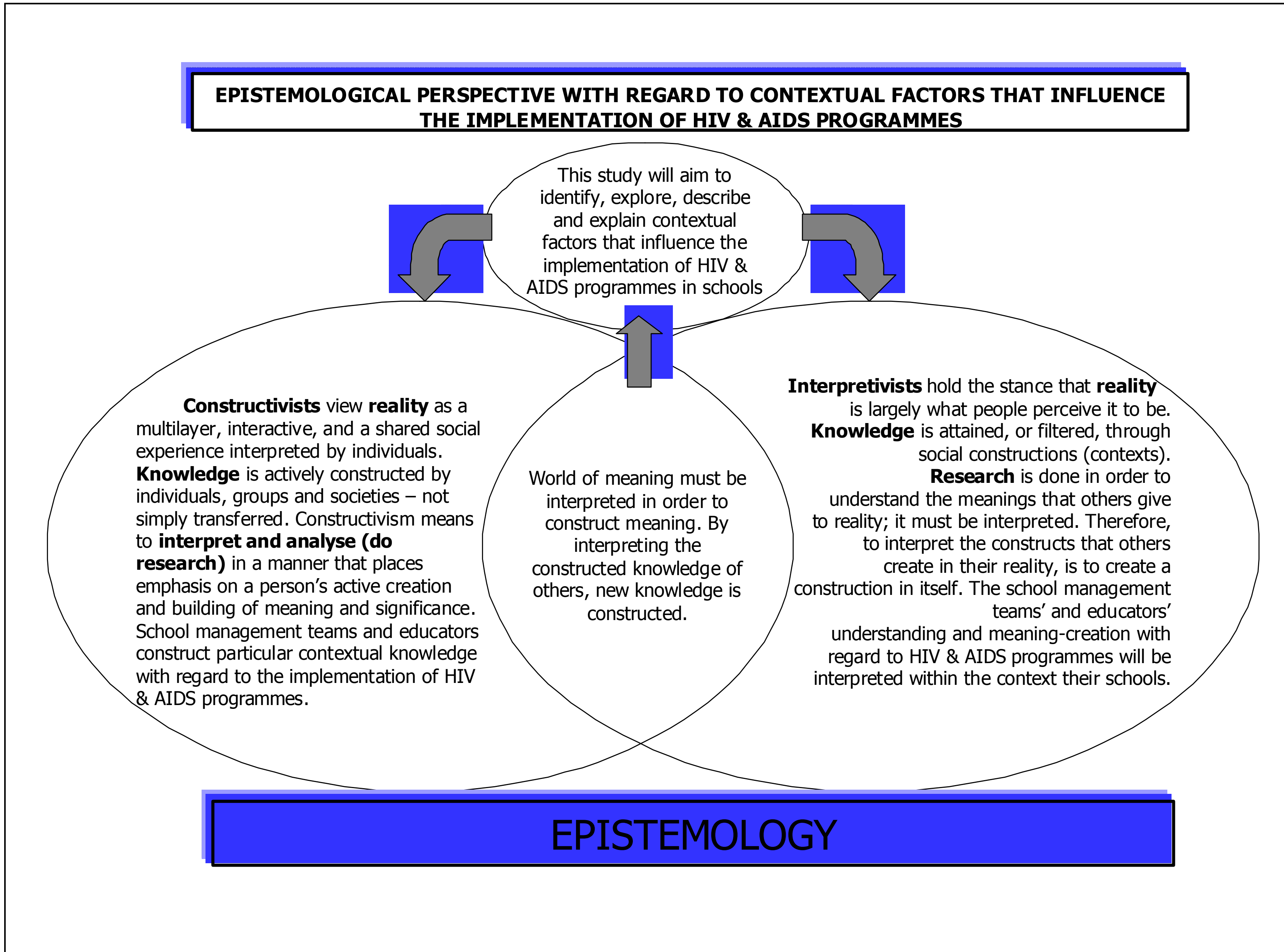


Diagram 3.2: Epistemological perspective with regard to interpretivism and constructivism

3.4 RESEARCH DESIGN AND METHODOLOGY

According to Creswell (2003:15), a case study design is appropriate for research that requires an in-depth exploratory and descriptive inquiry into an activity, process, programme, event, or one or more individuals. Therefore, I selected a case study design, considering that the purpose of my research is to identify and investigate the contextual factors that influence the implementation of the HIV & AIDS programme in their schools (Creswell 2003:15). Furthermore, in the light of the interpretivist and constructivist paradigms, as well as the qualitative nature of my research (refer to paragraph 3.3.1 and 3.3.2), this study may be described as interpretative and subjective, and will be conducted as a case study. As can be expected in a case study, the collected data proved to be a mixture of new and existing information, due to the "*low degree of control and structure*" in a qualitative case study design itself (Mouton 2001:149). Nevertheless, I am of the opinion that this design reinforced the exploratory and inductive approach of my study, and proved to be coherent with my aim to identify and investigate contextual factors that influence the implementation of the HIV & AIDS programme in schools.

3.4.1 Instrumental case study design

I consider a research design to relate the purpose of the study and the primary research questions to the methodological building blocks and finally to the findings and conclusions, in a coherent and logical manner. Therefore, I support Bless and Higson-Smith's (1995:63) definition of research design as "*a programme to guide the researcher in collecting, analysing and interpreting observed facts and phenomena".* For the purpose of my study, and in order to answer my descriptive and exploratory research questions, I selected an instrumental multiple-site, case study design. This decision enabled me to scientifically investigate and obtain an in-depth description of the lived-

experiences of my research participants (in three schools) with regard to the implementation of the HIV & AIDS programme (the case). The selected schools were of secondary importance, as my primary aim was to obtain insight into the factors that influence the implementation of the HIV & AIDS programme. Such a design type specifically focuses on providing a clear understanding of a specific issue (Stake 2000:437; Merriam 1998:65; Bless & Higson-Smith 1995:68). Furthermore, an instrumental case study design is selected with the aim of addressing my research question, and in order to obtain insight into one essential issue, rather than the cases themselves (Bergen & While 2000:45; Stake 2000:438; Berg 2001:68; Cohen *et al.*, 2003:183). This may provide me with a clear understanding of the manner in which contextual factors influence the implementation of HIV & AIDS programmes in schools.

My selection of and inquiry into the status of this specific programme concurs with a case study design, which entails a detailed description of a single individual or a few individuals, a set of documents, an event, a programme or an activity (described within their settings), in order to provide the necessary context (Creswell 2003:15; Henning *et al.*, 2004:41). In the context of my study, I did not aim to obtain knowledge that is generalisable, but instead I aimed to gain an in-depth understanding of the experiences of teachers that are responsible for implementing the HIV & AIDS programme in their schools. However, the probability of transferring certain trends or similarities to other comparable implementation efforts or schools does exist, as other schools in the country might display a context and characteristics similar to the ones described in this research. Although I acknowledge that the potential for generalization is limited, I had the opportunity to provide rich, in-depth information and material for readers to uncover on their own (that which even I might have overlooked); as well as to reflect on theory and to encourage hypotheses for consequent studies (Stake 2000:440; Berg 2001:231).

By selecting an instrumental case study design, I considered it possible to acquire a thorough understanding of other possible external theoretical questions or problems with regard to the implementation of an HIV & AIDS programme in schools (Berg 2001:225). Although I investigated the selected schools as cases, analysed the contexts that were evident, and described relevant activities (Stake 2000:439), these schools functioned as supportive role players in focussing on my actual research interest (primary question), which is exploring the factors that influence the implementation of the HIV & AIDS programme. By utilizing an instrumental case study design, I was able to acquire authentic descriptions of the experiences of school management teams and teachers, who are responsible for the implementation of HIV & AIDS programmes in their schools. Therefore, I concur with Stake (2000:439) that an instrumental case study design offered me the opportunity to not only comprehend the central issues with regard to my research problem, but it also brought other critical dynamics with regard to the implementation of the HIV & AIDS programme to light.

I decided on an instrumental case study design, as it also offered me the advantage of constantly reflecting on and reconsidering the significance and value of the impressions that I gained (Creswell 2003:16; Stake 2000:440).

3.4.2 Selection of participants

In view of the importance of selecting a reliable sample of literature and participants for this study, my intention with the selection of the participants was primarily to ensure that they are directly, or as closely as possible, related to the research problem. Therefore, I aimed to select teachers that were responsible for the implementation of HIV & AIDS programmes in secondary schools (McMillan & Schumacher 2001:39; Creswell 2003:185).

In consideration of my intention, to explore and describe a phenomenon (contextual factors that influence the implementation of the HIV & AIDS programme) and not to involve all teachers in South Africa, I chose a qualitative approach. A small sample size is characteristic of a qualitative approach, as larger groups would not necessarily guarantee more representivity (Cohen *et al.*, 2003:185). Furthermore, it would have been problematical to interview every teacher that is responsible for implementing the HIV & AIDS programme, hence I selected a sample population by means of purposeful or convenience sampling.

3.4.3 Convenience and purposive sampling

I initially gained access to the schools by means of a "gatekeeper" (Creswell 2003:184), whom I regard as an insider in the schools where I conducted my study. This "gatekeeper" was the subject facilitator for Life Orientation in the Tshwane North District of Education for several years, as well as a resident in the area where the schools are located. On this person's recommendation, I selected three secondary schools to participate in my study. The three secondary schools were conveniently selected for the purpose of this research, as I am currently a teacher at a school in Soshanguve. Therefore the selection of schools enhanced my accessibility to the research participants, as well as to suitable facilities for conducting semi-structured interviews. In utilizing convenience sampling as an initial sampling technique, I kept in mind that convenience sampling (or opportunity sampling) required that the nearest individuals (schools) serve as participants, and that the sampling process continues in order to obtain the required sample size (Cohen *et al.*, 2003:102).

After the principals of the three schools had permitted me to conduct my research at their schools, I purposively sampled four participants from each school. I kept in mind that, in research on effective teaching (programme

implementation), it is considered to be most informative to select expert or master teachers, instead of a sample of all teachers, and that convenience and purposive sampling has the purpose of selecting information-rich cases, in order to obtain in-depth understanding (McMillan & Schumacher 2001:176; Patton 2002:230).

I therefore purposively selected four participants from each of the three conveniently selected schools. To assist the school principals, two teachers in each school, that had been trained as "Master Trainers" with reference to the implementation of HIV & AIDS programmes, were included as participants in my study (in the absence of such teachers, I included teachers that were responsible for teaching Life Orientation in the school). These "Master Trainers" are nominated teachers from secondary schools that had been trained by their respective School Districts with regard to HIV & AIDS education. These teachers had attended a four-day training course, in order to enable them to implement the HIV & AIDS education programme. It was expected that these teachers (Master Trainers) would then provide the same training to colleagues of their own schools, as well as neighbouring schools in their cluster. I choose to include these teachers because of their apparent special interest in the HIV & AIDS programme in schools, and the specialised training they had received from the Gauteng Department of Education. I regarded these participants as having specialised knowledge with regard to the implementation of HIV & AIDS programmes, and as people who would most likely be able to provide me with valuable information.

I further purposively included the school principal and the head of department for Human and Social Sciences of each selected school that I regard to be ultimately accountable and responsible for the school curriculum and implementation thereof. I decided to include only secondary schools to be the focus of my study, because the policy of the Department of Education at that time only required for HIV & AIDS programmes to be implemented in

secondary schools. Similar programmes have not been developed for primary schools yet, and secondary schools in Soshanguve only include Grade 10, 11 and 12. My selection of the case and participants is summarised in Table 3.1.

Table 3.1: A summary of the participants in the sample

CATEGORY	DESCRIPTION	TOTAL NUMBER	SAMPLING STRATEGY	CRITERIA FOR SELECTION
Case	Secondary schools implementing the HIV & AIDS programme	3	Typical case sampling, and convenience sampling	Secondary schools that are required to implement the HIV & AIDS programme as part of Life Orientation
Participants	Principals as participants	3	Purposive sampling	Responsible for the schools' curriculum delivery
	Heads of department as participants	3	Purposive sampling	Responsible for the schools' curriculum delivery
	Teacher participants	6	Purposive sampling	Trained as "Master Trainers" and/or teaching Life Orientation

In view of the fact that the participants in my study only represent a small section of the people and schools to whom the research might possibly apply, I strived to select participants who are fairly typical of the larger group of people and schools on which I focused, being South African teachers who are responsible for the implementation of HIV & AIDS programmes in secondary schools (Creswell 2003:199; McMillan & Schumacher 2001:404).

In my opinion, I employed appropriate sampling strategies with regard to the purpose of my study, for various reasons, that include the sensitivity of HIV & AIDS as a topic, and the corresponding limited insight into contextual factors that influence the implementation of HIV & AIDS programmes. Furthermore, I had to consider that the participants should be easily reachable, and be able to be frank with their responses, in the light of the sensitive nature of HIV & AIDS, as well as be able to communicate their perceptions through English, as

I did not make use of an interpreter (Henning *et al.*, 2004:71; McMillan & Schumacher 2001:405).

3.4.4 Data collection and documentation

During the collection of data, I made use of multiple data collection strategies and actions in order to obtain relevant, in-depth and context-rich information with regard to contextual factors that influence the implementation of the HIV & AIDS programme in schools (McMillan & Schumacher 2001:39). Furthermore, I aimed to ensure that the process of crystallisation would be possible, by making use of several data collection methods and by indicating different nuances of the gathered data (Janesick 2000:288). In the light of my selected qualitative paradigm and instrumental case study design, I decided to make use of a conceptual analysis, the analysis of primary and secondary sources, semi-structured interviews, audio-visual methods, field observations, and a reflective journal, in order to collect data.

3.4.4.1 Conceptual analysis

I included a conceptual analysis, as a non-interactive qualitative mode of inquiry, in order to portray the meanings, use and application of concepts in relation to the purpose of my study. During this process, I aimed to isolate the combined units of words or concepts, in order to identify and investigate contextual factors that influence the implementation of the HIV & AIDS programme in schools. McMillan and Schumacher (2001:39) regard the use of a conceptual analysis as a data collection method with the aim to "*take apart, revisit, reconsider, study and describe*" the diverse meanings of concepts, to present unambiguous perspectives of the problem that is being investigated. I decided to include my conceptual analysis, as it relates to the problem of my study in Chapter 2 of this thesis (refer to paragraph 2.8).

3.4.4.2 Analysis of primary and secondary sources

In view of the fact that the case in my study is **contextual factors that influence the implementation of the HIV & AIDS programme**, I considered the analysis of primary and secondary sources (as one of my data collection methods) as of paramount importance (McMillan & Schumacher 2001:451; Henning *et al.*, 2004:99). Therefore, I conducted an analysis of primary sources, that included original documentation or the remains thereof, statements from persons who participated in HIV & AIDS programme related events in schools, or were eyewitnesses to such events. I also considered the remains of sources such as HIV & AIDS school policies and documentation, that I presumed had to be developed and available in order to supply information. Furthermore, I perused official documentation with relation to HIV & AIDS, with the aim of providing a vivid picture of the departmental stance and requirements with regard to the implementation of HIV & AIDS programmes in schools.

I also scrutinized textbooks, encyclopaedias, dissertations and theses as secondary sources of data (McMillan & Schumacher 2001:42; Henning *et al.*, 2004:188; Leedy 1997:101). Although these sources are considered to be reports from people who were not eyewitness to, or part of, an event – but only reported what the person, who had physically been part of an event, had said or wrote – I found these sources invaluable with regard to current theories and developments in the field of HIV & AIDS prevention and education.

3.4.4.3 Semi-structured interviews

I conducted semi-structured interviews with six teachers who are responsible for Life Orientation and/or HIV & AIDS programmes, as well as with three principals and three heads of department for Human and Social Sciences in

the three selected schools. I decided to conduct semi-structured interviews in order to allow for flowing discussions, and to obtain detailed information with regard to the participants' experiences with the implementation and presentation of the HIV & AIDS education programme in their schools (Merriam 1998:74). As semi-structured interviews enable the participants to share their personal experiences and perceptions (O'Donoghue & Punch 2003:57), I included probes within the questions in order to prompt the participants for clarifying information. The questions on the interview instrument (refer to Addendum A) were developed by myself and my study supervisor on the basis of an intensive literature study. The questions were then scrutinised by two critical readers, and some adjustments were made in order to create more opportunities for the participants to share their own opinions. For the purpose of my study, I included more open-ended questions with the aim of creating occasions for the participants to communicate their personal experiences, opinions and beliefs (Cohen *et al.*, 2003:271; Schurink 1998:300). Thereafter, the instrument was viewed and approved by the ethical committee of the University of Pretoria as well as the Research Approval Committee of the Department of Education (refer to Addenda B and C).

From an interpretivist perspective, I obtained valuable information on the participants' perspectives and experiences with regard to the implementation of the HIV & AIDS programme in their schools, based on my view that qualitative interviewing is an interactive process of meaning-making. I believe that the questions asked during the interviews invited the participants to share their perspectives, knowledge and significant experiences regarding the implementation of the HIV & AIDS programme (Patton 2002:306; Cohen *et al.*, 2003:268). I approached the interviews with the stance that it is a two-way communication interaction, during which I, as the interviewer, endeavoured to create meaning of what was expressed by the interviewee (verbally and non-verbally), thereby gaining information with regard to

contextual factors that influence the implementation of the HIV & AIDS programme in schools. I regard a qualitative interview is a conversation between the researcher and a research participant. The researcher has a broad plan of investigation for the interview, but not a definite set of questions that have to be asked in particular words or in a particular order. I view a qualitative interview as a conversation during which specific topics, that are raised by the participant, are dealt with, while I (as the interviewer) am able to determine a general direction, to obtain research-relevant information (Babbie & Mouton 2001:278; McMillan & Schumacher 2001:269). The interviews were audio-taped with the permission of the participants. My reporting of this activity was supported by my field observations and reflective journal, as supplementary data collection strategies. I then commenced with my first level of analysis, by using the recorded data, with the advantage that I was able to correct possible limitations such as a lack of intuition and recollection (Silverman 1994:119).

At the onset of my data collection, I encountered a serious delay. I scheduled my interviews during May and June 2007, but was forced to postpone my research, because of the National Public Service Strike Action that occurred in the same period. After the schools had re-opened in July 2007, I was fortunately able to re-schedule the interviews at the schools during August and September 2007. Although I was frustrated by the delay in my research, I realised that this was a typical occurrence one could experience while doing research, and this is the reality in which many teachers are attempting to implement the HIV & AIDS programme in their schools. I considered this as an example of external factors that influence the implementation of not only the HIV & AIDS programme in a school, but the whole curriculum as such.

I conducted twelve interviews during August and September 2007 (refer to Table 3.2 below for the schedule of interviews). I managed to have two interviews per school during a week, because the management of the school

and the Department of Education only allowed for interviews to be conducted after school hours, and the teachers were following a busy schedule in order to recover time that had been lost during the National Public Service Strike Action. My intention was to avoid disrupting the organisation of the school, in view of the fact that an interview took an average of 50 minutes. After each interview had been transcribed, I gave the transcript to the participant to verify the correctness thereof. This action was welcomed and appreciated by the participants, and I believe it enhanced their trust in me as a researcher, and contributed to the authenticity of my data.

Table 3.2: The schedule for interviews conducted

DATE	PARTICIPANT	CONFIRMATION OF TRANSCRIPT
1st August 2007	Case 1: Principal	6th August 2007
1st August 2007	Case 1: Head of Department	6th August 2007
6th August 2007	Case 1: Teacher 1	13th August 2007
6th August 2007	Case 1: Teacher 2	13th August 2007
13th August 2007	Case 2: Principal	20th August 2007
13th August 2007	Case 2: Head of Department	20th August 2007
20th August 2007	Case 2: Teacher 1	27th August 2007
20th August 2007	Case 2: Teacher 2	27th August 2007
27th August 2007	Case 3: Principal	3rd August 2007
27th August 2007	Case 3: Head of Department	3rd September 2007
3rd September 2007	Case 3: Teacher 1	10th September 2007
3rd September 2007	Case 3: Teacher 2	10th September 2007

3.4.4.4 Field Observation

In view of the fact that field observation is considered a fundamental part of nearly all qualitative research methods (McMillan & Schumacher 2001:41; Adler & Adler 1994:389), I employed observation as a part of my data collection. During the interviews, my observation mainly served as a validation measure, allowing me to authenticate what I had heard via participants, confirming and verifying my observations, that included any non-verbal signals during verbal conversations. I documented descriptive observational data in the form of a field journal and photographs of events, people, actions, and objects in the setting (school). During the interviews, I made notes *in*

situ, then after the interview and initial observations, I expanded and recorded my observations as comprehensively and as soon as possible in my reflective journal, in order to paint a clear picture of my observations and develop a tentative record of ongoing analysis and interpretation.

3.4.4.5 Visual data collection

I included the use of visual data collection by means of photographs to supplement the data generated during the interviews and observations, mainly as means of data capturing. These methods of qualitative research presented me with verifications of the activities of the participants, and made it possible to collect information that could be difficult to obtain otherwise (Cohen *et al.*, 2003:282; Creswell 2003:189), such as visual evidence that could be missed during interviews. I believe that the use of visual data collection (photographs) contributed to the richness of my data. Furthermore, the use of visual data collection methods limits the potential subjective bias of observations of a single event, as well as the probability that only frequently occurring events are noticed (Cohen *et al.*, 2003:313). In addition to documenting interviews and observations, I made use of visual material to mainly document the setting of the schools, and to provide visual substantiation in terms of HIV & AIDS programme implementation efforts in the schools. Visual data were collected in the school's community as well as on the school premises, photographing the setting, facilities and resources.

3.4.4.6 Reflective journal

I made use of a reflective journal (Cohen *et al.*, 2003:228), firstly as an additional data collection and capturing method, and secondly as a means of portraying and reflecting on my experiences, perceptions and interpretations during my study (refer to Addendum F). I included descriptive field notes on aspects such as a reflection on the methods that I used during the process of

data collection and analysis; my reactions to observations and interviews; as well as the ethical issues, tensions and challenges experienced during my inquiry (Bogdan & Biklen 1992:122).

During the data collection and analysis processes, I made notes of the research procedures and progress, which allowed me to reflect on the processes when the need arose. I kept record of the dates, interview schedules, venues and duration of interviews. Field notes also enabled me to document my observations during school visits, and comprehensively contributed to my reflective journal. In addition, I documented my own personal reflections, emotions, experiences, achievements and misfortunes whenever they occurred (Cohen *et al.*, 2000:313; Lincoln & Cuba 1985:327).

Even though I continuously tried to compile extensive field notes, I occasionally forgot to note down immediate impressions when interviewing participants or being involved in informal discussions. Therefore, I wrote down my observations and occurrences during the interviews and school visits, as soon as possible after each session. I am aware that some detailed information might have been lost doing this, therefore I relied on the audio-tapes of each session, making it possible to revisit the process at later stages and elaborate on my field notes (Patton 2002:310; Creswell 2003:190).

I believe that my reflective journal contributed to the depth of my data. The journal enabled me to reflect on the practicalities of my fieldwork and on initial interpretations of the collected data. I regard my journal as an attempt to facilitate and systematise the interpretative process that is at the heart of qualitative research (Ezzy 2002:72).

3.4.5 Data analysis and interpretation

During the analysis of my collected data, I made use of inductive thematic analysis (also referred to as content analysis or pattern analysis), which is commonly linked to a case study design. My intention with the data analysis was to understand the different core meanings of the data by means of an investigation of the relationship between concepts, constructs and variables, to uncover any possible patterns or trends that can be isolated, and to establish themes in the data. Therefore, I examined the data for constructs, themes, and patterns that I could use to identify, explore, describe and explain contextual factors that influence the implementation of HIV & AIDS programmes in schools, by means of an arrangement of the collected data into larger coherent wholes (Mouton 2001:108-109; Hatch 2002:148; Merriam 1998:7; O'Donoghue & Punch 2003:47). Leedy (1997:158) refers to this type of analysis as interpretational or structural analysis. I analysed my data systematically by means of thematic analysis. The data were inductively analysed to enable me to identify recurring patterns or common themes that are evident across the data. My main focus during the data analysis was to obtain an understanding of the essences of the lived-experiences of my participants with regard to the implementation of HIV & AIDS programmes.

On the basis of the basic guidelines for inductive thematic analysis and interpretation, I analysed and interpreted the raw data collected from the interview sessions, observations, reflective journal and visual data (photographs). I commenced my analysis by reviewing all the raw data, in order to obtain a general sense of the information and its global meaning. During the data collection, I already started data analysis by making short notes during interviews and observations (as described in paragraph 3.4.4.3), as part of the continuous process of searching for similarities, differences, categories, themes, concepts and ideas. This was followed by transcribing the interviews, and typing my field notes and reflective journal. Again, I made

margin notes with regard to my general thoughts and impressions, to serve as my initial sorting process. I then gave the transcribed interviews and preliminary findings to the participants in order for them to be part of the data analysis process, and to verify that the data were a true reflection of what had transpired. I trust that this contributed to and enhanced the authenticity and dependability of my findings (Cohen *et al.*, 2003:164), based on the assumptions of interpretivism and constructivism. I regard participant evaluation (or member checking) as an important and valuable process during data collection and analysis, as the participants may wish to include additional information or even propose an alternative way of conveying the issue at hand. I also conducted member checking during my interviews, by means of rephrasing topics and asking explanatory questions, to obtain a more comprehensive and accurate understanding of the communications of the participants (McMillan & Schumacher 2001:410, 462).

After this process, I grouped the data into manageable "chunks" of data (clusters) and created a basic classification system or categories for coding. I found it very useful to group the categories together within tables in order to be able to identify emerging patterns and/or themes. I organised the raw data and possible topics (that I discussed with my supervisor) and identified related themes, patterns, similarities and differences, which I later named and listed (Creswell 2003:191-194; Henning *et al.*, 2004:127).

I then conducted an independent data analysis, and had it examined by my supervisor. Hereafter, I scrutinized the data again and systematically engaged in a formal coding process to generate a description of the setting and categories for analysis. I repeatedly read the sections of raw data until I was satisfied that all the raw data were tabled, sorted, coded and grouped into appropriate categories. This resulted in the development of a classification system in terms of themes and sub-themes, and eventually in my

interpretation, based on my opinions and on information obtained from the literature (Creswell 2003:195; Henning *et al.*, 2004:128; Mouton 2001:109).

3.6 QUALITY CRITERIA

I regard the quality and trustworthiness of qualitative research as dependent upon the extent to which the researcher (myself) is able to persuade the reader or listener that the outcomes of the study are noteworthy and reliable (Babbie & Mouton 2001:271). The quality of qualitative research can be enhanced by way of rigorous methods, the credibility of the researcher, an underlying philosophical belief in the value of qualitative research, and the consequent significance of qualitative methods, purposive sampling, inductive analysis and a holistic way of thinking. In order to account for the trustworthiness of my study, I exercised critical self-awareness and did not regard myself as the expert. I instead, focused on being open to listen and learn, rather than to speak, teach and control. I was also mindful of my potential biases throughout my study, reflecting in my field journal, and having debriefing sessions with my supervisor. In this regard, Denzin and Lincoln (2000:21) explain that the trustworthiness of qualitative research is enhanced by strategies that focus on the 'credibility', 'transferability', 'dependability' and 'confirmability' of the study (terms that replace the customary positivist criteria of internal and external validity, reliability and objectivity). Cohen *et al.* (2003:108) include 'authenticity' as a strategy to increase the trustworthiness of research. I shall now elaborate on the quality of my study in terms of the credibility, transferability, dependability, confirmability and authenticity thereof.

3.6.1 Credibility

I view the qualitative concept of credibility as referring to the purpose of presenting a truthful account of the phenomenon that is described in the

study. Credibility, in qualitative terms, is used as the equivalent of the (positivist) quantitative term of internal validity. Poggenpoel (1998:351) regards credibility as an indication that "*the research was conducted in such a manner as to ensure that the phenomena were accurately identified and described*". Furthermore, I regard credibility as an indication that the research findings that were captured are a true account of the context that was studied, and that the researcher learned what he/she intended to learn (Babbie & Mouton 2001:276). Credibility answers to the question as to what extent the findings are truthful, and implies professional integrity, intellectual precision and methodological competence (Creswell 2003:196; McMillan & Schumacher 2001:603; Henning *et al.*, 2004:149, 151)

In order to ensure the credibility of my findings and study, I made use of several strategies and procedures. Firstly, I conducted twelve interviews with participants at their schools, with the aim of relating to them in the setting in which they are responsible for the implementation of the HIV & AIDS programme. I supported this primary data collection strategy with a field journal and observations, as well as visual data in the form of photographs. Secondly, I continuously reflected on my subjectivity and biases, and aimed to remain open-minded, in order to obtain insight into my personal orientations and prejudices that might influence my research and interpretations. As a third strategy, I made use of field notes and a reflective journal to describe the research context and environment, and to document observations. A fifth strategy entailed a continuous review, critical report and guidance from my supervisor during the process of data collection, analysis and interpretation. I further made use of member checking, and provided the participants with transcripts of the interviews in order for them to verify, correct and elaborate, as a sixth strategy. My seventh strategy was to include examples and evidence of the raw data and analysis in this thesis, in order to provide a trail of evidence of the research process. Lastly, I applied crystallisation by considering multiple perspectives, such as various forms of

data collection. I used the same method of data collection regarding different participants in various settings and on different occasions. I utilized theory (conceptual framework in Chapter 2) as a basis to interpret the data from different perspectives, and my supervisor assisted and monitored me during data analysis and interpretation, although I was primarily responsible for finalising the analysis (Cohen *et al.*, 2003:113; Babbie & Mouton 2001:277; Creswell 2003:197).

3.6.2 Transferability

I understand transferability as referring to the possibility of the findings of a study being transferred to the wider population (Babbie & Mouton 2001:277). Transferability is the qualitative parallel to the quantitative concept of 'external validity', and refers to the dependability of the findings of the study, indicating whether or not the findings are applicable and can be transferred to other contexts. In consideration of the fact that meanings vary across different contexts of human interaction, I aimed to obtain transferable rather than generalisable findings, by providing sufficient descriptive information with regard to contextual factors that influence the implementation of HIV & AIDS programmes in schools, as well as about the meanings that evolved during the investigation. It is the onus of the readers of my study to determine whether they regard transferability of this study and the findings thereof possible, by establishing their own index of transferability (Cohen *et al.*, 2003:109).

In view of the fact that I conducted my study from an interpretivist paradigm and qualitative approach, I did not aim to generalise the findings of my study to the wider community, or to other schools. Although the primary focus of my study was to identify, explore, explain and describe contextual factors that influence the implementation of the HIV & AIDS programme in schools, I only included selected schools and participants whose opinions do not necessarily

represent those of other teachers and schools. Therefore, my results and findings cannot be generalised and applied to other settings (Henning *et al.*, 2004:146; Creswell 2003:196; Leedy 1997:34, 169).

3.6.3 Dependability

The qualitative term *dependability* (or *auditability*) is equal to the quantitative (positivist) term *reliability*. It refers to an indication of whether or not the findings would be the same if the study was replicated in the same (or a similar) context or with similar participants (Babbie & Mouton 2001:278). According to Guba and Lincoln (in Babbie & Mouton 2001:278), a display of credibility seems to be sufficient to establish the existence of dependability.

As I have mentioned in paragraph 3.6.2 above, the aim of my study was not to generalise, but rather to gain an in-depth understanding of contextual factors that influence the implementation of HIV & AIDS programmes in schools. I considered and included contributions from other persons during the data analysis, namely my supervisor's and the participants' affirmation, and I regard this as a strategy that strengthened the possibility of my findings being fairly dependable and possibly comparable to findings regarding similar groups of people and contexts. In addition to this, I provided a highly detailed methodological description, in order to allow replication of the study in similar contexts (Shenton 2004:71; Henning *et al.*, 2004:146).

3.6.4 Confirmability

Confirmability is regarded as the extent to which the findings of the research are the product of the focus of research and not of the biases of the researcher. In quantitative terms, this refers to the level of objectivity that was adhered to during the research (Cohen *et al.*, 2003:108). Freedom from bias is contradictory to the underlying theories of the interpretivist and

constructivist approach, according to which the values and motives of the researcher do play a fundamental part in the research process (Babbie & Mouton 2001:278). Observer and researcher bias can be regarded as a given during any qualitative study, in view of personal views and values that unavoidably influence the manner in which data are interpreted during qualitative analysis. In my attempt to answer to the criterion of confirmability of my findings, I declared such biases from the start, and involved others such as my supervisor and the participants during data analysis. In addition to this, I constantly reflected on my thoughts and experiences in my field journal, and provided a chain of evidence as a demonstration of interpretations and the processes that I used to reach conclusions (Henning *et al.*, 2004:151; Cohen *et al.*, 2003:36).

I also considered the fact that scientific research on sensitive issues (such as HIV & AIDS, gender, and sexuality) usually compels the researcher to maintain meticulous self-control during data collection and analysis. I therefore regarded confirmability as more important than my being dispassionate or unbiased in the collection and interpretation of the data, and cautioned myself not to alter the personal views of others to match my own preconceived notions or preferences. Research integrity necessitated that I overcome personal and prejudicial attitudes, personal preconceptions and value judgements, and not be subject to traditional or "received systems of thought" (Cohen *et al.*, 2003:129). I took care to not only consider seemingly strong ideas and most apparent discoveries, but I also considered the inexplicable or complex ones in respect of the importance they had for addressing the primary question of my study.

3.6.5 Authenticity

Ensuring authenticity in qualitative research implies that the researcher portrays a balanced view of the various perspectives, opinions, beliefs and

values of the participants. I regard authenticity as the outcome of the ability of the researcher to report a situation through the eyes of the participants (Cohen *et al.*, 2003:108). In my study, I attempted to achieve authenticity by means of member checking and various data collection methods, in order to obtain fairness and to exhibit a balanced portrayal of various realities with regard to the implementation of HIV & AIDS programmes in schools. I aimed to ensure ontological authenticity by providing a fresh and more sophisticated understanding of the implementation of HIV & AIDS programmes in schools. I attempted to provide a better understanding of the challenges (contextual factors) that teachers experience, and to contribute to the improvement of the implementation of HIV & AIDS programmes in schools, and, as such, to ensure catalytic authenticity in my research (Cohen *et al.*, 2003:108, 120; McMillan & Schumacher 2001:415).

3.7 ETHICAL CONSIDERATIONS

In view of the nature of my data collection strategies, I was conscious about the responsibility that I bear with regard to respect for the teaching profession as well as for the participants (Strydom 1998:25; Cohen *et al.*, 2003:292). During my research, I aimed not to infringe upon the dignity of the participants, and constantly provided them with a clear picture of the purpose of my study and the processes that I was following.

3.7.1 Informed consent

Considering the sensitive nature of certain data that I might collect, I obtained authorization from the relevant authorities, such as the Gauteng Department of Education, school principals, and teachers prior to entering the research field (see Addenda C and D regarding permission to conduct research, and Addendum E for the various letters of voluntary informed consent). This indicates that the research participants had the right to choose

whether or not to participate in the research study, after I provided them with information that could have influenced their decisions (McMillan & Schumacher 2001:421; Cohen *et al.*, 2003:292). During the data collection, I provided the research participants with adequate information about the purpose of the study, the procedures I would follow, as well as the possible advantages of the outcomes of the study. I also made it clear that the confidentiality and anonymity of the participants, the schools and the data would be respected, and that participants had the right to withdraw from the study at any time, if they wished to do so. No participants withdrew their consent or any information that they had provided during the study. In addition to inviting the participants to ask questions in order to clarify uncertainties, I explained the possible outcome and benefits of the study to the participants at the beginning of the interview sessions, and provided the opportunity to clarify their own thoughts and also learn from the process (Creswell 2003:64; Cohen *et al.*, 2003:291).

3.7.2 Privacy, confidentiality and anonymity

In view of the principle of privacy, I aimed to ensure and protect the confidentiality and anonymity of the participants at all times (Strydom 1998:28; McMillan & Schumacher 2001:422; Cohen *et al.*, 2003:292). The benefit of providing the participants with the assurance, that their privacy will be protected, was that it assured me that I would obtain their maximum response and cooperation during interviews. This entailed that I did not disclose the identities of the research participants during or after the study, and that I dealt with all information obtained during the research process in a confidential manner. In this regard, I excluded or changed the names in the raw data and resolved to preserve all field notes, audio and visual material, transcripts and other data in a safe environment, and to destroy them only after the stipulated time had expired. I also did not include any identifying information with regard to the exact setting and the schools in which I

conducted the study, protecting the identity and privacy of both the participants and their schools.

3.7.3 Protection from harm

In order to protect participants from possible harm, I avoided or at least recognised and communicated probable risks to the participants, such as exposure to psychological, physical or social harm (Strydom 1998:33; Berg 2001:232). No participants were exposed to any physical risks or harm other that those they faced during normal daily life. I adhered to the principles of caring and fairness, as mentioned by McMillan and Schumacher (2001:422), with the intention of protecting participants from harm. I foresaw that the participants might be anxious not to be labelled as informants that divulge sensitive information with regard to the implementation of HIV & AIDS programmes in their schools. In order to avoid possible social harm, I assured the participants of their privacy and anonymity. I also kept in mind that dealing with HIV & AIDS as a topic might be a sensitive issue for some participants, therefore I was open and honest about the fact that we were dealing with a sensitive issue and that it must be treated as such.

3.8 SIGNIFICANCE OF THE METHODOLOGICAL CHOICES FOR MY STUDY

Selecting a case study design to conduct my study implies that there are certain advantages that I consider to have contributed to the significance of my study. I only focused on one case (the implementation of the HIV & AIDS programme), with several participants sharing their opinions on the same programme implementation, resulting in the opportunity to gain an in-depth insight into the personal experiences and opinions of the participants (Creswell 2003:186). This created the possibility of obtaining data that are true to the lived-experiences of the participants with regard to a focus on the

implementation of the HIV & AIDS programme in their schools' context. The selected activities (interviews) can also be regarded as cost-effective in terms of time, as elaborate information could be obtained within a relatively short period of time. The selected activities were not experienced as interfering with the normal activities of the institutions, as they were conducted after school hours with the intention not to disrupt and not to intrude upon the responsibilities of the participants.

In the light of my methodological choices and the consequent outcomes of my study, I am certain that the identification of contextual factors that influence the implementation of HIV & AIDS programmes has the possibility of enhancing relevant curriculum development and improving curriculum delivery to learners. I believe my study contributed new knowledge with regard to the manner in which contextual factors influence the implementation and management of curricula in schools. In addition, the outcomes of this study may inform policy developers with regard to shortcomings in the current HIV & AIDS schools policy and result in the improvement of prevention programmes in schools. I am further convinced that the findings of my study will significantly contribute to the advancement of teacher training in respect of the Life Orientation Learning Area. I believe that my study has the potential to inform policy makers and persons involved with curriculum design and implementation regarding the lived-experiences of teachers and managers at school level with regard to the challenges that they experience during the implementation of HIV & AIDS programmes in schools.

3.9 METHODOLOGICAL CHALLENGES OF MY STUDY

Regarding the methodology that I followed during my study, some challenges occurred. The interpretivist and constructivist paradigms, that formed the underpinning epistemology of my research, resulted in the subjective interpretation of data and consequent construction of my own subjective

understanding of the manner in which teachers gave meaning to the implementation of the HIV & AIDS programme. Therefore, I cannot claim absolute objectivity regarding this study, although, being aware of this, I continuously reflected on my personal biases and prejudices, and requested clarity when uncertainties arose. I also acknowledged (as already mentioned in Chapter 1) that I am a white, Afrikaans-speaking South African male, with my own unique personality, religion, culture and life-history, that will influence the outcome of this study with respect to the possibilities of subjectivity and prejudice.

When following a case study design, the first challenge was to identify the number of schools that would be part of the data collection process. I decided to follow an instrumental case-study design, as my focus was on the implementation of the HIV & AIDS programme, and not the school as such. I included three schools in order to obtain various perspectives from participants that experience different contexts with regard to the same programme, in order to obtain an in-depth and multi-faceted perspective, thereby enhancing the in-depth feature of findings, instead of merely focussing on the limited experiences in one case (school).

Initially my view was that during data collection the first language differences between myself and the participants would be a serious challenge to the study. I entered the field as a person with a cultural and linguistic background that differed from those of the research participants, and the participants also communicated through English as their second language. According to Berg (2001:58), the interviewer's language ought to be understandable to the research participants, and preferably on their level, or in their preferred language. Even though none of the participants spoke English as a first language, I decided to conduct all the interviews in English, in consideration of the fact that these were secondary schools, and English is being used as a medium of instruction. Nevertheless, I arranged for an interpreter to be

available during interviews in order to overcome this challenge and to ensure that possible doubts and uncertainties could be clarified. This was, however, not necessary, as all the discussions during the interviews went fluently and the participants were able to clarify any misunderstandings.

Another challenge of employing an instrumental case study design was that generalisations could not be made from a single or even only three case studies, and secondly, causal links were difficult to test, as they were in danger of being influenced by observer bias that could be subjective, personal, selective and presumptuous (Terre Blance & Durrheim 2002:133; Cohen *et al.*, 2003:184). I constantly reminded myself of these challenges while also keeping in mind that the focus of my data collection was to obtain an in-depth inquiry of the case, which was to identify and investigate contextual factors that influence the implementation of the HIV & AIDS programme in schools. Although more cases and a larger sample of participants normally imply a greater possibility to ensure generalisation of findings, this was not my purpose, based on the interpretivist paradigm of my study (Creswell 2003:196; Cohen *et al.*, 2003:146).

3.10 SUMMARY

In view of the literature review that I undertook in Chapter 2, I planned an empirical study at three secondary schools in Soshanguve, in order to identify and investigate contextual factors that influence the implementation of the HIV & AIDS programme in schools. In this chapter, I concentrated my discussion on a detailed description of the research process that I followed.

I presented an exposition of my research methodology with regard to the research questions and the purpose of my study. I included a focussed discussion on the strengths and challenges that I regard significant in view of my experiences during the data collection and analyses of my study. In

addition to this, I deliberated on the manners in which I handled ethical considerations as well as my consistent efforts to enhance the trustworthiness of my study. Chapter 4 will constitute a report of the results of my study, followed by an interpretation and discussion of the findings.

CHAPTER 4

REPORTING THE RESULTS OF THE STUDY

4.1 THE AIM OF THIS CHAPTER

In Chapter 3, I described the empirical part of my study in terms of the selected research design and my preferred methodological choices. I also justified my methodological choices and procedures on the basis of the research questions and purpose of my study, as formulated in Chapter 1.

In this chapter I shall report the results of my study. I aim to provide a holistic view of the results by making use of tables and diagrams that will illustrate the responses of the participants as well as my interpretations thereof. I shall discuss the aims, responses and outcomes of the various questions directed during my field work sessions (interviews[12]) I shall use verbatim responses and visual images to enrich my discussions with the aim of addressing my primary research question, namely: In what manner do contextual factors influence the implementation of HIV & AIDS programmes in schools?

In order to enable the reader to clearly follow the discussions in this chapter, I present Diagram 4.1, in which the abbreviations are explained.

[12] A copy of the questionnaire is included as Addendum A.

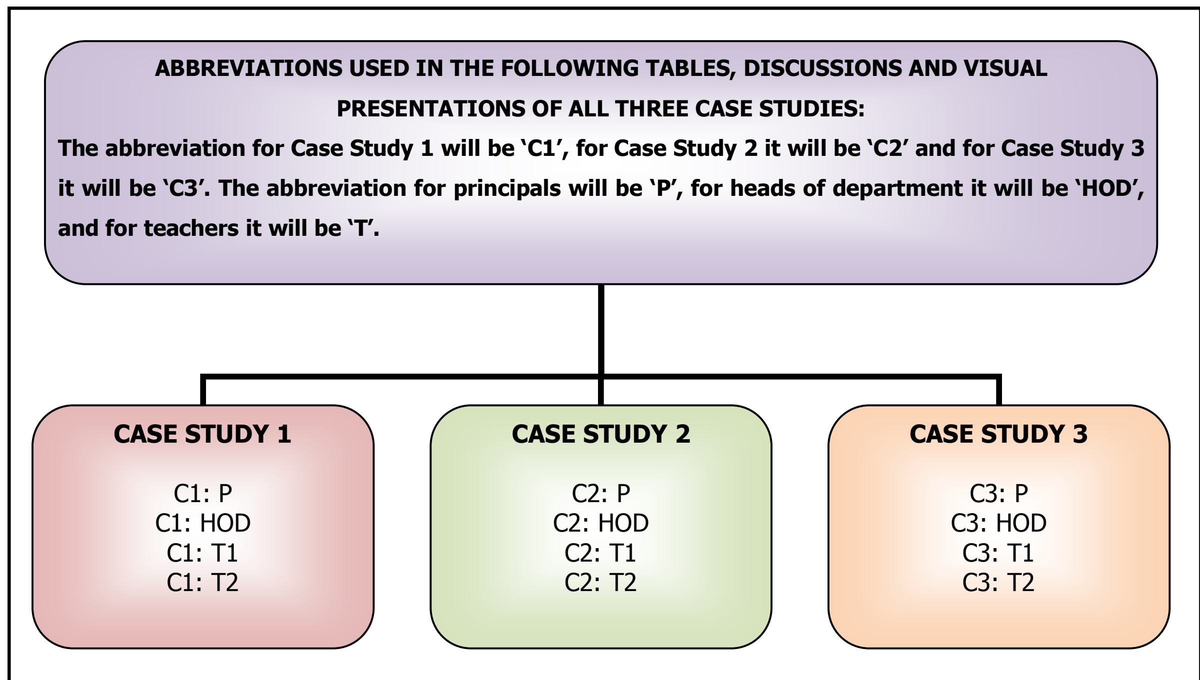


Diagram 4.1: Key to abbreviations

Section A: Biographical information

I asked Question 1, 2, 3 and 4 in order to gather biographical information regarding the research participants. The responses to each question are tabled below, in order to create a biographical analysis of the research participants who were interviewed during my study.

4.2 QUESTION 1: WHAT IS YOUR POSITION AT THE SCHOOL?

4.2.1 The aim of Question 1

The aim of Question 1 was to determine a participant's position at the school. For the purpose of my study, I anticipated that the position of the participant may provide an important indication with regard to the extent of his/her

responsibility for implementing the programme in his/her school. I presumed that on higher levels of authority, the responsibility would be greater.

Table 4.1: Number and positions of participants

Number and positions of participants in Case Studies 1, 2 and 3	
Position at school	**Number**
C1: P	**1**
C1: HOD	**1**
C1: T1	**1**
C1: T2	**1**
C2: P	**1**
C2: HOD	**1**
C2: T1	**1**
C2: T2	**1**
C3: P	**1**
C3: HOD	**1**
C3: T1	**1**
C3: T2	**1**
Total	**12**

4.2.2 Interpretation of Table 4.1

Table 4.1 reflects the fact that twelve[13] participants were interviewed in three different Case Studies. The twelve participants consisted of three principals, three heads of department, and six teachers, as visually presented in Diagram 4.2 below.

[13] For the purpose of this study all numbers up to twelve will be spelled (Reader's Digest 1985:395).

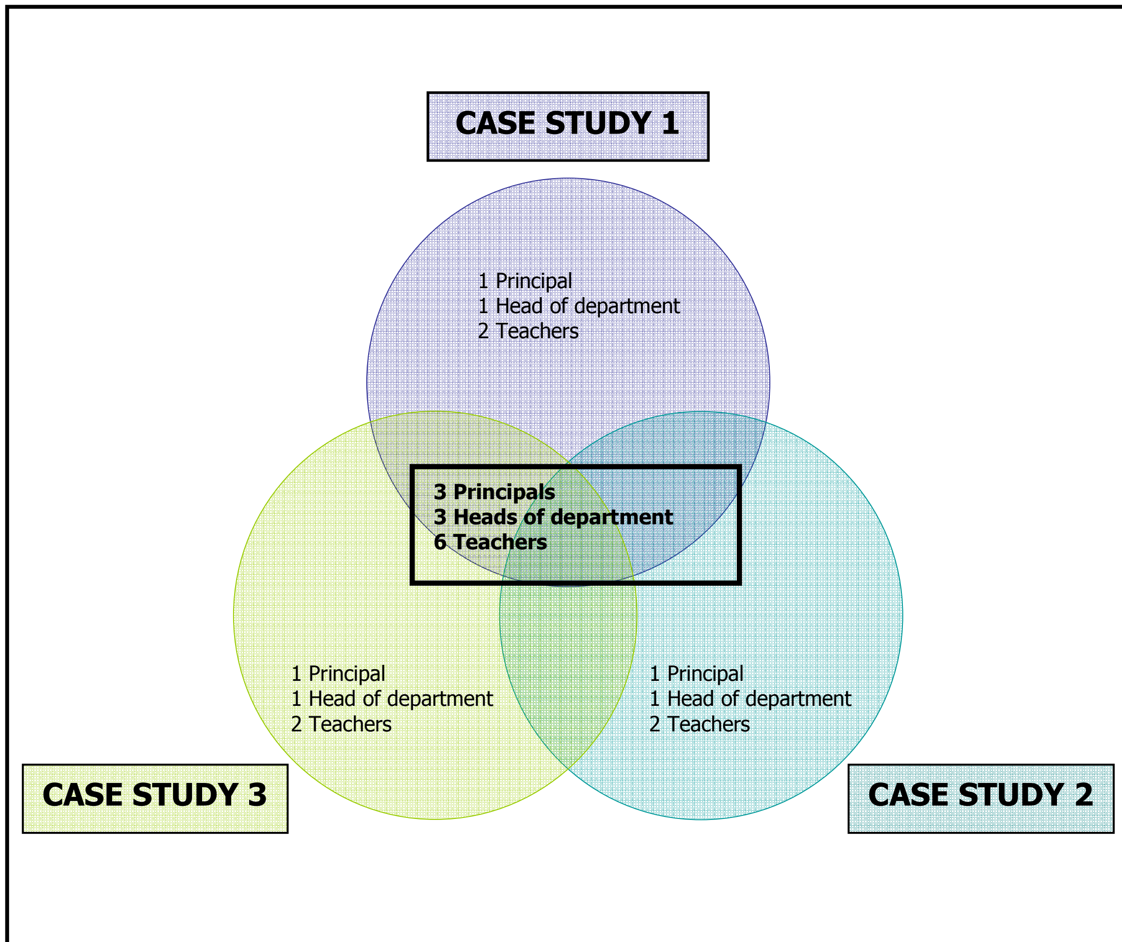


Diagram 4.2: Summary: number of participants

4.2.3 Assumption regarding Question 1

I assume that the responses of the participants will to a certain extent reflect the experiences of school managers and teachers with regard to the implementation of the HIV & AIDS programme, and, as such, will highlight possible contextual factors that influence the implementation thereof.

4.3 QUESTION 2: WHAT IS YOUR HIGHEST QUALIFICATION?

4.3.1 The aim of Question 2

Question 2 was asked to determine the training that the participant had received. I anticipated that this information (together with the information obtained from question 3) may indicate a participant's level of academic and professional development, growth and maturity.

Table 4.2: Participants' qualifications

CASE STUDY 1, 2 and 3	
Participant	**Qualification**
C1: P	BEd degree in Education Management
C1: HOD	BEd in Educational Studies
C1: T1	BA degree in Psychology
C1: T2	BEd (Hons) Learning Support and Counselling. Master Trainer for HIV & AIDS
C2: P	BComm (Hons)
C2: HOD	BA degree in Psychology
C2: T1	National Diploma in Education
C2: T2	BA (HED) and trained as counsellor
C3: P	BComm (Hons)
C3: HOD	BA Degree in Psychology
C3: T1	National Diploma in Education
C3: T2	BA (HED) and trained as a counsellor

4.3.2 Interpretation of Table 4.2

My interpretation of Table 4.2 revealed that all the participants were qualified teachers. Twelve of the participants were graduated teachers with a vast variety of expertise in the field of education, from management and psychology to counselling. Two of the participants did not have a degree in a particular field. One principal had specialised in education management.

4.3.3 Conclusions regarding Question 2

I found it remarkable that in each Case Study there was at least one participant who was qualified in psychology and/or counselling. Teachers who are qualified in this regard may be considered beneficial to the implementation of the HIV & AIDS programme in schools. I reasoned that, with the considerable number of qualifications and experience with regard to further education and studies, the participants would be able to provide responses that are educationally sound in relation to the implementation of the HIV & AIDS programme, and that they would be able to identify contextual factors that influence the implementation thereof. The fact, that only one principal (C1:P) has a qualification in education management, highlights the possible shortage of sound management practices in the schools, which may be a contextual factor that influences the implementation of HIV & AIDS programmes.

4.4 QUESTION 3: HOW LONG HAVE YOU BEEN A TEACHER?

4.4.1 The aim of Question 3

I posed Question 3 to determine the participants' years of teaching experience. I believed that this information would contribute to my understanding of the competence level of a participant, and of the relation between the latter fact and his/her involvement in HIV & AIDS programmes in the school. A participant's expertise and skills acquired through years of teaching might serve as motivation (a contextual factor) for his/her willingness (or reluctance) to become involved in HIV & AIDS programmes that include very sensitive content.

Table 4.3: Participants' teaching experience

Participants' teaching experience				
Participant	**Years experience as a teacher**			
	0-5 years	**5-10 years**	**10-20 years**	**20 years or more**
C1: P				X
C1: HOD				X
C1: T1				X
C1: T2				X
C2: P				X
C2: HOD			X	
C2: T1	X			
C2: T2			X	
C3: P				X
C3: HOD			X	
C3: T1	X			
C3: T2	X			
TOTAL	**3**	**0**	**3**	**6**

4.4.2 Interpretation of Table 4.3

Regarding the number of years experience of the participants, the three principals each had more than 20 years experience. Each of the three heads of department had more than 10 years experience (one had more than 20 years experience). Two of the six teachers each had more than 20 years experience, while three of the teachers each had up to 5 years experience, as illustrated in Diagram 4.3 below.

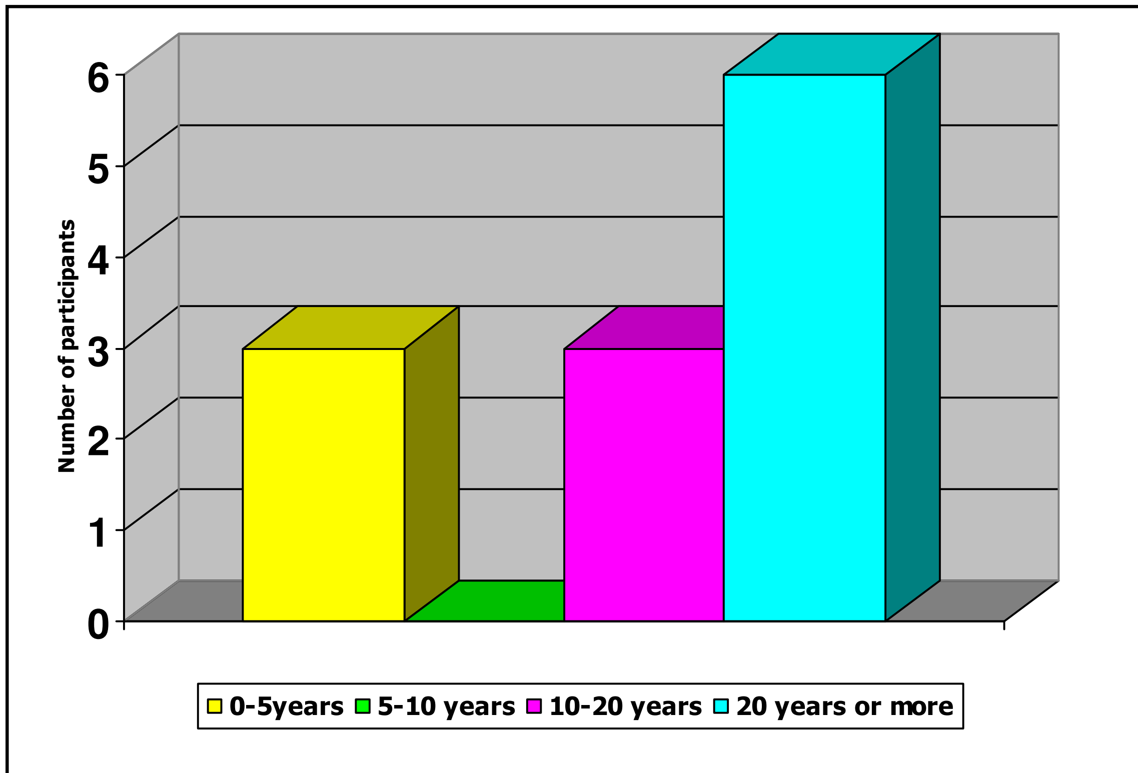


Diagram 4.3: Visual presentation of the participants' years of experience

4.4.3 Conclusions regarding Question 3

In view of the fact that the participants in managerial positions (three principals and three HODs) each had more than ten years of teaching experience, I am of the opinion that the schools in the Case Studies had experienced education managers on site who ought to be competent with regard to the implementation of the HIV & AIDS programme. Furthermore, the participants in managerial positions in all three Case Studies have adequate educational qualifications, as discussed in paragraphs 4.3.2 and 4.3.3 above. I thus conclude that there were teachers with adequate qualifications and managerial experience in these schools for the implementation of the HIV & AIDS programme.

4.5 QUESTION 4: TO WHAT EXTENT ARE YOU INVOLVED IN HIV & AIDS PROGRAMMES IN YOUR SCHOOL?

4.5.1 The aim of Question 4

The aim of Question 4 was to determine the extent of the participant's involvement in HIV & AIDS programme implementation or in the management thereof in his/her school. This information may indicate significant relations between position (Question 1), highest qualification (Question 2), years of experience (Question 3), and level of involvement (Question 4), which may be contextual factors.

Table 4.4: A summary of the involvement of all the participants

Participants' level of involvement			
Participant	**Involvement**		
	Not involved at all	**Indirectly involved**	**Directly involved**
C1: P		X	
C1: HOD		X	
C1: T1		X	
C1: T2			X
C2: P		X	
C2: HOD			X
C2: T1			X
C2: T2			X
C3: P			X
C3: HOD			X
C3: T1		X	
C3: T2			X
TOTAL	**0**	**5**	**7**

4.5.2 Interpretation of Table 4.4

Table 4.4 indicates the fact that the twelve participants regarded themselves as being either directly or indirectly involved in the HIV & AIDS programme in their respective schools. Five participants (2 principals, 1 head of department and 2 teachers) indicated their indirect involvement. Seven participants (1 principal, 2 heads of department and 4 teachers) indicated their direct involvement. These facts are visually displayed in Diagram 4.4.

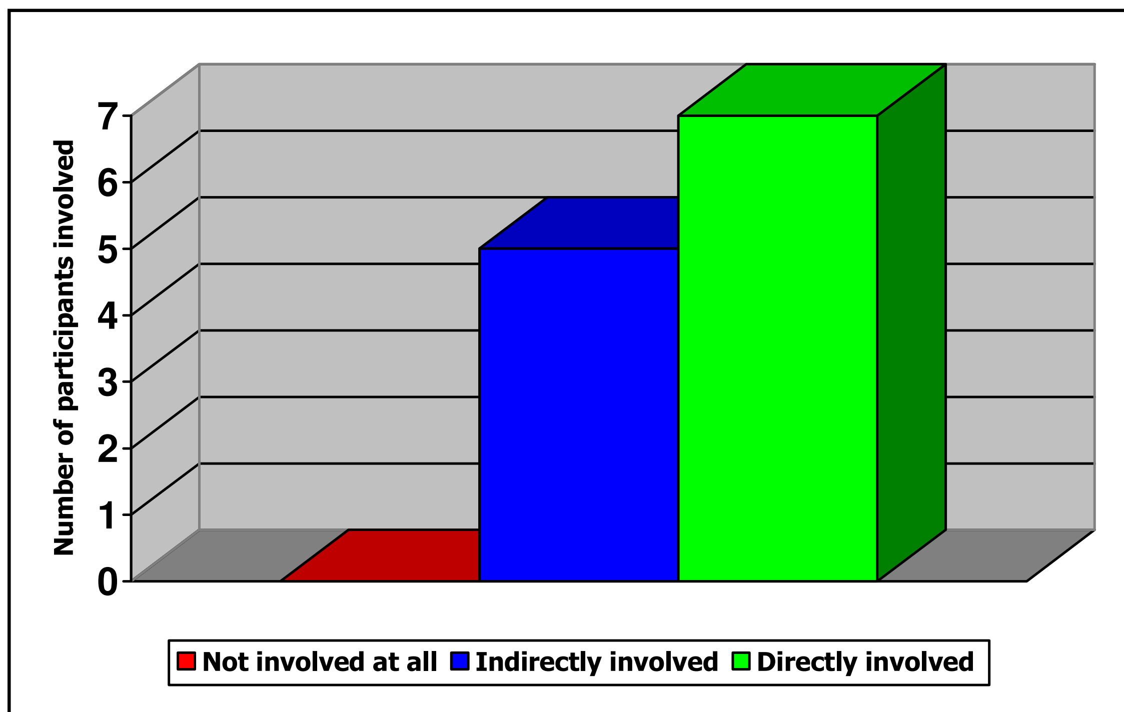


Diagram 4.4: Visual presentation of the involvement of the participants in HIV & AIDS programmes in their schools

4.5.3 Conclusions regarding Question 4

It is encouraging to note that all the participants regard themselves as being either directly or indirectly involved in the implementation of the HIV & AIDS programme. This may imply that the HIV & AIDS programme is implemented at

the schools in the Case Studies. The question would then remain as to the manner in which the programme is implemented in the respective schools.

I noted that one HOD and two teachers indicated that they were indirectly involved in the implementation of the HIV & AIDS programme. This confusion may be ascribed to teachers not being aware that the HIV & AIDS programme forms part of Life Orientation as a school subject, or that HIV & AIDS is not dealt with, within the subject. I also consider the possibility that teachers are not aware of or are not complying with the requirements in respect of Life Orientation as a subject (in this regard also refer to paragraph 4.11.3).

SECTION B: TRAINING WITH REGARD TO HIV & AIDS EDUCATION

4.6 QUESTION 5: HAVE YOU ATTENDED ANY TRAINING SESSIONS, WORKSHOPS OR INFORMATION SESSIONS WITH REGARD TO HIV & AIDS? IF SO, WHERE, WHEN AND BY WHOM WERE THESE SERVICES RENDERED?

4.6.1 The aim of Question 5

I posed Question 5 with the aim of determining the nature and duration of the training that the participants had received. I assumed that this information would highlight the specialised training that the participants had received with regard to HIV & AIDS programmes, and would indicate the relation between further training (a contextual factor) and the quality of the implementation of HIV & AIDS programmes in schools.

Table 4.5.1: Training that participants in Case Study 1 had received

CASE STUDY 1				
Participant	**Trained**	**Nature of HIV & AIDS training**	**When?**	**Provided by?**
C1: P	Yes	Workshop for principals	2002	Department of Education (Tshwane North district office)
C1: HOD	No	No training	n/a	n/a
HT1	Yes	HIV & AIDS training	Long ago	Department of Education
HT2	Yes	HIV & AIDS workshops	Continuously	City Council of Pretoria Department of Education NGOs
Total	**3**	**n/a**	**n/a**	**n/a**

4.6.2 Interpretation of Table 4.5.1

In Case Study 1, three participants affirmed that they had received training with regard to HIV & AIDS. One participant had no training (C1: HOD had not received any training). This was an alarming discovery, because I would expect the head of department (of Human and Social Sciences) of a school to be at the forefront of programmes and developments within the department for which he/she is responsible. Two of the participants who had received training stated that this had happened long ago. This convinced me that, although they had attended training, the current relevancy and significance thereof might be questionable.

Table 4.5.2: Training that participants in Case Study 2 had received

CASE STUDY 2				
Participant	**Trained**	**Nature of HIV & AIDS training**	**When?**	**Provided by?**
C2: P	Yes	Lecture on HIV & AIDS at school	Long ago	Lecturers
C2: HOD	Yes	HIV & AIDS training Training for the girl learners	2003	Department of Education
C2: T1	No	Attended no such training	n/a	n/a
C2: T2	Yes	HIV & AIDS training Training as counsellor	2006	District office (medical doctor) University
Total	**3**	**n/a**	**n/a**	**n/a**

4.6.3 Interpretation of Table 4.5.2

Case Study 2 revealed that three participants were trained while one participant was not trained. The principal and HOD of the school reported that their training had been received 'long ago' and in 2003. Again, this raised the question with regard to the current relevancy and significance of their training.

Table 4.5.3: Training that participants in Case Study 3 had received

CASE STUDY 3				
Participant	**Trained**	**Nature of HIV & AIDS training**	**When?**	**Provided by?**
C3: P	Yes	HIV & AIDS training (Support for infected and affected learners)	2006	Department of Education
C3: HOD	Yes	Attended a workshop	2003	Unknown
C3: T1	Yes	HIV & AIDS training	2006	Department of Education
C3: T2	No	Never received any training	n/a	n/a
Total	**3**	**n/a**	**n/a**	**n/a**

4.6.4 Interpretation of Table 4.5.3

In Case Study 3 the same pattern with regard to the training of participants emerged. I established that three of the participants had received training, while one participant had no training. One participant (C3: HOD) once attended a workshop in 2003. Two participants (C3: P and C3: T1) reported that they had received training in 2006, and that was the last training opportunity they were aware of. This again gave me a clear indication that training opportunities for these two participants had been inconsistent and limited.

Table 4.5.4: Summary of participants' training

Participant	Trained	Nature of HIV & AIDS training	When?	Provided by?
C1: P	Yes	Workshop for principals (general/ generic training)	2002	Department of Education (Tshwane North district office)
C2: P	Yes	Lecture on HIV & AIDS at school	Long ago	Unknown
C3: P	Yes	HIV & AIDS training: To support infected and affected learners	2006	Department of Education
C1: HOD	No	No training	n/a	n/a
C2: HOD	Yes	General HIV & AIDS workshop	2003	Department of Education
C3: HOD	Yes	Workshop	2003	Unknown
C1: T1	Yes	HIV & AIDS training	Long ago	Department of Education
C1: T2	Yes	General HIV & AIDS workshops	Continuous training	City Council of Pretoria, Department of Education, NGOs
C2: T1	No	n/a	n/a	n/a
C2: T2	Yes	HIV & AIDS training Training as counsellor	2006	Department of Education, University
C3: T1	Yes	HIV & AIDS training	2006	Department of Education
C3: T2	No	n/a	n/a	n/a
Total	**9**	**n/a**	**n/a**	**n/a**

4.6.5 Interpretation of Table 4.5.4

Nine of the participants indicated that they had undergone training with regard to HIV & AIDS. The remaining three participants indicated that they had not received any training. One HOD (who I assumed would bear more responsibility with regard to the implementation of HIV & AIDS programmes) had not received any training in this regard. One principal mentioned that he had only attended an information lecture offered at the school (during the interview this participant seemed distant and not interested in HIV & AIDS).

In contrast, three participants who were teachers, seemed to have a sincere interest in HIV & AIDS related issues. They were either involved in community structures where they supported people with HIV & AIDS education, or they were enrolled at higher education institutions to improve their qualifications.

4.6.6 Conclusions regarding Question 5

In the light of the above responses I concluded that opportunities for attending training, workshop or information sessions with regard to the implementation of the HIV & AIDS programme varied significantly. There appears to be a lack of training opportunities for teachers with regard to the implementation of the HIV & AIDS programmes in schools. I am also of the opinion that information sessions and workshops ought to be presented on a continuous basis, in order to assist and monitor the implementation of the HIV & AIDS programme. The continuous further training of teachers involved in the implementation of the HIV & AIDS programme should be made a priority.

4.7 QUESTION 6: ON A SCALE OF 1 TO 5, HOW HIGH WOULD YOU RATE YOUR KNOWLEDGE WITH REGARD TO HIV & AIDS?

4.7.1 The aim of Question 6

The aim of Question 6 was to determine how adequate the participants regarded their knowledge with regard to HIV & AIDS. I presumed that this information would indicate how candid and open a participant might respond to HIV & AIDS related issues.

Table 4.6: Participants' self-perceived level of knowledge with regard to HIV & AIDS

CASE STUDY 1, 2 and 3					
Participant	**Level of knowledge**				
	1: Low	**2: Below average**	**3: Moderate**	**4: Above average**	**5: Very high**
C1: P			X		
C1: HOD			X		
C1: T1			X		
C1: T2				X	
C2: P			X		
C2: HOD			X		
C2: T1			X		
C2: T2					X
C3: P			X		
C3: HOD			X		
C3: T1				X	
C3: T2					X
TOTAL	**0**	**0**	**8**	**2**	**2**

4.7.2 Interpretation of Table 4.6

Three of the participants in Case Study 1 perceived their knowledge with regard to HIV & AIDS as being moderate, while one participant considered himself as having an above average knowledge.

As in Case Study 1, three of the participants in Case Study 2 considered their knowledge with regard to HIV & AIDS to be moderate, but one participant felt that his knowledge was exceptional.

Only two participants in Case Study 3 perceived their knowledge with regard to HIV & AIDS as moderate. One participant considered his knowledge as being moderate, while one participant regarded his knowledge as exceptional.

In total, eight of the participants indicated that their knowledge with regard to HIV & AIDS was moderate, two participants indicated an above average knowledge, and two participants reported outstanding knowledge.

I found it interesting that, even though these participants rated their knowledge as being above average, there was no indication that a specific HIV & AIDS programme was being followed in their schools.

I found it interesting that the principals and heads of department indicated only a moderate level of knowledge, while the teachers perceived their knowledge as being above average or outstanding (as visually presented in Diagram 4.5 below).

4.7.3 Additional information

One teacher, who is involved in the community, remarked the following:

- The level of ignorance with regard to HIV & AIDS is still very high.
- People within the community still ignore the existence of the disease and believe that it is "... the whites that are coming with the stories…".
- People are not using condoms, although there are "many funerals and the HIV & AIDS death rate is high".
- Even educated people in the community take risks.

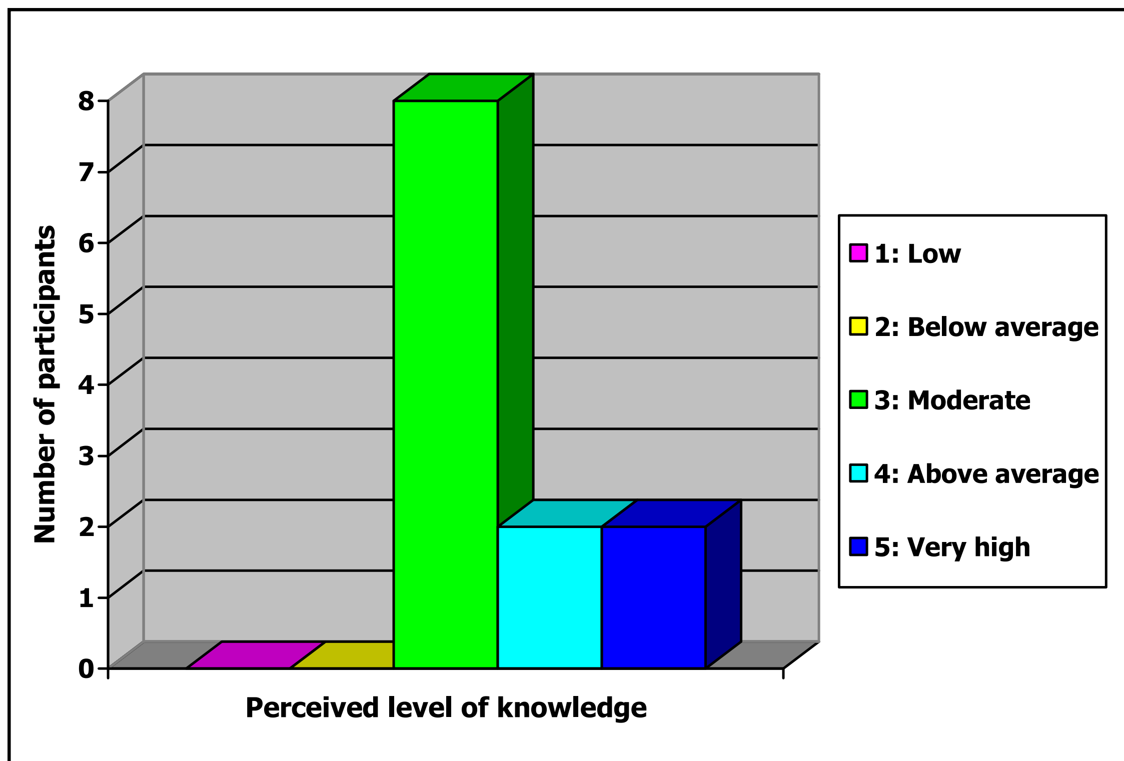


Diagram 4.5: Visual presentation of the participants' perceived level of knowledge with regard to HIV & AIDS

4.7.4 Conclusions regarding Question 6

An interesting consistency became evident, that those participants, who reported an above average to exceptional knowledge with regard to HIV & AIDS, had attended various departmental training activities and/or had enrolled at higher institutions of learning. They were also involved in other community structures, and manifested a very enthusiastic attitude during the interview.

One participant indicated that he had not attended any training programme with regard to HIV & AIDS, but reflected that he had outstanding knowledge with regard to the programme. This apparent contradiction made me wonder where and how the participant had acquired his knowledge. It became clear that the participant, although not officially trained by the department of education, had acquired knowledge on HIV & AIDS from the local clinic and by means of extensive reading.

It became clear to me that the participants perceived themselves as being knowledgeable with regard to HIV & AIDS related matters. They revealed self-confidence in this regard during the interviews, and I therefore expected that high levels of knowledge with regard to HIV & AIDS matters may ensure and enhance the implementation of the HIV & AIDS programme. This proved not to be the case. Even though the participants perceived themselves as being knowledgeable with regard to HIV & AIDS, and displayed confidence in discussing matters related to HIV & AIDS, it did not ensure their involvement in and implementation of the HIV & AIDS programme.

4.8 QUESTION 7: DO YOU AGREE OR DISAGREE WITH THE STATEMENT THAT HIV & AIDS CAN BE PREVENTED. IF YES, HOW?

4.8.1 The aim of Question 7

I presented Question 7 in order to determine what the participants' insights and perceptions were about the fact that HIV & AIDS infection could be prevented. This information would provide me with insight into the participants' opinions with regard to the feasibility of HIV & AIDS prevention. I assumed that the participants' views with regard to the prevention of HIV infection might be a decisive contextual factor that could influence the implementation of an HIV & AIDS programme in their schools.

Table 4.7: Participants' opinions on HIV & AIDS prevention

SUMMARY OF CASE STUDY 1, 2 AND 3			
Can HIV & AIDS be prevented?			**How can HIV & AIDS be prevented?**
Participant	**YES**	**NO**	
C1: P	**X**		Prevent HIV by educating people, learners and the community. They must know the causes and how the virus is spread. They have to use ABC (Abstain, Be loyal and Condomise).
C2: P	**X**		It is easy to prevent HIV & AIDS by advising people to abstain from sex.
C3: P	**X**		Prevention should entail abstinence from sexual activity (ABC). Transmission through body fluids, such as blood, should also be prevented.
C1: HOD	**X**		It can be prevented, but learners do not take prevention seriously. Leaders and authority figures have a negative impact on HIV & AIDS prevention. We need a campaign that is supported by all stakeholders. Adults need to set good examples to learners. The low morality of society makes prevention difficult.
C2: HOD	**X**		Prevention should include teaching morals. Some cultures do not allow parents to talk to their children about sex. Parents should be involved in prevention by talking to their children openly about sex and prevention.
C3: HOD	**X**		Prevention can be done by providing workshops and information sessions. When you share knowledge, you are doing prevention.
C1: T1	**X**		Young people must abstain and adults must be faithful to one partner.
C1: T2	**X**		All stakeholders such as government, teachers, learners and the community must participate in HIV & AIDS prevention programmes (education) to make it work.
C2: T1	**X**		Prevention can be done by abstaining from sex. Parents are not involved in prevention efforts.
C2: T2	**X**		Prevention is to take precautionary measures, educating the community and being open about HIV & AIDS. Schools should assist parents to talk to their children about HIV & AIDS. Cultural taboos often make it difficult for parents to talk about it.
C3: T1	**X**		Prevention is to educate our learners about sexuality and sex. Learners should abstain from sex and protect themselves if they are sexually active by using condoms. Prevention is to inform the learners and the community.
C3: T2	**X**		Prevention means that you should abstain from sex, or condomise if it is possible.
Total	**12**		

4.8.2 Interpretation of Table 4.7

The participants in Case Study 1 agreed that HIV & AIDS can be prevented. They mentioned education, abstinence (ABC), faithfulness, loyalty and the participation of all stakeholders in prevention programmes, as topics that they associate with prevention. One participant referred to the fact that learners do not take the disease seriously. The participant also referred to the negative impact of the behaviour of authority figures and low social morality as obstacles in the prevention of HIV & AIDS.

The participants in Case Study 2 had the same opinion as those in Case Study 1, that HIV & AIDS can be prevented. The participants associated abstinence, teaching of morals, precautionary measures and openness about HIV & AIDS with prevention. They mentioned two obstacles to prevention efforts: cultural taboos that do not allow parents to talk about sex, and uninvolved parents.

In Case Study 3 the participants were in agreement that HIV & AIDS can be prevented. The participants' opinions on HIV & AIDS prevention included aspects such as abstinence, workshops and information sessions for learners and the community, education, and the use of condoms. I found it interesting that none of the participants mentioned any obstacles with regard to HIV & AIDS prevention.

In summary, there were seven participants who indicated that they regard abstinence from sexual activity as the most important strategy in the prevention of HIV & AIDS transmission. Three participants held the opinion that prevention also entailed the use of condoms and faithfulness to one's partner.

4.8.3 Additional information

In addition to sharing their understanding of HIV & AIDS prevention, the participants also mentioned the following obstacles that they felt were important to keep in mind when dealing with prevention in the school. This included aspects such as:

- The teaching of appropriate moral values.
- The examples that were set by adults and authority figures in society and the school.
- The lack of parent involvement in prevention efforts.
- The poor support from other stakeholders in education, such as the government, teachers and the community.

4.8.4 Conclusions regarding Question 7

In view of the responses to Question 7, I concluded that the participants are familiar with the ways in which HIV infection can be prevented, that is abstinence from sexual activity, faithfulness to one's partner and condomising. I am of opinion that this might indicate the high level of knowledge of the participants with regard to HIV & AIDS, as discussed in paragraph 4.7.3 and 4.7.4 above.

4.9 QUESTION 8: WHAT IS YOUR VIEW WITH REGARD TO THE ROLE OF EDUCATION IN THE PREVENTION OF HIV & AIDS INFECTION? DOES EDUCATION HAVE A ROLE TO FULFIL IN PREVENTION?

4.9.1 The aim of Question 8

I directed Question 8 in order to create an opportunity for the participants to clarify their perceptions with regard to the role of education in HIV & AIDS prevention. This information could help me understand how important the participants regarded education in preventing HIV infection. I anticipated that the perceptions with regard to the importance (or unimportance) of education regarding HIV & AIDS might be a prominent contextual factor that influences the implementation of HIV & AIDS programmes.

Table 4.8: Participants' opinions on the role of education in the prevention of HIV & AIDS

Participant	Does education have a role in prevention of HIV infection?		Participants' views with regard to the role of education in the prevention of HIV infection.
	YES	**NO**	
C1: P	**X**		Prevention through education can work if learners are educated and they "listen". Parents must play a role in prevention efforts and the same efforts must be emphasised at school. The African cultural taboos make it difficult for the parents to talk about sexuality. Parents must also be educated to talk to their children about sex and HIV & AIDS.
C2: P	**X**		Education must inform and provide knowledge to learners and parents that HIV & AIDS is a serious reality.
C3: P	**X**		Education provides learners with knowledge on HIV & AIDS as the parents are unable to do so. Education also assists learners who are infected or affected to cope and care.
C1: HOD	**X**		Prevention in education requires the integration of all programmes, and sending the same message on prevention. "All must sing the same song". Sexual relationships between teachers and learners make prevention difficult. The morality of some teachers causes prevention to fail.
C2: HOD	**X**		Education plays a minimal role because it only provides learners with information on HIV & AIDS.
C3: HOD	**X**		Education is a way to make contact with vulnerable children. The school environment makes it possible to establish contact with learners.
C1: T1	**X**		Education is a way to inform learners and the community about HIV & AIDS.
C1: T2	**X**		Education can help to impart knowledge and provide programmes in order to prevent HIV & AIDS infection.
C2: T1	**X**		Education provides learners with knowledge with regard to issues that parents are not discussing with them because their culture prohibits it. Education helps to overcome cultural barriers to information.
C2: T2	**X**		Education provides learners with knowledge on preventing HIV & AIDS as well as how to care for and to cope with those who are infected. Education provides an opportunity for learners who are affected by HIV & AIDS to come to terms with their situations.
C3: T1	**X**		Education must provide learners with knowledge on prevention by means of the Life Orientation programme.
C3: T2	**X**		Education must make people aware of HIV & AIDS.
Total	**12**	**0**	

4.9.2 Interpretation of Table 4.8

The twelve participants answered positively to the question whether education has a role to play with regard to the prevention of HIV & AIDS. The participants' views with regard to the role of education in HIV & AIDS prevention included the following aspects:

- The provision of knowledge and information to learners and parents about sexuality, sex and HIV & AIDS.
- Assistance to parents who are unable to talk to their children about HIV & AIDS because of cultural barriers.
- Support for learners who are infected or affected by HIV & AIDS to care and/or cope with their situations.
- Creates an environment for establishing contact with vulnerable learners, for example orphans.

4.9.3 Additional information

One participant viewed the role of education with regard to prevention of HIV & AIDS as minimal. The participant felt that the time allocated to Life Orientation (the programme in which HIV & AIDS education is offered) was limited. The participant was of the opinion that more time was needed to reach the learners, and that teachers should be allocated who solely dealt with Life Orientation as a programme. I realised that HIV & AIDS programmes were only dealt with during Life Orientation periods (2 hours per week), and that teachers were allocated to the programme over and above their other programmes.

Another participant strongly felt that all school programmes should convey the same prevention message ... "all teachers must sing the same song". The participant also stated that sexual relationships between teachers and learners

were hindering prevention efforts and messages communicated through education.

4.9.4 Conclusions regarding Question 8

In view of the responses to Question 8, I concluded that all the participants regarded education as having an important role with regard to the prevention of HIV infection. This indicated that the participants might also regard the implementation of the HIV & AIDS programme as equally important.

In addition, I concluded that the two hours per week, allocated to the HIV & AIDS programme as per departmental requirements, were either insufficient or the allocation of time on the schools' timetables had been wrongly calculated.

4.10 QUESTION 9: WHICH ASPECTS DO YOU REGARD AS IMPORTANT WHEN DEALING WITH HIV & AIDS PREVENTION?

4.10.1 The aim of Question 9

The intention of asking Question 9 was to allow the participant to identify and prioritise aspects with regard to HIV & AIDS prevention according to his/her view. I was of the opinion that his/her answer would elucidate how he/she understood prevention, and what his/her view on prevention programmes encompassed. This information might lead the participant to a realisation of the importance of education in changing behaviour.

Table 4.9: Important aspects with regard to HIV & AIDS prevention in Case Studies 1, 2 and 3

SUMMARY OF CASE STUDIES 1, 2 AND 3							
Participants	**Important aspects with regard to HIV & AIDS prevention**						
	Abstinence	**Safe sex/ Condomising**	**Sexual activity**	**Faithfulness**	**Education/ Knowledge**	**Communication /Openness**	**Life style/ risks**
C1: P			X		X		
C2: P			X		X		
C3: P					X	X	X
C1: HOD	X	X					
C2: HOD					X		
C3: HOD	X	X		X		X	X
C1: T1	X	X		X			
C1: T2					X		
C2: T1	X	X		X		X	
C2: T2	X	X			X	X	
C3: T1	X	X					X
C3: T2			X		X	X	
Total	**6**	**6**	**3**	**3**	**7**	**5**	**3**

4.10.2 Interpretation of Table 4.9

The participants spontaneously mentioned 7 aspects that they regarded as important with regard to HIV & AIDS prevention. These aspects were reported in different frequencies as follows (refer to Diagram 4.6 below):

- Education/Knowledge, (seven responses);
- Abstinence, (six responses);
- Condomising/Safe sex, (six responses);
- Communication/Openness, (five responses);
- Faithfulness, (three responses);
- Life style/Risks, (three responses);
- Sexual activity, (three responses).

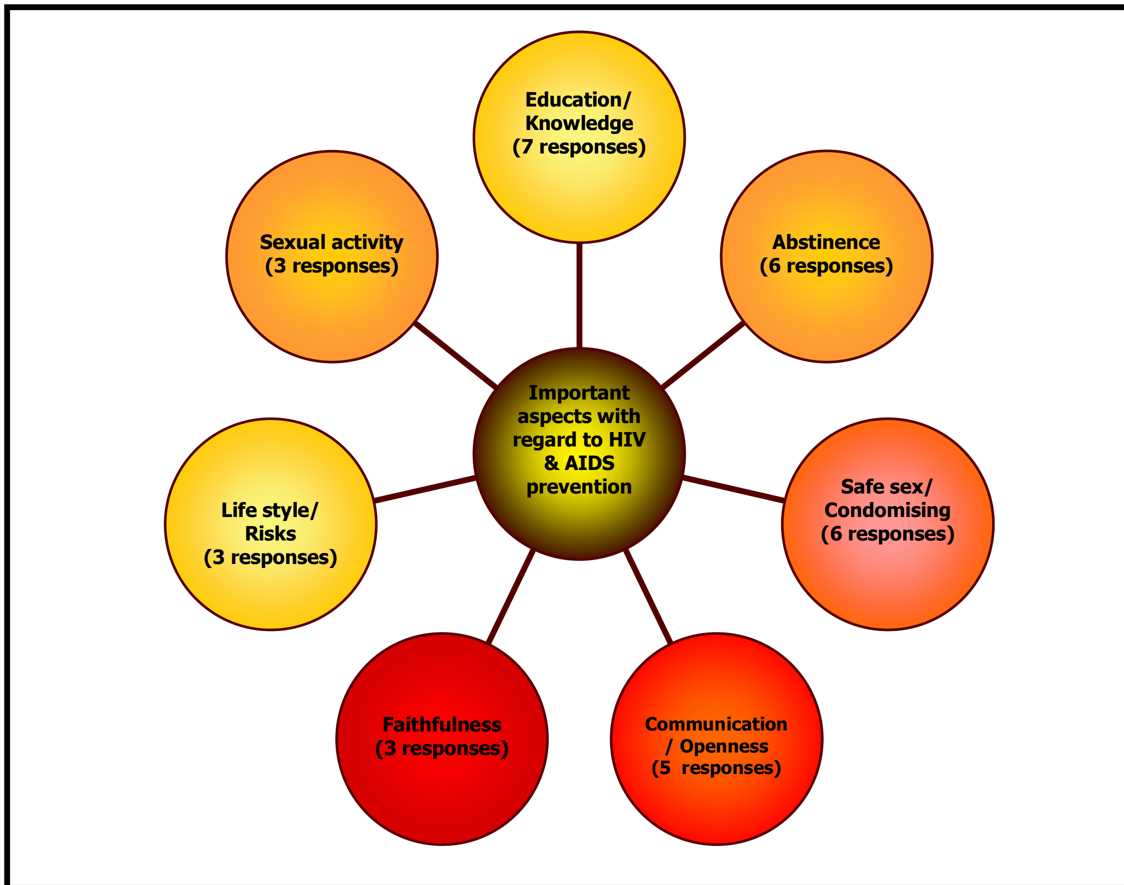


Diagram 4.6: Important aspects mentioned with regard to HIV & AIDS prevention

4.10.3 Additional information

In response to Question 9, the participants provided additional information with regard to aspects of HIV & AIDS education that they found challenging. These include:

- The encouragement of learners to condomise if they do not want to abstain from sex;
- Simultaneously dealing with learners who are sexually active, and learners who have not yet engaged in sexual activities, without differentiating between them;

- The mindset of learners and parents who still believe that HIV & AIDS does not exist;
- The law that allows 12 year old children to obtain condoms (may be interpreted as permission to have sex);
- The limited time in school that is allocated for HIV & AIDS awareness (only two hours per week and one day per year);
- Myths that only people of a certain age can become infected with the virus, or that if you live in a certain area you are sure to be infected, or that HIV & AIDS does not exist;
- Poverty, peer pressure and substance abuse make learners vulnerable to becoming sexually active.

4.10.4 Conclusions regarding Question 9

In view of the responses, I conclude that the participants have a sound understanding of what prevention of HIV infection entails. This concurs with the expected high levels of knowledge with regard to HIV & AIDS, as discussed in paragraphs 4.7.3, 4.7.4 and 4.8.4 above. I also conclude that, despite their apparent high levels of knowledge, the participants experience challenges with regard to the implementation of HIV & AIDS programmes.

SECTION C: The school's HIV & AIDS programme

4.11 QUESTION 10: DOES YOUR SCHOOL PRESENT AN HIV & AIDS PROGRAMME TO THE LEARNERS? IF NOT, IGNORE QUESTION 10 AND PLEASE ANSWER QUESTIONS 11A TO 11D.

4.11.1 The aim of Question 10

The aim of Question 10 was to determine whether a participant's school has an HIV & AIDS programme in place. I anticipated that the answer to this question would confirm whether the school was (was not) implementing an HIV & AIDS programme, and whether the participant was aware of it.

Table 4.10: Implementation of an HIV & AIDS programme at school

Participant	Implementation of an HIV & AIDS programme		
	YES	**NO**	**Details**
C1: P	X		Life Orientation and an HIV & AIDS awareness day.
C1: HOD		X	Had a class for HIV & AIDS programmes years ago.
C1: T1	X		Life Orientation programme.
C1: T2	X		Life Orientation programme.
C2: P		X	Will have one HIV & AIDS awareness day during the year.
C2: HOD	X		Life Orientation programme and one HIV & AIDS awareness day.
C2: T1		X	Waiting for a programme to be provided by the education department.
C2: T2	X		Life Orientation.
C3: P	X		Life Orientation and an HIV & AIDS awareness day, a clinic that visits the school; people living with HIV & AIDS visiting the school.
C3: HOD	X		Life Orientation.
C3: T1	X		Life Orientation and HIV & AIDS programme integration with other programmes.
C3: T2	X		Life Orientation.
Total	**9**	**3**	

4.11.2 Interpretation of Table 4.10

Table 4.10 shows that nine participants indicated that their schools were implementing an HIV & AIDS programme. Three participants stated that their schools were not implementing an HIV & AIDS programme.

4.11.3 Conclusions regarding Question 10

I realised that there were significant contradictions regarding the responses of participants of the same school. One participant (a principal) indicated that his school was implementing an HIV & AIDS programme, while the head of department indicated that no programme was being implemented. I realised that the participants, who indicated that their schools did not implement an HIV & AIDS programme, might not be aware that the HIV & AIDS programme for schools is included within Life Orientation. I explained to these three participants that the HIV & AIDS programme forms part of the Life Orientation curriculum. The ignorance of these teachers may be ascribed to a lack of communication and understanding within the management of the school, or to a possible misconception of what an HIV & AIDS programme comprises. Therefore I also conclude that some teachers (principals and HODs included) may not be abreast with the development and implementation of the subjects within the New Curriculum Statement for the Further Education and Training band (in this regard also refer to paragraphs 4.5.3, 4.16.3 and 4.17.5).

After clarifying the possible misunderstanding and/or lack of knowledge of the three participants, I conclude that all three schools were implementing the HIV & AIDS programme as part of Life Orientation.

ALTERNATIVE QUESTIONS TO QUESTION 10, IN THE INSTANCE OF NON-IMPLEMENTATION OF THE HIV & AIDS PROGRAMME.

4.12 QUESTION 11a: WITH REFERENCE TO QUESTION 10, WHY IS YOUR SCHOOL NOT IMPLEMENTING THE HIV & AIDS PROGRAMME?

4.12.1 The aim of Question 11a

Question 11a was presented in order to obtain information as to why the participant's school is not implementing the HIV & AIDS programme.

Table 4.11: Reasons for not implementing the HIV & AIDS programme

SUMMARY OF CASES STUDY 1, 2 AND 3	
Participant	**Why the school is not implementing the HIV & AIDS programme**
C1: P	n/a
C1: HOD	n/a
C1: T1	n/a
C1: T2	n/a
C2: P	n/a
C2: HOD	n/a
C2: T1	n/a
C2: T2	n/a
C3: P	n/a
C3: HOD	n/a
C3: T1	n/a
C3: T2	n/a

4.12.2 Interpretation of Table 4.11

All the participants reported that their schools were implementing the HIV & AIDS programme as part of the prescribed Life Orientation[14] curriculum (in this regard please refer to paragraphs 4.5.3 and 4.11.3).

4.12.3 Additional information

Even though the participants reported that their schools were implementing the HIV & AIDS programme, as prescribed within the Life Orientation curriculum, they mentioned the following factors that have an effect on the implementation:

- The lack of facilities such as sick rooms and rooms for private counselling of learners.
- Timetables that are very congested with other subjects in addition to Life Orientation.
- Some male teachers do not regard the pandemic as serious, and want to continue sexual relationships with girls.
- Schools need more information and guidance on how to handle HIV & AIDS within the school.
- Teachers must take it upon themselves to become knowledgeable with regard to HIV & AIDS programmes.
- Schools are in need of resources that make the content of HIV & AIDS programmes come "...alive..." for the learners.
- The management of the school does not take Life Orientation as a subject seriously, and consequently teachers neglect the subject.

[14] In this regard refer to paragraph 2.8.8

4.13 QUESTION 11b: DO YOU REGARD THE IMPLEMENTATION OF THE HIV AND AIDS PROGRAMME AS IMPORTANT? IF NOT, WHY?

4.13.1 The aim of Question 11b

The aim of Question 11b was to determine whether the participants, whose schools were not implementing the HIV & AIDS programme, regarded such a programme as important or not.

Table 4.12: Participants' views on the importance or unimportance of the HIV & AIDS programme

SUMMARY OF CASES STUDIES 1, 2 AND 3			
Participant	**Do you regard the implementation of the HIV & AIDS programme as important? If not, why?**		
	Yes	**No**	**Reasons for regarding the implementation as unimportant.**
C1: P	X		
C1: HOD	X		
C1: T1	X		
C1: T2	X		
C2: P	X		
C2: HOD	X		
C2: T1	X		
C2: T2	X		
C3: P	X		
C3: HOD	X		
C3: T1	X		
C3: T2	X		
Total	**12**		

4.13.2 Interpretation of Table 4.12

In Table 4.12, the twelve participants stated that they regard the implementation of the HIV & AIDS programme as important.

4.13.3 Additional information

The participants regarded the implementation of the HIV & AIDS programme as important because:

- The programme will promote the prevention of HIV infection.
- HIV & AIDS negatively affects individuals, families, the economy and the nation as a whole.
- Most people still believe that HIV & AIDS is "just a story", and they need to change their behaviour.
- Learners must be reminded continuously about the danger of HIV & AIDS, and about prevention (abstinence and condomising).
- Many learners, who are sexually active, believe that they cannot become infected with HIV, because they are still young and attending school.

4.14 QUESTION 11c: DO YOU THINK THE IMPLEMENTATION OF SUCH A PROGRAMME CAN MAKE A DIFFERENCE?

4.14.1 The aim of Question 11c

I asked Question 11c in order to determine the participant's perceptions with regard to the possible difference that the implementation of the HIV & AIDS programme might make.

Table 4.13: The difference that an HIV & AIDS programme makes

SUMMARY OF CASES STUDIES 1, 2 AND 3			
Participant	**Do you think the implementation of such a programme can make a difference?**		
	Yes	**No**	**Additional information about participants' perceptions**
C1: P	X		It must promote prevention of HIV & AIDS.
C1: HOD	X		
C1: T1	X		Must make learners more aware of HIV & AIDS in order to change their behaviour.
C1: T2	X		
C2: P	X		If learners are informed about HIV & AIDS, they will inform other people such as their parents.
C2: HOD	X		Learners must continuously hear about HIV & AIDS in school.
C2: T1	X		
C2: T2	X		
C3: P	X		
C3: HOD	X		The school can inform learners about prevention.
C3: T1	X		
C3: T2	X		HIV & AIDS information must be presented continuously in order to show the learners that the school is serious about the matter.
Total	**12**	**0**	

4.14.2 Interpretation of Table 4.13

The twelve participants were of the opinion that the implementation of the HIV & AIDS programme can make a difference in the sense that the programme:

- ought to promote the prevention of HIV & AIDS;
- ought to enhance learners' awareness with regard to HIV & AIDS, in order to encourage behaviour change;
- can reach other community members such as parents;
- should continuously provide information on HIV & AIDS, consequently emphasizing the seriousness thereof.

4.15 QUESTION 11d: HOW CAN THESE CHALLENGES BE ADDRESSED IN ORDER TO FACILITATE THE IMPLEMENTATION OF SUCH A PROGRAMME IN YOUR SCHOOL?

4.15.1 The aim of Question 11d

I presented Question 11d in order to provide the participants with an opportunity to reflect on their own practices and identify the challenges they experience. I further aimed to explore the participants' views on possible solutions to the challenges they faced with regard to the implementation of the HIV & AIDS programme in their schools.

Table 4.14: Addressing challenges to the implementation of the HIV & AIDS programme in schools

SUMMARY OF CASE STUDIES 1, 2 AND 3	
Participant	**Ways to address challenges with regard to the implementation of the HIV & AIDS programme.**
C1: P	Need to have more resources and a HIV & AIDS resource centre that serves as a library with regard to HIV & AIDS issues.
C1: HOD	All teachers must provide learners with the same message with regard to HIV & AIDS. Sexual relationships between teachers and learners must be strictly addressed. Government officials and leadership must convey the same message with regard to HIV & AIDS, in order not to confuse the public.
C1: T1	More should be done than what is prescribed in the Life Orientation programme like visiting hospices, inviting people living with HIV & AIDS to school, and management should take Life Orientation more seriously.
C1: T2	Teachers should receive more training, and follow-up school visits must be done to ensure that schools are implementing the programme.
C2: P	There should be more trained Life Orientation teachers.
C2: HOD	The Department of Education must provide more training and help schools to develop an HIV & AIDS policy.
C2: T1	Schools need more resources and training for Life Orientation teachers.
C2: T2	Schools need to have a policy in place providing guidelines and safeguarding learners and teachers.
C3: P	Learners need something new to listen; they are tired of hearing the same message about HIV & AIDS. The mindset and attitude of the learners need to be changed through a fresh approach that utilizes resources that learners possess, like cell phones and television sets.
C3: HOD	The Department of Education and the School Governing Body must be more involved.
C3: T1	Schools must obtain specialists from outside to assist in developing the Life Orientation programme. Teachers need more guidance and training.
C3: T2	The Department of Education, NGOs and people from the community must be more involved in the school in order to assist with HIV & AIDS programmes. Parents do not discuss sex and HIV & AIDS with their children.

4.15.2 Interpretation of Table 4.14

In response to Question 11d, the participants provided possible solutions to the challenges that they experience with the implementation of the HIV & AIDS programme. The solutions included the following:

- Obtaining more resources.
- Establishing an HIV & AIDS resource centre.
- Integrating the HIV & AIDS programme with all school subjects.
- More training and guidance for teachers with regard to HIV & AIDS.
- Addressing sexual relationships between teachers and learners.
- Including visits to hospices and to people living with HIV & AIDS in the school's programme.
- Developing and implementing an HIV & AIDS school policy.
- Involving other stake-holders such as the Department of Education, NGOs, the community, SGB and parents in the implementation of the HIV & AIDS programme.

4.16 QUESTION 12: ARE YOU AWARE OF THE FACT THAT THE IMPLEMENTATION OF THE HIV & AIDS PROGRAMME IS COMPULSORY?

4.16.1 The aim of Question 12

Question 12 was asked in order to determine whether the participants were aware of the fact that the implementation of the HIV & AIDS programme is compulsory. I anticipated that this information might indicate whether the school consulted relevant departmental policy documents, and, as a consequence thereof, adhered to prescribed curriculum requirements.

Table 4.15: Compulsory development of an HIV & AIDS programme

Participant	Awareness of the compulsory implementation of the HIV & AIDS programme		
	YES	**NO**	**Details about documentation**
C1: P	X		Departmental circulars state that content with regard to HIV & AIDS in Life Orientation is compulsory.
C1: HOD		X	Not aware of any documentation.
C1: T1	X		Not aware of any documentation.
C1: T2	X		The HIV & AIDS policy at school makes it compulsory.
C2: P	X		Not aware of any documentation.
C2: HOD	X		Not aware of any documentation.
C2: T1	X		Not aware of any documentation.
C2: T2	X		Not aware of any documentation.
C3: P	X		Not aware of any documentation.
C3: HOD		X	Not aware of any documentation.
C3: T1	X		Programme guidelines for Life Orientation.
C3: T2	X		Not aware of any documentation.
Total	**10**	**2**	

4.16.2 Interpretation of Table 4.15

Table 4.15 indicates that ten participants were aware of the compulsory implementation and development of an HIV & AIDS programme in schools, while two participants were unaware. I found it contradictory that, even though ten participants were aware of the compulsory implementation of HIV & AIDS programmes in schools, nine participants were not aware of any documentation in this regard. It is interesting to note that two HOD participants were unaware of HIV & AIDS programmes being compulsory, despite the responsibilities they have with regard to the implementation thereof (in this regard also refer to paragraphs 4.11.3 and 4.17.5).

4.16.3 Conclusions regarding Question 12

In this regard I conclude, that despite being aware of the compulsory development and implementation of the HIV & AIDS programme, the

participants were mostly unaware of the documentation that provides guidelines for the implementation of such a programme. I also conclude that teachers in managerial positions, who are expected to monitor and oversee the implementation of such a programme, seem to be less informed with regard to relevant documentation than teachers who present the programme.

4.17 QUESTION 13: REGARDING YOUR SCHOOL'S HIV & AIDS PROGRAMME, ANSWER THE FOLLOWING QUESTIONS:

When is the programme presented?	
Who is responsible for the programme?	
How long does the presentation take?	
Where is the programme presented?	
According to your opinion, what is the core message of the programme?	

4.17.1 The aim of Question 13

Question 13 was presented in order to determine what the HIV & AIDS programme in a participant's school entailed. I believed that this ought to provide me with an overview of the school's HIV & AIDS programme, as well as an indication of what the logistical set-up for the programme in his/ her school was.

Table 4.16.1: The HIV & AIDS programme in Case Study 1

CASE STUDY 1		
Participant	**What does your school's HIV & AIDS programme entail?**	**Response**
C1: P	When is the programme presented?	In Life Orientation periods.
	Who presents (implements) the programme?	Life Orientation teachers and specialists in the subject.
	How long does the presentation take?	90 minutes a week for Life Orientation (2 periods of 45 minutes each).
	Where is the programme presented?	In classes and sometimes specialists at assembly.
	What is the content (message) of the programme?	Prevention of HIV & AIDS as well as taking care of people who are infected or affected.
C1: HOD	When is the programme presented?	In Life Orientation periods.
	Who presents (implements) the programme?	Life Orientation teachers.
	How long does the presentation take?	90 minutes a week for Life Orientation.
	Where is the programme presented?	In classes.
	What is the content (message) of the programme?	Prevention of HIV & AIDS.
C1: T1	When is the programme presented?	In Life Orientation periods.
	Who presents (implements) the programme?	Life Orientation teachers (six teachers).
	How long does the presentation take?	Four lessons for HIV & AIDS in the year.
	Where is the programme presented?	In classes.
	What is the content (message) of the programme?	Knowledge of HIV & AIDS. "We just give them knowledge".
C1: T2	When is the programme presented?	In Life Orientation periods.
	Who presents (implements) the programme?	Life Orientation teachers (six teachers).
	How long does the presentation take?	Six lessons a year in the Life Orientation periods.
	Where is the programme presented?	In classes.
	What is the content (message) of the programme?	Awareness and prevention.

4.17.2 Interpretation of Table 4.16.1

In Table 4.16.1 it became apparent that this school's HIV & AIDS programme formed part of the official Life Orientation Programme. Two participants explained that in their school, six teachers were involved in the presentation of

Life Orientation. Two periods of 45 minutes per week with a total of six periods per year were allocated for this purpose. To the question regarding the core message of the programme, the above-mentioned participants gave a variety of answers, ranging from knowledge and awareness regarding HIV & AIDS, ways to prevent HIV infection, to caring for people infected with HIV & AIDS.

Table 4.16.2: The HIV & AIDS programme in Case Study 2

CASE STUDY 2		
Participant	**What does your school's HIV & AIDS programme entail?**	**Response**
C2: P	When is the programme presented?	The end of August.
	Who presents (implements) the programme?	The Human and Social Science Department of the school.
	How long does the presentation take?	One school day.
	Where is the programme presented?	At their assembly area.
	What is the content (message) of the programme?	Awareness of HIV & AIDS.
C2: HOD	When is the programme presented?	In Life Orientation periods and one AIDS awareness day.
	Who presents (implements) the programme?	Life Orientation teachers (four female teachers).
	How long does the presentation take?	In Life Orientation periods and one whole day.
	Where is the programme presented?	In classes and at assembly area.
	What is the content (message) of the programme?	Abstaining and condomising when they "...indulge in sex".
C2: T1	When is the programme presented?	In Life Orientation periods.
	Who presents (implements) the programme?	Life Orientation teachers.
	How long does the presentation take?	90 minutes a week (two periods of 45 minutes each).
	Where is the programme presented?	In classes. (Learners remain in same class and teachers rotate).
	What is the content (message) of the programme?	Awareness of HIV & AIDS.
C2: T2	When is the programme presented?	In Life Orientation periods and one Aids awareness day.
	Who presents (implements) the programme?	Life Orientation teachers (four female teachers).
	How long does the presentation take?	90 minutes a week (two periods of 45 minutes each).
	Where is the programme presented?	In classes.
	What is the content (message) of the programme?	Abstinence.

4.17.3 Interpretation of Table 4.16.2

On the basis of Table 4.16.2, it became clear that this school's HIV & AIDS programme formed part of the official Life Orientation Programme. A special AIDS awareness day is also organised during the year. Four female teachers, who were also responsible for the organisation of an HIV & AIDS awareness day, presented the school's Life Orientation programme in two periods of 45 minutes each per week. The core message of the school's HIV & AIDS programme included knowledge and awareness regarding HIV & AIDS, and abstaining and condomising.

It is interesting to note that the teachers in this school rotated from one class to another, while learners remained in the same class for the whole school day.

Table 4.16.3: The HIV & AIDS programme in Case Study 3

CASE STUDY 3		
Participant	**What does your school's HIV & AIDS programme entail?**	**Response**
C3: P	When is the programme presented?	In Life Orientation periods and one AIDS awareness day.
	Who presents (implements) the programme?	Life Orientation teachers.
	How long does the presentation take?	In Life Orientation periods and one school day.
	Where is the programme presented?	In classes and at assembly area.
	What is the content (message) of the programme?	Awareness, prevention and support for people who are infected or affected.
C3: HOD	When is the programme presented?	In Life Orientation periods.
	Who presents (implements) the programme?	Life Orientation teachers and NGOs who come to school.
	How long does the presentation take?	35 minutes a period. ("...not sure how many periods we have.")
	Where is the programme presented?	In classes.
	What is the content (message) of the programme?	Awareness and prevention.
C3: T1	When is the programme presented?	In Life Orientation periods.
	Who presents (implements) the programme?	Life Orientation teachers (four teachers).
	How long does the presentation take?	Two periods of 35 minutes each (70 minutes a week).
	Where is the programme presented?	In classes. (Learners remain in the same class and teachers rotate).
	What is the content (message) of the programme?	Abstinence.
C3: T2	When is the programme presented?	Last year for one day.
	Who presents (implements) the programme?	"Someone from outside".
	How long does the presentation take?	One day for three hours.
	Where is the programme presented?	At the assembly area.
	What is the content (message) of the programme?	Abstinence and prevention.

4.17.4 Interpretation of Table 4.16.3

The responses in Table 4.16.3 indicate that this school's HIV & AIDS programme included the content of the formal Life Orientation Programme[15], as well as one AIDS awareness day per year. Four Life Orientation teachers were responsible for implementing the HIV & AIDS programme within Life Orientation, for two periods of 35 minutes each per week. An AIDS awareness day is organised once a year. According to the participants, the core message of the school's programme ranged from awareness, abstinence and prevention to caring for people infected and affected by HIV & AIDS.

In this school, learners remain in one class for the whole school day, while teachers rotate to different classes.

4.17.5 Conclusions regarding Question 13

On the basis of Question 13, I conclude that the three schools implement the HIV & AIDS programme as part of Life Orientation. It appears that not all schools adhere to the prescribed time allocation for the programme according to policy requirements, and this finding highlights the fact that not all teachers are aware of the relevant documentation and official requirements with regard to the implementation of the HIV & AIDS programme within Life Orientation (in this regard also refer to paragraphs 4.5.3 and 4.16.3). In addition to this, some schools seem to regard the one-day HIV & AIDS awareness day that they organise as the only HIV & AIDS programme.

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[15] In this regard it has to be kept in mind that HIV & AIDS is only being treated as a topic in the Life Orientation Programme and not as an independent programme as stated in the relevant policy (in this regard refer to paragraph 2.8.8).

I also conclude that the teachers, who are responsible for the implementation of the HIV & AIDS programme, experience logistical challenges due to a lack of suitable venues for presenting the programme (in this regard also refer to paragraphs 4.19.2 and 4.19.3).

4.18 QUESTION 14: IN YOUR OPINION, WHAT IS THE IMPACT OF YOUR SCHOOL'S HIV & AIDS PROGRAMME?

4.18.1 The aim of Question 14

The aim of Question 14 was to determine the manner in which a participant viewed the impact of his/her school's HIV & AIDS programme on the learners, in other words: Does the programme make a difference? I anticipated that this information would highlight the participants' perceptions of the value that their schools' HIV & AIDS programme had for learners.

Table 4.17: The impact of the schools' HIV & AIDS programmes

SUMMARY OF CASE STUDIES 1, 2 AND 3													
Participant	The programme has an impact	The programme has a limited impact	The programme has no impact	Additional information that represents personal views of participants									
				Aware of many new HIV infections in the school	Number of teenage pregnancies increase	Learners still have unsafe sex	Behaviour does not change	Programme not integrated with different subjects	Programme only focuses on awareness	Teachers not sufficiently trained	A more direct approach is necessary	No parental support	Learners share their problems with teachers
C1: P	n/a	X	n/a	X	X	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
C2: P	n/a	X	n/a	n/a	n/a	n/a	n/a	n/a	X	n/a	n/a	n/a	n/a
C3: P	n/a	X	n/a	X	n/a	n/a	X	n/a	n/a	X	n/a	X	n/a
C1: HOD	n/a	n/a	X	n/a	X	X	n/a	n/a	n/a	n/a	n/a	n/a	n/a
C2: HOD	n/a	X	n/a	n/a	n/a	n/a	n/a	n/a	X	n/a	n/a	n/a	n/a
C3: HOD	n/a	X	n/a	n/a	X	X	X	n/a	n/a	n/a	n/a	n/a	n/a
C1: T1	n/a	X	n/a	n/a	n/a	n/a	X	n/a	n/a	X	n/a	n/a	n/a
C1: T2	n/a	X	n/a	n/a	n/a	n/a	n/a	X	n/a	n/a	n/a	n/a	n/a
C2: T1	n/a	n/a	X	n/a	n/a	n/a	n/a	n/a	n/a	X	n/a	n/a	n/a
C2: T2	n/a	X	n/a	n/a	n/a	n/a	X	n/a	X	n/a	X	n/a	n/a
C3: T1	n/a	n/a	X	n/a	X	X	n/a	n/a	n/a	n/a	n/a	X	n/a
C3: T2	n/a	X	n/a	n/a	X	X	n/a	n/a	n/a	n/a	n/a	n/a	X
Total	**0**	**9**	**3**	**2**	**5**	**4**	**4**	**1**	**3**	**3**	**1**	**2**	**1**

4.18.2 Interpretation of Table 4.17

In Table 4.17 nine participants reported that the HIV & AIDS programme of their schools had a limited impact. Three participants reported that their school's programme had no impact. The participants lack of confidence in the programme, can be ascribed to the fact that they only view and present HIV & AIDS as a topic in the Life Orientation programme.

4.18.3 Additional information

The participants shared the following personal views regarding the causes of the limited or no impact that the programme had, according to their opinions (refer to Diagram 4.7 below):

- Two participants reported they were aware of many new HIV infections in their school.
- Five participants stated that the number of teenage pregnancies had increased in their schools.
- Four participants mentioned that they suspect learners still practise unsafe sex.
- Four participants held the opinion that sexual behaviour did not change.
- One participant reported that HIV & AIDS education was not integrated with different subjects.
- Three participants held the view that the programme only focused on awareness of HIV & AIDS.
- Three participants were of the opinion that teachers were not sufficiently trained.
- One participant suggested that a more direct approach (for example handing out condoms) must be followed.

- Two participants' viewpoint was that there was no parental support.
- One participant stated that the impact of the programme was limited, although learners began sharing their problems with teachers.

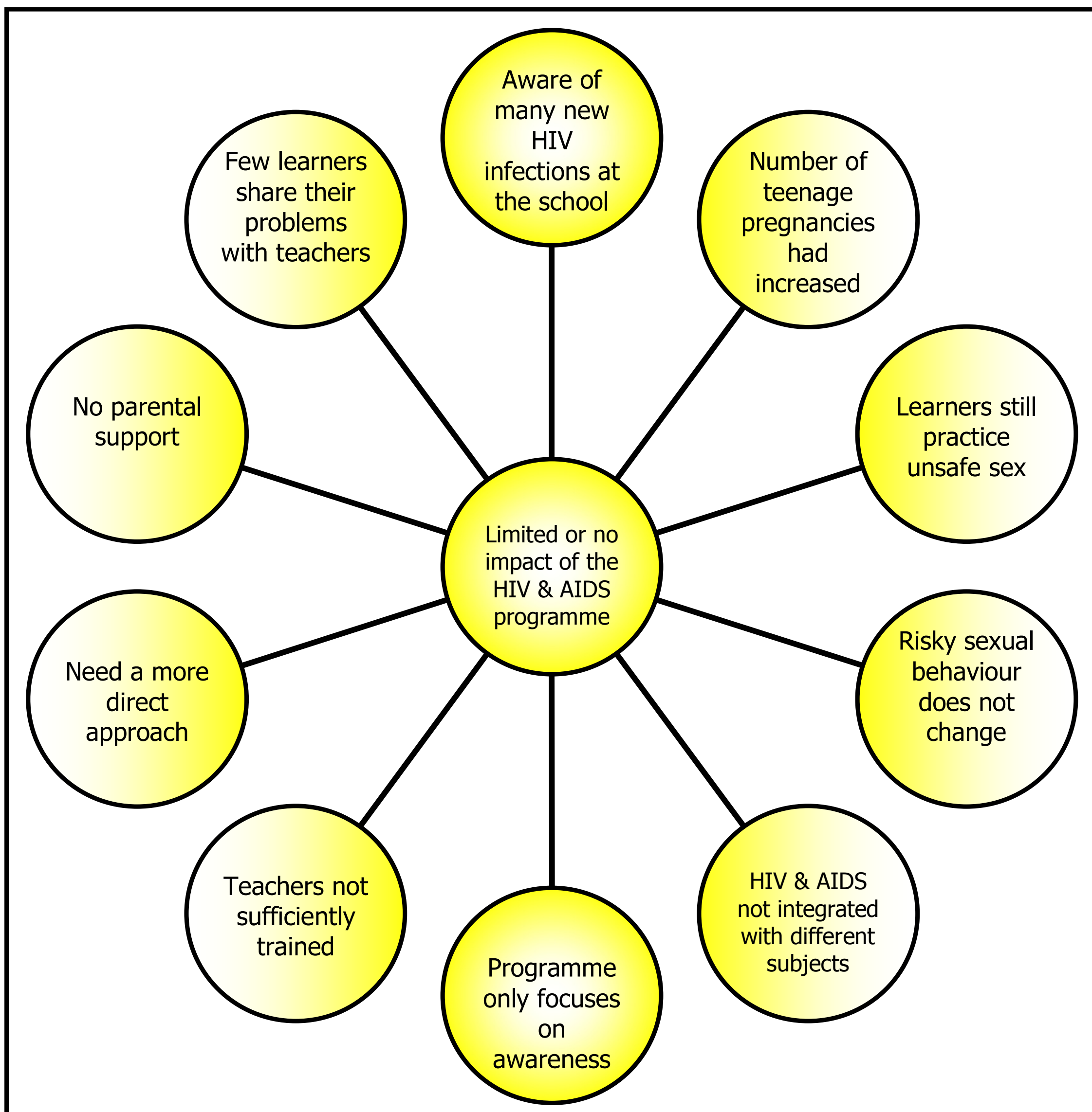

Diagram 4.7: Visual presentation of participants' opinions on the limited or no impact of HIV & AIDS programmes

4.18.4 Conclusions regarding Question 14

Regarding Question 14, I conclude that the HIV & AIDS programme, as implemented by the schools, seems to have little or no impact. Even though the HIV & AIDS programme is apparently implemented teachers experience the following:

- new HIV infections still occur;
- teenage pregnancies increase;
- learners still practise unsafe sex;
- risky sexual behaviour does not change;
- HIV & AIDS is not integrated into all subjects;
- teachers are not sufficiently trained;
- parental support with regard to the HIV & AIDS programme is poor.

4.19 QUESTION 15: WHICH RESOURCES FOR FACILITATING THE IMPLEMENTATION OF THE HIV & AIDS PROGRAMME ARE AVAILABLE IN YOUR SCHOOL?

RESOURCE	AVAILABLE	UNAVAILABLE
Teachers allocated to the HIV & AIDS programme.		
Teachers trained with regard to HIV & AIDS education.		
Classrooms dedicated to the HIV & AIDS programme.		
Textbooks.		
Posters, wall charts.		
Pamphlets, booklets.		
Video player and/or a DVD player.		
Videocassettes and/or DVD material related to HIV & AIDS education.		
First aid kit and supplies.		
Library.		
Internet.		
Computer access for teachers.		
Computer access for all learners.		
Budget allocation for HIV & AIDS education.		

4.19.1 The aim of Question 15

The aim of Question 15 was to determine what resources for the implementation of an HIV & AIDS programme were available at the school. The availability of (or lack of) resources could be a contextual factor within the school that impact on the implementation of an HIV & AIDS programme.

Table 4.18: Availability[16] or unavailability of resources ir

Participant	Resources that are available or unavailable in Case studies 1, 2 and 3																											
	Teachers allocated to the HIV & AIDS programme.		Teachers trained with regard to HIV & AIDS education.		Classrooms dedicated to the HIV & AIDS programme.		Textbooks.		Posters, wall charts.		Pamphlets, booklets.		Video player and/or a DVD player.		Videocassettes and/or DVD material related to HIV & AIDS education.		First aid kit and supplies.		Library.		Internet.		Computer access for teachers.		Computer access for all learners.		Budget allocation for HIV & AIDS.	
	A	U	A	U	A	U	A	U	A	U	A	U	A	U	A	U	A	U	A	U	A	U	A	U	A	U	A	U
C1: P	X		X			X	X		X		X			X		X		X		X		X		X		X		X
C2: P	X		X			X		X	X		X			X		X		X	X		X		X			X		X
C3: P	X		X			X	X		X		X			X		X	X			X		X		X		X		X
C1: HOD	X		X			X	X		X		X			X		X		X		X		X		X		X		X
C2: HOD	X		X			X	X		X			X		X		X		X	X			X	X			X		X
C3: HOD	X			X		X		X	X		X			X		X		X		X		X		X		X		X
C1: T1	X		X			X	X		X		X			X		X		X		X		X		X		X		X
C1: T2	X		X			X	X		X		X		X		X			X		X		X		X		X		X
C2: T1	X			X		X	X			X	X			X		X		X	X			X	X			X		X
C2: T2	X		X			X	X		X		X			X		X		X	X			X	X			X		X
C3: T1	X		X			X		X	X		X			X		X		X		X		X		X		X		X
C3: T2	X			X		X		X		X		X		X		X		X		X		X		X		X		X
Total	**12**	**0**	**9**	**3**	**0**	**12**	**8**	**4**	**10**	**2**	**10**	**2**	**1**	**11**	**X**	**11**	**1**	**11**	**4**	**8**	**1**	**11**	**4**	**8**	**0**	**12**	**0**	**12**

[16]Please note that in Table 18 'A' will refer to Available and 'U' will refer to Unavailable.

4.19.2 Interpretation of Table 4.18

According to Table 4.18, twelve participants reported that their schools had teachers who were allocated to the HIV & AIDS programme of the school. Nine participants indicated that they had trained teachers with regard to HIV & AIDS education available, while three participants reported that they did not have teachers trained in this regard.

All twelve participants indicated the unavailability of classrooms for the HIV & AIDS programme. The unavailability of classrooms must be interpreted in the light of the fact that the schools in the three case studies use a system whereby the learners remain in the same classroom for the whole day, while the teachers rotate to different classrooms. As a result thereof, classrooms where teachers can dedicate themselves exclusively to implementing the HIV & AIDS programme are unavailable, as one classroom is actually shared by several teachers (in this regard also refer to paragraphs 4.17.3, 4.17.4 and 4.17.5).

Eight participants reported that they had relevant textbooks available, while four participants reported that relevant textbooks were unavailable. I found it contradictory that some participants from the same school, for example Case Study 2, indicated that textbooks were available while their colleagues indicated that textbooks were unavailable. I ascribed this contradiction to participants that might have interpreted the question as relating to the availability of textbooks that only deal with HIV & AIDS, or to textbooks that were not sufficient.

Ten participants affirmed the availability of resources such as posters and wall charts, while two participants said it was unavailable. Pamphlets and booklets were available according to ten of the participants, while two participants stated that they were unavailable.

One participant reported that a video and a DVD player as well as videocassettes and DVD material were available at their school, while eleven participants reported the unavailability of such resources.

One participant indicated that their school had a first aid kit with supplies, while eleven participants declared that their schools lacked such resources.

Four participants, all from one school, confirmed the existence of a library at their school. Eight participants, from two different schools, affirmed that their schools were in need of library facilities.

One participant affirmed the availability of access to the Internet, while eleven participants reported that access to the Internet was unavailable at their schools.

Four participants stated that teachers at their schools had access to computer facilities, while eight participants indicated that teachers at their schools did not have access to computer facilities.

Twelve participants reported that computers at their schools were not accessible to all learners.

Twelve participants affirmed that at their schools no budget allocation had been made with regard to HIV & AIDS. This may be an indication of the lack of commitment to HIV & AIDS programmes in the midst of the School Governing Body (SGB) and members of the management team that are responsible for the school's budget, or of the fact that sufficient funds are not available.

4.19.3 Conclusions regarding Question 15

Regarding Question 15, I conclude that schools do not have adequate resources available for the implementation of the HIV & AIDS programme. Even though schools have allocated teachers with the responsibility to implement the HIV & AIDS programme, not all of them are trained to do so. The insufficient number of classrooms available may compel schools to resort to teaching practices that are not conducive to the implementation of the HIV & AIDS programme. Furthermore, resources that directly support teaching practices, such as textbooks, posters, wall charts, pamphlets, booklets, libraries, video and DVD players as well as videocassettes and DVD material are not available at all schools. Many of the schools are also in need of computers and access to the Internet, in order to support and enhance their teaching practices and keep abreast with new developments.

4.20 QUESTION 16: HOW IS THE HIV & AIDS PROGRAMME ACCOMMODATED WITHIN THE SCHOOL'S TIMETABLE?

4.20.1 The aim of Question 16

I asked Question 16 in order to determine how the programme had been organised within the daily timetable of the school. The implementation of an HIV & AIDS programme is supposed to be reflected on the school's timetable. The manner in which the timetable had been structured, in order to accommodate the implementation of an HIV & AIDS programme, may be a contextual factor that influences the implementation of such a programme. The responses to Question 16 would also enable me to validate the responses to Question 13 (page 41) and therefore determine the consistency of responses by the participants.

Table 4.19: Facilitation of the HIV & AIDS programme within the school's timetable

SUMMARY OF CASE STUDIES 1,2 AND 3	
Participant	**Participant's response with regard to the facilitation of the HIV & AIDS programme in the school's timetable**
C1: P	Two Life Orientation periods of 45 minutes each per week, and an HIV & AIDS week for the whole school.
C1: HOD	Two Life Orientation periods of 45 minutes each per week. Dealing with HIV & AIDS is "periodical", depends on when the teachers deal with it.
C1: T1	Two Life Orientation periods of 45 minutes each per week.
C1: T2	Two Life Orientation periods of 45 minutes each per week.
C2: P	Two Life Orientation periods of 40 minutes each per week.
C2: HOD	Two Life Orientation periods of 40 minutes each per week. One HIV & AIDS day per year.
C2: T1	Two Life Orientation periods of 45 minutes each per week.
C2: T2	Two Life Orientation periods of 45 minutes each per week. One HIV & AIDS day and on Cultural day.
C3: P	Four Life Orientation periods of 30 minutes each per week.
C3: HOD	Four Life Orientation periods of 30 minutes each per week. "… long since we had the HIV & AIDS awareness day."
C3: T1	Four Life Orientation periods of 30 minutes each per week.
C3: T2	Four Life Orientation periods of 30 minutes each per week.

4.20.2 Interpretation of Table 4.19

According to Table 4.19, the four participants in Case Study 1 indicated that their school's HIV & AIDS programme was facilitated in two Life Orientation periods of 45 minutes each per week (90 minutes per week) in the school's timetable. One of the participants highlighted the fact that, in addition to this, the school also made a week available for HIV & AIDS related issues.

The four participants in Case Study 2 pointed out that their school implemented the HIV & AIDS programme during two Life Orientation periods of 45 minutes each per week (90 minutes) in the school's timetable. Two participants added that their school also had one additional HIV & AIDS day and one cultural day during the year during which HIV & AIDS issues were addressed.

In Case Study 3, the four participants explained that their school's timetable allowed for four Life Orientation periods of 30 minutes each per week (2 hours). One participant added that "... it was long since we had the HIV & AIDS awareness day".

4.20.3 Conclusion regarding Question 16

With regard to Question 16, I conclude that not all schools allocate the prescribed time to the implementation the HIV & AIDS programme, as required by the Department of Education.

4.21 QUESTION 17: DOES YOUR SCHOOL HAVE AN OWN, UNIQUE SCHOOL POLICY ON HOW TO DEAL WITH HIV & AIDS RELATED ISSUES, IN THE SCHOOL AND ON THE PLAYGROUND?

4.21.1 The aim of Question 17

I asked Question 17 in order to determine whether the participant's school had developed its own school policy with regard to HIV & AIDS education, in accordance with the requirements of the departmental policy on HIV & AIDS.

Table 4.20: Existence of a school policy on HIV & AIDS

SUMMARY OF CASE STUDIES 1, 2 AND 3			
Participant	**Does your school have an own unique school policy on how to deal with HIV & AIDS related issues, in the school and on the playground?**		
	YES	**NO**	**Additional information**
C1: P	X		"Draft policy that still has to be ratified"
C1: HOD		X	
C1: T1		X	
C1: T2		X	
C2: P	X		"Was done long ago"
C2: HOD		X	
C2: T1		X	
C2: T2		X	
C3: P	X		"I found it here"
C3: HOD		X	"Never had that policy here"
C3: T1		X	
C3: T2		X	
Total	**3**	**9**	

4.21.2 Interpretation of Table 4.20

Three participants, all of them principals, reported that their schools had developed their own unique school policy on how to deal with HIV & AIDS related issues, in the school and on the playground. Nine of the participants, all HODs and teachers, stated the opposite, that their schools did not have such a policy.

I ascribed this contradiction in responses between the principals and the rest of the participants to the possibility that policies might have been developed but not communicated to the teachers that were supposed to implement them. It can also be that all the relevant stake-holders were not involved when the policy was developed, and therefore they were not aware of its content. Consequently, the policy was limited to managerial level and did not reach the teachers responsible for the presentation thereof. Furthermore, it might be that the policy was only developed for the sake of satisfying the managerial requirements of the

department, and that it was never implemented. I also ascribe this to the possibility that the principals wanted to impress me during the interviews, and that they provided information that reflected favourably on them, although it was not the truth.

4.21.3 Conclusion regarding Question 17

With regard to Question 17, I seriously doubt whether unique school policies with regard to HIV & AIDS were ever developed.

4.22 QUESTION 18: CAN YOU DESCRIBE THE PROCESS THAT WAS FOLLOWED FOR DEVELOPING THE SCHOOL'S HIV & AIDS POLICY?

4.22.1 The aim of Question 18

Question 18 was included in order to determine the process that a participant's school followed in developing an own HIV & AIDS school policy. Information on the development of the school's HIV & AIDS policy would indicate whether the school was adhering to the prescribed policy on HIV & AIDS. Compliance or non-compliance with the prescribed policy would be regarded as a contextual factor that influences the implementation of an HIV & AIDS programme. This question will also serve as verification of the responses obtained to Question 17.

Table 4.21: Process followed during the development of the school's HIV & AIDS policy

SUMMARY OF CASE STUDIES 1, 2 AND 3	
Participant	**Response regarding the development process of the school's HIV & AIDS policy.**
C1: P	One staff member with knowledge with regard to HIV & AIDS designed the policy. It was studied by the staff and school governing body and must still be ratified.
C1: HOD	There was no process.
C1: T1	There was no process.
C1: T2	There was no process.
C2: P	The policy was drafted by the HOD, who attended workshops.
C2: HOD	There was no process.
C2: T1	There was no process.
C2: T2	There was no process.
C3: P	It was based on the HIV & AIDS policy of Gauteng Department of Education (GDE).
C3: HOD	There was no process.
C3: T1	There was no process.
C3: T2	There was no process.

4.22.2 Interpretation of Table 21

In Table 4.21 only the three principals from the respective schools indicated that they had followed a process during the 'development' of the schools' HIV & AIDS policies. The responses of the other nine participants indicated that no process had been followed for the development of HIV & AIDS policies for their schools. The responses to Question 18 correspond to the responses given to Question 17, which indicates to me a consistency in the responses of the participants.

4.22.3 Conclusion regarding Question 18

In addition to my initial doubt as to the existence of HIV & AIDS policies in the schools, I conclude that no development process had been followed, should such a policy exist.

4.23 QUESTION 19: ARE YOU AWARE OF OTHER SOURCES THAT WERE CONSULTED DURING THE DEVELOPMENT OF YOUR SCHOOL'S HIV & AIDS POLICY, FOR EXAMPLE EXPERTS, DEPARTMENTAL REQUIREMENTS, THE INTERNET OR BOOKS?

4.23.1 The aim of Question 19

The aim of Question 19 was to determine whether a participant's school had consulted other sources during the development of the school's HIV & AIDS policy. This information would indicate to what extent the school had made efforts with the development of an HIV & AIDS policy. The effort and seriousness with regard to the development of an HIV & AIDS policy could give me an impression of the vigour with which it will be implemented.

Table 4.22: Sources utilised for HIV & AIDS policy development in schools

SUMMARY OF CASES STUDIES 1, 2 AND 3	
Participant	**Sources that were utilised for the development of schools' HIV & AIDS policies**
C1: P	Experts on HIV & AIDS and departmental requirements.
C1: HOD	Not aware of any.
C1: T1	Not aware of any.
C1: T2	Not aware of any.
C2: P	Only what the department requires.
C2: HOD	Not aware of any.
C2: T1	Not aware of any.
C2: T2	Not aware of any.
C3: P	Only what the department requires.
C3: HOD	Not aware of any.
C3: T1	Not aware of any.
C3: T2	Not aware of any.

4.23.2 Interpretation of Table 4.22

Three participants, all of them principals, indicated that they had made use of departmental requirements when their respective schools' HIV & AIDS policies were developed. One of the three participants added that experts on HIV & AIDS had been consulted in addition to the departmental requirements for the development of an HIV & AIDS policy for the school. I requested a copy of each school's HIV & AIDS policy, but did not receive any. One participant (C2:P) only provided me with the Departmental Guidelines for an HIV & AIDS policy (refer to Figure 6 in Addendum G). Nine participants reported that they were not aware of any HIV & AIDS policy that had been developed for their schools; consequently they were not aware of any sources that had been consulted.

4.23.3 Conclusion regarding Question 19

I am of the opinion that not much (if any) effort was made in order to consult sources other than the requirements of the Department of Education. None of the participants could provide me with any HIV & AIDS policy for a school except the official departmental requirements. I therefore conclude that no school had developed an own unique policy with regard to HIV & AIDS, and, should such a policy exist, it may not consist of much more than mere statements regarding what is required by the department.

4.24 QUESTION 20: WHO WERE THE STAKEHOLDERS THAT WERE INVOLVED IN DRAFTING YOUR SCHOOL'S HIV & AIDS POLICY?

4.24.1 The aim of Question 20

Question 20 was asked in order to determine whether a participant's school had involved the relevant stakeholders during the development of the school's HIV & AIDS policy, for example parents, community leaders, experts, departmental representatives, learners, and the clergy. The inclusion of stakeholders could indicate the effort and seriousness that the school displayed with regard to the involvement of the community in the implementation of the HIV & AIDS programme.

Table 4.23: Involvement of stakeholders in drafting the HIV & AIDS school policy

SUMMARY OF CASES STUDIES 1, 2 AND 3	
Participant	**Stakeholders that were involved during the development of schools' HIV & AIDS policies**
C1: P	The teachers and the School Governing Body (SGB).
C1: HOD	No policy was drafted, no one was involved.
C1: T1	No policy was drafted, no one was involved.
C1: T2	No policy was drafted, no one was involved.
C2: P	A member of the SGB and a teacher.
C2: HOD	No policy was drafted, no one was involved.
C2: T1	No policy was drafted, no one was involved.
C2: T2	No policy was drafted, no one was involved.
C3: P	The former deputy principal and a teacher.
C3: HOD	No policy was drafted, no one was involved.
C3: T1	No policy was drafted, no one was involved.
C3: T2	No policy was drafted, no one was involved.

4.24.2 Interpretation of Table 4.23

The three principals indicated that stakeholders such as the SGB and teachers had been involved during the development of the schools' HIV & AIDS policies. In contrast to these responses nine participants indicated that they were neither aware of the development of a school policy nor of any stakeholders that had been involved during the development thereof.

4.24.3 Conclusions regarding Question 20

I doubted the inclusion of stakeholders and the community in the development of HIV & AIDS policies, as it seemed to me that no policy had been developed in any case. Nevertheless, I consider the exclusion of stakeholders, such as teachers who are supposed to implement the HIV & AIDS policy, and the community, as a contextual factor that will have a significant impact on the implementation and presentation of a school's HIV & AIDS programme (also refer to paragraphs 4.21.3; 4.22.3 and 4.23.3 in this regard).

4.25 QUESTION 21: DOES YOUR SCHOOL'S HIV & AIDS POLICY DEAL WITH UNFORESEEN INCIDENCES THAT MAY OCCUR ON THE CAMPUS OF THE SCHOOL (ACCIDENTS WHICH COULD LEAD TO BLEEDING)?

4.25.1 The aim of Question 21

The aim of Question 21 was to determine whether a school's policy provides for unforeseen accidents. This information would serve as an indication of the scope and quality of a school's HIV & AIDS policy.

Table 4.24: Provision made for unforeseen incidences in the school's HIV & AIDS policy

SUMMARY OF CASES STUDIES 1, 2 AND 3	
Participant	**How provision is made for unforeseen incidences in the school's HIV & AIDS policy**
C1: P	Yes, it does.
C1: HOD	No provision is made for unforeseen incidences.
C1: T1	No provision is made, "... we deal with it as if there is no AIDS."
C1: T2	No provision is made.
C2: P	Yes, learners and teachers must wear gloves and not touch any blood.
C2: HOD	Not in a policy, "... but one teacher received first aid training and is usually called to help..."
C2: T1	Not in a policy, "... we apply first aid and call the parents..."
C2: T2	Not in a policy, "... the teachers will call the parents or look away..."
C3: P	No provision is made.
C3: HOD	No provision is made, "... we do not have trained people..."
C3: T1	No provision is made, "... we use gloves and do not touch the blood."
C3: T2	No provision is made, "... if a learner bleeds, we must use gloves."

4.25.2 Interpretation of Table 4.24

Table 4.24 shows that only two participants affirmed that their school's HIV & AIDS policies provided for unforeseen incidences such as accidents which could lead to bleeding. Ten participants stated that no provision had been made for such incidences in the HIV & AIDS policy of the school. Teachers either "deal with it as if there is no AIDS", or "use gloves and do not touch the blood".

4.25.3 Conclusion regarding Question 21

In consideration of the fact that nine participants stated that no school policy with regard to HIV & AIDS had been developed in their schools, it is sound to conclude that no provision for unforeseen incidences, such as accidents that could lead to bleeding, had been made in any school policy (also refer to paragraphs 4.21.3; 4.22.3; 4.23.3 and 4.24.3 in this regard).

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4.26 QUESTION 22: DOES YOUR SCHOOL MAKE PROVISION FOR/ALLOW OUTSIDERS SUCH AS LOVELIFE, SOUL BUDDYZ, THE DEPARTMENT OF HEALTH, COMMUNITY INSTITUTIONS, NGOs OR THE CLERGY TO PARTICIPATE IN OR PRESENT HIV & AIDS PROGRAMMES IN YOUR SCHOOL?

4.26.1 The aim of Question 22

I put Question 22 in order to determine whether a participant's school had made provision for or had allowed other stakeholders to become involved in the implementation of the school's HIV & AIDS programme.

Table 4.25: Other stakeholders that were involved in the implementation of the school's HIV & AIDS programme

SUMMARY OF CASES STUDIES 1, 2 AND 3			
Participant	**Does your school make provision for/allow outsiders such as loveLife, Soul Buddyz, the Department of Health, community institutions, NGOs or the clergy to participate in or present HIV & AIDS programmes in your school?**		
	YES	**NO**	**OUTSIDERS THAT ARE ALLOWED**
C1: P	X	n/a	loveLife, the Department of Health, people living with HIV & AIDS.
C1: HOD	X	n/a	loveLife.
C1: T1	X	n/a	loveLife, the Department of Health.
C1: T2	X	n/a	loveLife, the Department of Health.
C2: P	X	n/a	loveLife.
C2: HOD	X	n/a	loveLife, the Department of Health.
C2: T1	X	n/a	loveLife, the Department of Health.
C2: T2	X	n/a	loveLife, the Department of Health.
C3: P	X	n/a	loveLife.
C3: HOD	X	n/a	loveLife.
C3: T1	X	n/a	loveLife.
C3: T2	X	n/a	loveLife, the Department of Health.
Total	**12**	**0**	

4.26.2 Interpretation of Table 4.25

Twelve participants indicated that they had made provision for or had allowed outsiders to participate in or present HIV & AIDS programmes in their schools, such as the Department of Health, loveLife and people living with HIV & AIDS.

4.26.3 Additional information

In Case Study 1 a participant indicated that loveLife had frequented the school in the past, but the programme had been discontinued, because it was presented after school hours, and the learners were "uneasy" (restless), and did not want to attend. Another participant (C1:T2) shared the fact that visits from people living with HIV & AIDS had made a real impact on the learners and teachers.

In Case Study 2 one participant mentioned that they were not allowed to invite the clergy to the school, because they (the clergy) "shy away from speaking about sex". The participant also remarked that the principal did not allow teachers to talk to learners about sex, because "she is a born-again Christian, and to them it is a no-no subject".

In Case Study 3 one participant was of the opinion that the presenters of the loveLife programme had made a greater impact on the learners than the teachers had. The learners were more "free and flexible" with the loveLife presenters, because they were young and could communicate easier with the learners. The participant also mentioned that talking to learners about sexual activities was difficult for both teachers and learners, because it is a cultural taboo to talk about sex, as the discussion thereof indicated a lack of respect and discipline.

4.26.4 Conclusions regarding Question 22

From the responses to Question 22, I concluded that outsiders such as loveLife and the Department of Health were allowed to participate and/or present HIV & AIDS programmes at the schools, although on a sporadic basis.

4.27 QUESTION 23: ARE YOU COMFORTABLE OR UNCOMFORTABLE ABOUT TALKING TO LEARNERS ABOUT SENSITIVE TOPICS SUCH AS:

TOPIC	Comfortable	Uncomfortable	Reasons for being uncomfortable with the topic
HIV & AIDS?			
HIV & AIDS transmission?			
HIV & AIDS prevention?			
HIV & AIDS testing?			
HIV & AIDS status?			
Caring for people living with HIV & AIDS?			
Sex?			
Sexual relationships?			
Sexual activities? (heterosexual, homosexual, bisexuality, oral, anal, group)			
Sexual orientation?			
Sexual reproductive development?			
Sexual abuse?			
Sexually Transmitted Infections?			
Condom availability and use?			
Unwanted pregnancies?			
Substance abuse?			
Prostitution?			
TOTAL			

4.27.1 The aim of Question 23

Question 23 was presented in order to determine whether a participant felt comfortable or uncomfortable when discussing sensitive topics such as those listed above. I anticipated that feeling comfortable or uncomfortable when dealing with sensitive topics such as these could influence participants' willingness to become involved in the implementation of the HIV & AIDS programme in the school.

Table 4.26: Feeling comfortable[17] or uncomfortable when dealing with sensitive topics

Topic	HIV & AIDS?		HIV & AIDS transmission?		HIV & AIDS prevention?		HIV & AIDS testing?		HIV & AIDS status?		Caring for people living with HIV & AIDS?		Sex?		Sexual relationships?		Sexual activities?		Sexual orientation?		Sexual reproductive development?		Sexual abuse?		Sexually Transmitted Infections?		Condom availability and use?		Unwanted pregnancies?		Substance abuse?		Prostitution?		Condensed summary of reasons for being uncomfortable with the topics?
Participant	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	**C**	**U**	
C1: P	X		X		X		X		X		X			X	X			X	X		X		X		X		X		X		X		X		**Age difference.**
C1: HOD	X		X		X		X		X		X			X	X			X		X		X	X		X		X		X		X		X		**Age difference. Cultural taboo. Embarrassment. Need training.**
C1: T1	X		X		X		X		X		X		X		X		X		X		X		X		X		X		X		X		X		
C1: T2	X		X		X		X		X		X		X		X		X		X		X		X		X		X		X		X		X		
C2: P	X		X		X		X			X	X			X	X		X		X		X		X		X			X	X		X		X		**Age difference. Condoms encourage sex.**
C2: HOD	X		X		X		X		X		X		X		X			X	X		X		X		X			X	X		X		X		**Language difficulties. Condoms encourage sex.**
C2: T1	X		X		X		X		X		X		X		X			X	X		X		X		X		X		X		X		X		**Cultural taboo.**
C2: T2	X		X		X		X		X		X			X	X		X		X		X		X		X			X	X		X		X		**Cultural taboo. Church does not encourage condoms.**
C3: P	X		X			X	X		X			X		X		X		X		X	X		X		X			X		X	X		X		**Condoms encourage sex. Afraid of infected people. Age difference. Too intimate. Against religion.**
C3: HOD	X		X		X		X		X		X		X		X		X		X		X		X		X		X		X		X		X		
C3: T1	X		X		X		X		X		X		X		X		X		X		X		X		X		X		X		X		X		
C3: T2	X		X		X		X		X			X	X		X		X		X		X		X		X		X		X		X		X		**Need training.**
Total	**12**	**0**	**12**	**0**	**11**	**1**	**12**	**0**	**11**	**1**	**10**	**2**	**7**	**5**	**11**	**1**	**7**	**5**	**10**	**2**	**11**	**1**	**12**	**0**	**12**	**0**	**8**	**4**	**11**	**1**	**12**	**0**	**12**	**0**	

[17] Note that in Table 4.26, 'C' will refer to Comfortable, and 'U' will refer to Uncomfortable.

4.27.2 Interpretation of Table 4.26

Twelve participants reported that they were comfortable talking to learners about HIV & AIDS, as well as HIV & AIDS transmission. Eleven participants indicated that they were comfortable talking to learners about HIV & AIDS prevention, while one participant was uncomfortable with the topic.

All twelve participants affirmed that they were comfortable dealing with the topic of HIV & AIDS testing. Eleven participants were comfortable with talking to learners about HIV & AIDS status, while one participant was uncomfortable. Ten participants felt comfortable dealing with the caring for people living with HIV & AIDS, whereas two participants felt uncomfortable.

Seven participants indicated that they were comfortable talking to learners about sex, whilst five participants stated that they were uncomfortable talking about sex. In contrast to this, eleven participants felt comfortable talking about sexual relationships, whilst one participant was uncomfortable. Seven participants were comfortable dealing with the topic of sexual activities with learners, although five participants were uncomfortable talking about sexual activities.

Ten participants reported that they were comfortable dealing with sexual orientation as a topic, whereas two participants felt uncomfortable talking about the topic. Eleven participants stated that they were comfortable guiding learners with regard to sexual reproductive development, whilst one participant was uncomfortable doing so.

All twelve participants felt comfortable discussing sexual abuse and sexually transmitted infections as topics with learners. Eight participants stated that they were comfortable dealing with condom availability and use as a sensitive topic, whereas four participants regarded the topic as too sensitive to deal with.

Eleven participants affirmed that they were comfortable discussing unwanted pregnancies with learners, and one participant reported being uncomfortable therewith. The twelve participants stated that they were comfortable with discussing sensitive topics such as substance abuse and prostitution with learners.

4.27.3 Additional information

The participants named the following reasons for being uncomfortable when dealing with sensitive topics (refer to Diagram 4.8 below):

- The age difference between teachers and learners.
- Cultural taboos that, for example, do not allow older people to talk to younger people about sex.
- Embarrassment that teachers want to avoid.
- The lack of specific training on how to deal with sensitive topics.
- Being afraid of encouraging sexual activity amongst learners by discussing condom use, sexual activities and intimate issues.
- Language difficulties, due to the fact that English is not their first language, and many first languages still lack the necessary vocabulary for describing sensitive topics.
- Churches and religious convictions that do not allow the use of condoms, or discussion of sexually related topics.
- Teachers will feel more comfortable if they had more time to discuss sensitive topics and did not have to rush through the prescribed content. The time allocated for the discussion of sensitive topics was not enough, and did not allow for the establishment of trusting relationships between teachers and learners.

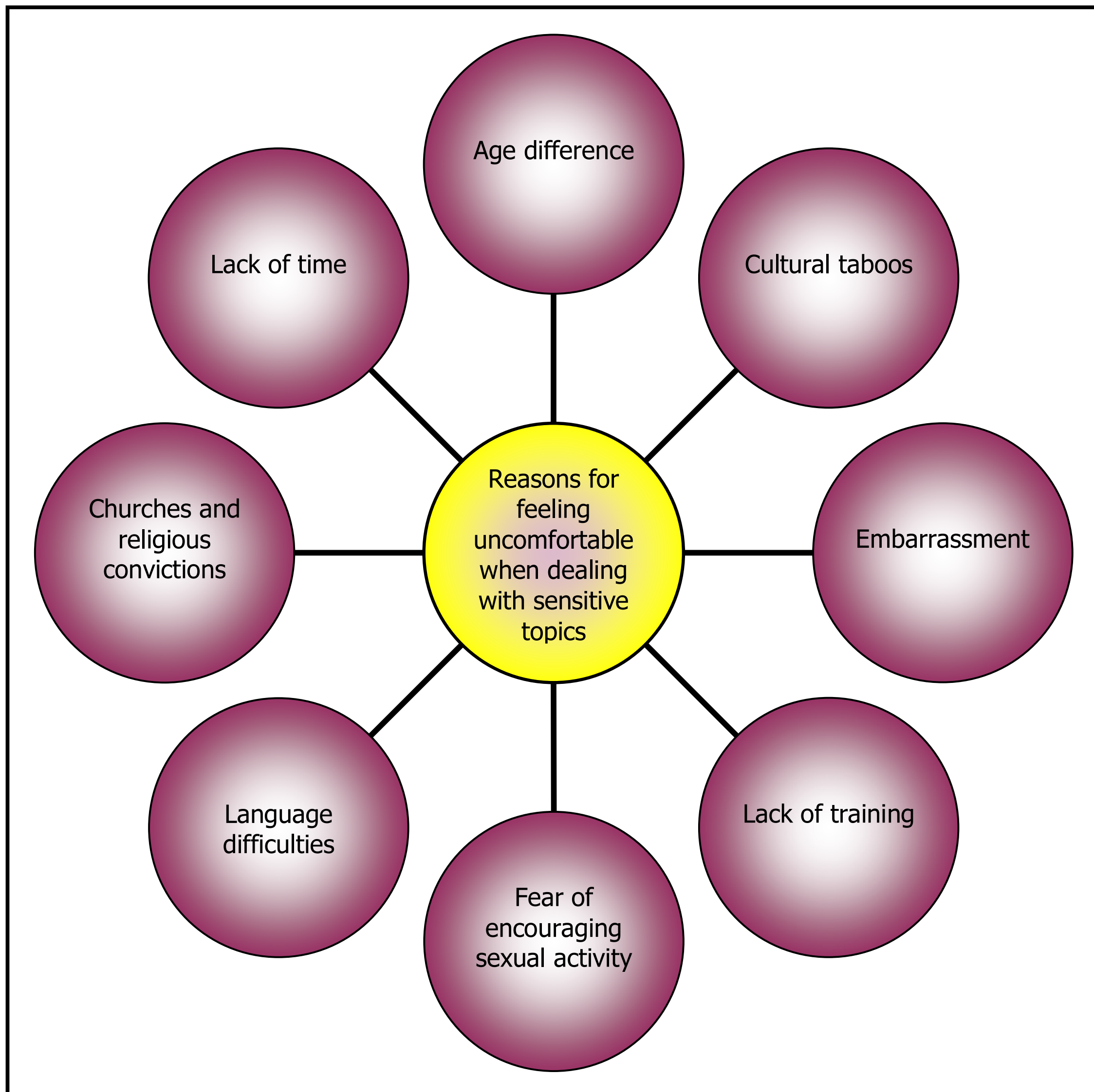

Diagram 4.8: Reasons for feeling uncomfortable when dealing with sensitive topics

4.27.4 Conclusions regarding Question 23

Regarding Question 23, I conclude that, although the HIV & AIDS programme is apparently implemented as part of Life Orientation, some participants feel

uncomfortable dealing with sensitive topics that are central to the prescribed curriculum content of the programme. In addition to this, I conclude that the participants' avoidance of dealing with sensitive topics apparently stems from personal convictions, preferences and experiences.

SECTION E: Reflection on the implementation of the HIV & AIDS programme at a participant's schools

4.28 QUESTION 24: ACCORDING TO YOU, WHAT ARE THE STRENGTHS AND WEAKNESSES OF THE IMPLEMENTATION PROCESS FOLLOWED BY YOUR SCHOOL?

4.28.1 The aim of Question 24

I asked Question 24 in order to investigate the participants' views with regard to the implementation process of their schools. This information would provide me with insight into the manner in which the participants reflect on the influences that contextual factors had on the implementation of the HIV & AIDS programme in their schools.

Table 4.27: Strengths and weaknesses in the schools' implementation of the HIV & AIDS programme

SUMMARY OF CASE STUDIES 1, 2 AND 3		
Participant	**The schools' implementation of the HIV & AIDS programme**	
	Strengths	**Weaknesses**
C1: P	Ability to educate learners about HIV & AIDS. Encourage learners to disclose their HIV status.	Learners and teachers do not know procedures in the HIV & AIDS policy.
C1: HOD	No strengths mentioned.	HIV & AIDS is not taken seriously enough at the school.
C1: T1	No strengths mentioned.	HIV & AIDS is not taken seriously enough at the school. The school has no policy and no follow-up is done in Life Orientation.
C1: T2	Teachers are eager to know more about HIV & AIDS.	Teachers do not have enough training with regard to HIV & AIDS. No male teachers at school are willing to discuss HIV & AIDS. Mainly seen as the female teachers' responsibility. Boys need male teachers as role models who are not afraid to discuss sex and HIV & AIDS.
C2: P	No strengths mentioned.	Most teachers are not interested in discussing HIV & AIDS. Not enough time at the school to implement the subject. Learners have many subjects.
C2: HOD	No strengths mentioned.	HIV & AIDS does not get much attention. The school management team regard HIV & AIDS and Life Orientation as a waste of time. Learners do not take it seriously.
C2: T1	No strengths mentioned.	HIV & AIDS is not regarded as a serious issue at school. Management and teachers undermine Life Orientation because it is not an examination subject.
C2: T2	No strengths mentioned.	HIV & AIDS and Life Orientation are not priorities.
C3: P	School has human and physical resources available to address HIV & AIDS issues.	School lacks consistency with regard to implementation of the HIV & AIDS programme. Events happen periodically and are not emphasized enough.
C3: HOD	Teachers are available to implement the HIV & AIDS programme.	Teachers are not adequately trained with regard to HIV & AIDS and Life Orientation.
C3: T1	No strengths mentioned.	Learners are ignorant with regard to HIV & AIDS and do not take it seriously.
C3: T2	Teachers are available to implement the HIV & AIDS programme.	The school management team does not take Life Orientation and HIV & AIDS seriously.

4.28.2 Interpretation of Table 4.27

Five participants affirmed that, regardless of weaknesses, their schools also had strengths with regard to the implementation of the HIV & AIDS programme. The strengths included the following:

- The availability of teachers to implement the programme.
- Teachers who were eager to know more about HIV & AIDS.
- Although limited, some physical resources were available for facilitating the implementation of the HIV & AIDS programme.

Seven participants stated that their schools lacked any strengths with regard to the implementation of the HIV & AIDS programme. The mentioned weaknesses included:

- The lack of an HIV & AIDS school policy and/or policy procedures that teachers and learners were not aware of.
- The lack of seriousness with regard to dealing with HIV & AIDS issues at schools.
- Teachers who were inadequately trained and supported with regard to Life Orientation and HIV & AIDS.
- The perception that dealing with HIV & AIDS related topics was the responsibility of female teachers.
- An aversion amongst teachers in general to discuss HIV & AIDS.
- The view amongst school management teams and teachers that Life Orientation was less important than other subjects, because it is perceived not to be examinable.
- Inadequate time allocation to Life Orientation, and inconsistent implementation of the HIV & AIDS programme.

4.28.3 Conclusions regarding Question 24

In light of answers to Question 24, I conclude that, although some schools have positive experiences with regard to the implementation of the HIV & AIDS programme, the majority are burdened with curriculum management challenges, insufficient training of teachers, cultural taboos and uninformed and unsupportive colleagues.

4.29 QUESTION 25: IF YOU WOULD BE ASKED TO ADVISE THE SCHOOLS IN SOSHANGUVE WITH REGARD TO IMPROVEMENT OF THE PROCESS OF HIV & AIDS PROGRAMME IMPLEMENTATION, WHAT WOULD YOUR ADVICE BE?

4.29.1 The aim of Question 25

Question 25 was asked in order to allow the participant to share his/her recommendations (possible solutions) for the implementation of the HIV & AIDS programme in schools. I anticipated that this question would urge the participants to reflect on the interview and on their roles in the implementation of the HIV & AIDS programme, and to share their expertise with regard to the implementation of the HIV & AIDS programme.

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Table 4.28: Advice on how to improve the implementation of an HIV & AIDS programme in schools

SUMMARY OF CASES STUDIES 1, 2 AND 3	
Participant	**Participants' advice on ways to improve the implementation of the HIV & AIDS programme in schools**
C1:P	All schools must have an HIV & AIDS policy, of which all concerned should be made aware of. All people in schools should be open about their HIV status in order to urge people to maintain a healthy life style. Schools should emphasize prevention at all cost.
C1:HOD	Schools should create a special classroom dedicated to HIV & AIDS with a specially trained teacher who can answer all the questions of the learners. Invite people who are living with HIV & AIDS to visit the school, so that learners can see the reality. Learners should be taken to Hospices and assist people who are living with HIV & AIDS.
C1: T1	Schools should regard HIV & AIDS and Life Orientation as serious as any other subject. There should be subject advisors for the control and enforcement of the subject.
C1: T2	The schools should ensure that all stakeholders are involved, to guarantee the implementation of the HIV & AIDS programme.
C2: P	The programme should be presented to learners in small groups. Parents should also be informed and workshopped about the programme. Female teachers should present the programme, because they find it easier than men.
C2: HOD	Schools should discuss HIV & AIDS on a continuous basis. Invite people who are living with HIV & AIDS to the school and visit hospices. All subjects in the school should deal with HIV & AIDS across the curriculum, not only in Life Orientation. Male and female teachers should be involved in dealing with HIV & AIDS. The Department of Education should be more serious, about Life Orientation and allocate the subject more time.
C2: T1	The whole community must be involved in the schools HIV & AIDS programme. Life Orientation should not be taken lightly and allocated more time.
C2: T2	All the teachers in the school should be involved. The Department of Education should provide more training for teachers. Schools should address the myths in the community with regard to HIV & AIDS.
C3: P	All schools should have a School Based Support Team (SBST). Schools should not take it for granted that learners will know about HIV & AIDS, they must reiterate the prevention message continuously. All teachers need to be trained and involved with regard to HIV & AIDS. Schools should also focus on counselling, support, coping and caring for people who are infected and affected by HIV & AIDS.
C3: HOD	Schools must involve all stakeholders in the presentation of the HIV & AIDS programme. The school must involve the community in order to show to the learners that the community is also serious about HIV & AIDS. Schools must have a classroom where they can deal specifically with HIV & AIDS issues.
C3: T1	Schools should involve the Department of Health and people from outside the school to assist in the presentation of the HIV & AIDS programme. All teachers in the school should be trained in order to be able to deal with HIV & AIDS issues in the school.
C3: T2	Schools should provide learners with knowledge, skills and condoms. Experts should be invited to the school on a regular basis to share their experiences with regard to HIV & AIDS with teachers and learners. Male teachers should become more involved and be prepared to talk to boys about sex, puberty and females.

4.29.2 Interpretation of Table 4.28

On the basis of their own experiences, and their reflection during the interview about the implementation of the HIV & AIDS programme in their schools, the participants made the following recommendations:

- All schools should develop an HIV & AIDS policy that includes all stakeholders and which is known to all involved.
- Life Orientation as a subject should receive the serious attention that it deserves by allocating more time to it and providing teachers with adequate training.
- Subject advisors should be appointed to guide and control the implementation of Life Orientation in schools.
- Special HIV & AIDS classrooms should be provided in schools, where learners and teachers can obtain information and counselling with regard HIV & AIDS issues.
- Learners should continuously be reminded of the reality of HIV & AIDS, and prevention must be emphasized.
- The HIV & AIDS programme should be integrated across the curriculum in all the subjects offered in the school.
- The school's HIV & AIDS programme should involve parents, the Department of Health, people living with HIV & AIDS, Hospices and the community as a whole.
- All the teachers should be trained with regard to dealing with HIV & AIDS in the school. Male teachers should become more involved in the HIV & AIDS programme and serve as a role models for male learners.
- The school HIV & AIDS programme should also focus on counselling, support, coping and caring for people who are infected and affected by HIV & AIDS.

- Schools should organise more interactions with, and visibly support, people living with HIV & AIDS, in order to bring learners closer to the reality of AIDS.

4.29.3 Conclusions regarding Question 25

I wish to conclude Question 25 with recommendations that the participants proposed for promoting the implementation of the HIV & AIDS programme. This includes the development of an HIV & AIDS school policy that includes all stakeholders; passionate support and attention regarding the implementation of Life Orientation as a subject that is as important as any other; the appointment of subject advisors for Life Orientation; development of HIV & AIDS information and counselling centres at schools; continuous reiteration of the prevention message and reality of HIV & AIDS; integration of HIV & AIDS programme (content) within all subjects; the involvement of all stakeholders and the community as a whole; training of teachers in order to involve more male teachers in the presentation of the programme; more interaction with and support at school level for people living with HIV & AIDS.

4.30 CONCLUSIVE SUMMARY

Diagram 4.9 (on page 222) provides a summary and visual presentation of all the above findings, as categorized in four themes, at a glance.

4.30.1 Reflections on the findings of the study

In reflection on the findings in my study, I categorised the contextual factors that influence the implementation of HIV & AIDS programmes in four themes that emerged during the data analysis.

The first theme highlights teachers' perceptions and experiences of the HIV & AIDS programme. It became apparent that teachers find it challenging to encourage positive behaviour change among learners (p. 164, par. 4.10.3; Chapter 2, par. 2.5.3.8). The sensitive nature of HIV & AIDS appears to be demanding and most teachers avoid HIV & AIDS as a topic because of personal convictions, preferences and beliefs (p. 203, par. 4.26.3; p. 210, Diagram 4.8; p. 210, par. 4.27.4; p. 213, par. 4.28.2; Addendum F, p. 280, line 20; Addendum F, p. 288, line 15). Teachers furthermore perceive the programme as having little or no impact on learners (p. 184, par. 4.18.2; p. 186, par. 4.18.4; Addendum F, p. 282, line 27). It became clear that the responsibility to deal with HIV & AIDS in these schools is regarded as the responsibility of female teachers (p. 217, par. 4.29.3; Addendum F, p. 283, lines 15-22; Addendum F, p. 285, line 5). The responses from the teachers also indicated that they are not fully aware of what the HIV & AIDS programme entails possibly because of a lack training opportunities for teachers in this regard (p. 150, par. 4.6.5 and par. 4.6.6; p. 154, par. 4.7.4; p. 167, par. 4.11.3; p.214, par. 4.28.2 and 4.28.3; Addendum F, p. 284, lines 1-3; Addendum F, p. 284, lines 4-5). Apparently, the continued sexual relationships between teachers and learners in some schools are hindering the implementation of HIV & AIDS programmes and defeat the aim thereof (p. 161, par. 4.9.3; p. 169, par. 4.12.3; Addendum F, p. 281, line 9).

The second theme that emerged categorizes the managerial factors in schools that influence the implementation of HIV & AIDS programmes. It became apparent that school managers are ignorant with regard to HIV & AIDS programmes and uninvolved in the implementation thereof (p. 145, par. 4.5.3; p. 167, par. 4.11.3; p. 175, par 4.16.2 and 4.16.3; p. 181, par. 4.17.5; Addendum F, p.280, line 12; Addendum F, p. 281, line 8; Addendum F, p. 285, line 17). The management further displayed a lack of sound management practices such as not involving all stakeholders and not developing HIV & AIDS policies in their schools (p. 162, par. 4.9.4; p. 167,

par. 4.11.3; p. 169, par 4.12.3; p. 174, par. 4.15.2; p. 175, par 4.16.3; p. 181, par 4.17.5; p. 195, par 4.21.3; p. 196, par. 4.22.3; p. 198, par. 4.23.3; p. 200, par. 4.24.3; Addendum F, p. 281, line 16; Addendum F, p.285, lines 10 and 19; Addendum G, Figure 6; Chapter 2, par. 2.6.7; Chapter 2, par. 2.6.7.1; Van Rooyen & Hartell 2001:17, 27, 28; Coombe 2001b:34). As a consequence of this limited and/or incorrect time is allocated for the HIV & AIDS programme and it appears that Life Orientation does not receive serious attention from school management (p. 179, par 4.17.3; p. 193, par. 4.20.3; p. 213, par 4.28.2; p. 217, par 4.29.3; Addendum F, p. 282, line 27; Addendum F, p.286, line 24; Addendum F, p287, lines 1, 16 and 22; Addendum G, Figure 1). This again highlights the need for intensified monitoring and evaluation of the HIV & AIDS intervention programmes as proposed by the World Bank (Chapter 2, p. 63; Chapter 2, par. 2.6.3; Chapter 2, par. 2.6.7).

Thirdly, I categorized societal and community influences as factors that influence the implementation of HIV & AIDS programmes in schools. It appeared that a lack of parental involvement, especially with regard to HIV & AIDS, is a barrier with regard to programme implementation (p. 186, par. 4.18.4; p. 209, par. 4.27.3; Addendum F, p. 283, line 1; Addendum F, p. 289 lines 1 and 23). Myths and cultural taboos in the community that do not allow parents to talk to learners about sex, sexuality and HIV & AIDS became apparent during the data analysis (p. 161, par. 4.9.2; p. 164, par. 4.10.3; p.184, par 4.18.3; p. 203, par. 4.26.3; p. 209, par. 4.27.3; Addendum F, p. 287, line 17; Addendum F, p. 290, line 10; Addendum F, p. 291, line 14). In addition to this the participants identified the low level of social morality in the community (p. 164, par. 4.10.3; p. 165, par. 4.10.4), and the behaviours and statements of authority figures (p. 158, par. 4.8.3; p. 161, par 4.9.3; p.174, par. 4.15.2; Addendum F, p. 281, line 10; Addendum F, p. 287, line 16) as factors that defeat the aims of the programme. The participants also mentioned societal factors such as poverty, substance abuse and peer

pressure in the community (p. 164, par. 4.10.3; p. 184, par. 4.18.3; p. 208, par. 4.27.2; Chapter 2, par. 2.5.3.5; Chapter 2, par. 2.5.3.6; Chapter 2, par. 2.5.3.8) as factors that encourage learners to engage in risky sexual behaviour and therefore complicates the implementation of the HIV & AIDS programme in schools.

The fourth theme categorizes the lived experiences of teachers with regard to HIV & AIDS as part of Life Orientation as a subject. It appears that Life Orientation is not perceived to be a serious subject (p. 175, par. 4.16.3; p. 184, p. 4.18.2; p. 196, par. 4.22.3; p. 213, par. 4.28.2; p. 216, par. 4.29.2; p. 217, par.4.29.3; Addendum F, p. 282, line 27; Addendum F, p. 283, line 14; Addendum F, p. 285, line 5) which may be regarded as a contextual factor that influence the implementation of HIV & AIDS programmes in schools. Furthermore, factors such as the sensitive subject matter that makes teachers to avoid the topic of HIV & AIDS (p. 203 par, 4.26.3; Diagram 4.8, p. 210; p. 210, par. 4.27.4; p. 213, par. 4.28.2; Addendum F, p. 280, line 22; Addendum F, p. 288, line 15). Teachers also indicated that the time allocation for Life Orientation in their schools is insufficient (p. 192, par. 4.20.2; p. 193, par. 4.20.3; p. 198, par. 4.23.3; p. 209, par. 4.27.3; p. 216, par. 4.29.2) in light of the two hours per week that is prescribed by policy (Chapter 2, p.92, lines 1-18; Haddon & Moore 2006:v). Schools apparently do not take initiative and sporadically have additional AIDS awareness days, involve NGOs and the Department of Health in their HIV & AIDS programme (p. 181, par. 4.17.5; p. 186, par. 4.18.4; p. 192, par. 4.20.2; p. 193, par. 4.20.3; p. 198, par. 4.23.3; p. 204, par. 4.26.4; p. 217, par. 4.29.3; Addendum F, p. 283, line 28; Addendum F, p. 287, lines 4-7; Addendum G, Figure 4). In addition to the inadequate utilisation of teaching resources (p. 191, par. 4.19.3; p. 213, par. 4.28.2; p. 216, par. 4.29.2; Addendum F, p. 281, line 5; Addendum G, p. 288, Figure 1 and p. 290, Figure 5), teachers also experienced logistical problems and a lack of suitable venues as serious contextual factors that influence the implementation of the HIV & AIDS programme in their schools (p. 181, par.

4.17.5; p. 213, par. 4.28.2; p. 216, par. 4.29.2; Addendum F, p. 286, lines 12-19; Addendum G, p. 290, Figure 5). The lived-experiences of teachers also highlighted that teachers and school managers are not abreast with NCS requirements with regard to Life Orientation (p. 145, par. 4.5.3; p. 167, par. 4.11.3; p. 175, par 4.16.2 and 4.16.3; p. 181, par. 4.17.5; Addendum F, p.281, line 14; Addendum F, p. 283, line 15; Addendum F, p.285, line 16). Teachers are also allocated Life-Orientation (for which they are not trained for) in addition to other subjects for which they are responsible. This apparently creates the impression that Life Orientation is of secondary importance and does not receive the serious attention it deserves from teachers and school management (p. 191, par. 4.19.3; p.193, par. 4.20.3; p.203. par. 4.26.3; p. 213, par. 4.28.2; p.214, par. 4.28.3; Addendum F, p. 282, lines 25-28; Addendum F, p. 287, lines 14-20).

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- Life Orientation not perceived as a serious subject – management and teachers view it as less important.
- Sensitive subject matter makes teachers uncomfortable and they avoid the topics.
- Time allocated to Life Orientation and HIV & AIDS not according to departmental requirements.
- Additional AIDS awareness days, involvement of NGOs and Department of Health, and inclusion of outsiders are sporadic (schools do not take initiative).
- Logistical problems and lack of suitable venues for implementation of the programme.
- Inadequate utilisation of teaching resources and materials.
- Teachers and school managers not abreast with NCS requirements with regard to Life Orientation.
- Teachers are allocated to Life Orientation in addition to other subjects for which they are responsible (secondary importance).

Teachers' perceptions and experiences of the HIV & AIDS programme

- Challenge to encourage behaviour change among learners.
- Simultaneously dealing with learners who are sexually active and those who are not.
- Sensitive nature of HIV & AIDS topics is challenging for teachers.
- In general most teachers avoid HIV & AIDS as a topic because of personal convictions, preferences and beliefs.
- Teachers perceive programme as having limited or no impact on learners.
- Teachers perceive dealing with HIV & AIDS as the responsibility of female teachers.
- Lack of HIV & AIDS training opportunities for teachers.
- Teachers not fully aware of what HIV & AIDS programme entails.
- Sexual relationships between teachers and learners defeat the aim of the programme.

HIV & AIDS as part of Life Orientation as a subject

Contextual factors that influence the implementation of the HIV & AIDS programme in secondary school in Soshanguve

Managerial factors in the school

- Lack of parental involvement in school, and especially with regard to HIV & AIDS.
- Cultural taboos in community do not allow parents to talk to learners about sex, sexuality and HIV & AIDS.
- Poverty, substance abuse and peer pressure in community and among learners.
- Myths with regard to HIV & AIDS in community.
- Low level of social morality in the community.
- Parents not involved in school activities and regard HIV & AIDS education as the school's responsibility.
- Learners are encouraged by community factors to engage in risky sexual behaviour.
- Not all stakeholders in the school community are involved by school management.
- Behaviours and statements of authority figures are defeating the aims of the programme.

Societal and community influences

- School managers are ignorant with regard to HIV & AIDS programmes and the implementation thereof.
- A lack of sound management practices.
- Management uninvolved in programme implementation.
- Not all stakeholders being involved by management.
- HIV & AIDS school policy not developed by management.
- Limited and/or incorrect time allocation for HIV & AIDS programme and Life Orientation.
- Life Orientation does not receive serious attention from school management.
- HIV & AIDS not integrated within all school activities and subjects.
- No funds allocated in school budget to support programme implementation and/or improvement.
- Management unaware of relevant documentation with regard to HIV & AIDS.

Diagram 4.9: Conclusive summary of the findings in Chapter 4

CHAPTER 5

SYNTHESIS, FINDINGS AND RECOMMENDATIONS

5.1 THE AIM OF THIS CHAPTER

The aim of this chapter is to summarize the findings of the research that I conducted in this study. I shall provide a summary in respect of Chapters 1 to 4, and follow this with a discussion of the main research findings with regard to the research questions that were formulated in Chapter 1. Recommendations based on these findings will be made. I believe that the recommendations in this chapter may contribute to the improvement of the implementation of HIV & AIDS programmes in schools.

5.2 SYNTHESIS

In this study, entitled **"Contextual factors that influence the implementation of an HIV & AIDS programme"**, several contextual factors that influence the implementation of HIV & AIDS programmes, as well as the implications thereof for education (especially secondary schools), were investigated.

During the literature study several facts became apparent. The staggering number of people living with HIV & AIDS is increasing and projections are that life expectancy in Southern Africa may drop to a mere 30 years by the year 2010 (in this regard refer to paragraph 2.3 in Chapter 2). The reality of sexual behaviour being the primary factor that fuels the spread of HIV & AIDS also became evident. A further fact that surfaced was that South Africa has progressed to a Stage 3 country, due to the unique socio-economic problems that prevail in this country. The fact, that the HIV & AIDS prevalence rate

remains unacceptably high, despite many prevention strategies that have been in place for several years, also became obvious. The most prominent prevention strategies appear to be education and positive changes in sexual behaviour. It seems as if HIV & AIDS programmes and education in schools might not be curbing the infection rate, as projected mortality rates among adolescents become a reality. In the light of this reality, several implications surfaced for the school as an institution that must assist in curbing the spread of HIV & AIDS, as part of its obligation to the community. The role and obligation of the school and its teachers with regard to the implementation of HIV & AIDS programmes, and especially with regard to learners in the shadow of HIV & AIDS, were kept in mind when the primary research question was formulated, namely: **"In what manner do contextual factors influence the implementation of HIV & AIDS programmes in South African schools?"**

With regard to the aims of this study, I distinguished between a primary aim and certain secondary aims, after the formulation of research questions. A number of questions were derived from the primary research question, and, by researching the answers to these questions, the primary question could be answered. The formulation of aims gave focus and direction to the study, in such a manner that meaningful empirical research could be conducted.

In Chapter 1 I focused on the background and orientation regarding my study. I indicated my area of interest and elucidated my rationale for undertaking the study. I outlined the aim and relevance of the study with regard to certain choices that I made during the planning phase. I formulated the main research question against the background of these choices and considerations. The formulation of the purpose and central research question of this study is descriptive by nature, and focuses on exploring the manner in which teachers experience and give meaning to the implementation of an HIV & AIDS programme in their schools, thereby highlighting contextual factors that influence

programme implementation. After formulating my research questions, I concisely mentioned the possible contribution of my study, and identified assumptions with which I approached the study. I then stated the paradigmatic perspective with which I approached my study, and presented a brief overview of my research design, methodological choices, ethical considerations and quality criteria. I concluded Chapter 1 with a brief overview of the thesis in terms of its five chapters.

In Chapter 2 I explored relevant literature as background to my study, and presented my conceptual framework. I started the investigation with an examination of the relevant literature on HIV & AIDS, as contextual backdrop of my study. I then focused on the extent and impact of the pandemic within the South African context, with special reference to the impact on education and the curricula. I included discussions on the challenges to, and expectations of education (schools), as an agent in society that has to implement HIV & AIDS programmes in order to combat the HIV & AIDS pandemic. I included a discussion on the theories with regard to behaviour change, that forms the basis of HIV & AIDS prevention and intervention programmes. In this chapter I also focused on the responsibilities of school management and teachers who are expected to implement the HIV & AIDS programme and develop an HIV & AIDS policy for their schools. I concluded Chapter 2 with a discussion on the Life Orientation programme in which HIV & AIDS education is embedded, and also clarified the key concepts of my study.

Chapter 3 includes my discussions and justification regarding the choices that I made with regard to designing and conducting the empirical part of my study. I employed a case study design in order to identify, explore and explain contextual factors that influence the implementation of HIV & AIDS programmes in schools. I specifically followed an instrumental case study design and utilised individual interviews, observation, a reflective field journal and visual data as data

collection strategies and data documentation procedures. I then justified my preferred methodology in terms of my research questions and purpose of my study. I also described the manner in which I conducted the thematic analysis and interpretation procedures during the study. This was followed by a discussion on the strengths and challenges of the selected methodology that I utilised during the empirical part of my research. I also highlighted the strategies that I employed to address these issues. I completed Chapter 3 with a discussion on the ethical guidelines that I adhered to during the data collection and analysis phases of my research, and on the manner in which I aimed to improve the quality of my research in the light of qualitative quality criteria.

I reported the results that I obtained during my study in Chapter 4. I provided a holistic view of the results by means of tables and diagrams in order to illustrate the responses of the participants as well as my interpretations thereof. I discussed the collected data in terms of the aims, responses and outcomes of the various questions posed during my field work sessions. I also made use of verbatim responses and visual images to supplement my discussions, with the aim of addressing my primary research question, namely: In what manner do contextual factors influence the implementation of HIV & AIDS programmes in schools?

5.3 FINDINGS REGARDING MY RESEARCH QUESTIONS

In the following discussion I shall present my findings and final conclusions in terms of the questions that were formulated in Chapter 1 (in this regard refer to paragraph 1.4 on pages 6 and 7). In believe that, by answering the secondary questions, light will simultaneously be shed on the primary research question, and in this manner the contextual factors that influence the implementation of the HIV & AIDS programme, are identified, explored, explained and described.

The findings will be categorised under the four secondary questions referred to above:

5.3.1 Secondary Question 1: What are the expectations of the Department of Education (as stipulated in the relevant policy) with regard to the HIV & AIDS programme and the implementation thereof in secondary schools?

I found that

- the Department of Education requires of schools to implement HIV & AIDS programmes that are part of the Life Orientation Learning Area within NCS requirements;
- the school is a service deliverer to the community and is expected to be the vanguard in the prevention of HIV & AIDS infection among adolescents;
- the escalation in the number of HIV & AIDS infections directs an appeal to the school to persevere in its mandatory obligation and responsibility for addressing the prevention of HIV & AIDS infection;
- the totality of a school (for example the curriculum, management, policy and organization) is affected by HIV & AIDS;
- HIV & AIDS impacts on education supply and delivery in a school;
- in schools Life Orientation is not perceived as a serious Learning Area, as management and teachers view it as less important than other Learning Areas;
- the sensitive nature of the Learning Area content makes teachers uncomfortable, and they rather avoid the topics and the programme as a whole;
- the time allocated to Life Orientation on the schools' timetables deviates from departmental requirements;

- additional AIDS awareness days and involvement of NGOs and the Department of Health in the schools' HIV & AIDS programme occur sporadically. Schools do not take initiative to provide and include these services within their HIV & AIDS programmes, and wait for others to offer their services;
- schools experience logistical problems and a lack of suitable venues for the implementation of the HIV & AIDS programme;
- schools experience the inadequate utilisation of teaching resources and materials with regard to the implementation of Life Orientation, and especially the HIV & AIDS programme;
- teachers and school managers are not abreast with NCS requirements with regard to Life orientation as a new, examinable subject;
- teachers are allocated to Life Orientation as a Learning Area in addition to other Learning Areas for which they are responsible; consequently the Life Orientation Learning Area is of secondary importance, and teachers are not able to specialise in Life Orientation as a Learning Area.

5.3.2 Secondary Question 2: What significance do the School Governing Body, the school management team and the teachers attach to the HIV & AIDS programme and the extent to what opportunities are created and resources made available in order to adequately implement the programme?

I found that

- teachers experience the encouragement of learners, to change behaviour that may expose them to HIV & AIDS infection, as a great challenge;

- simultaneously dealing with learners who are sexually active and those who are not, creates a barrier for the implementation of the HIV & AIDS programme, as teachers experience this as difficult;
- the sensitive nature of HIV & AIDS topics is challenging for teachers, and in many cases these topics are not dealt with;
- in general most teachers avoid HIV & AIDS as a topic because of personal convictions, preferences, beliefs and probably being infected with HIV themselves;
- teachers perceive the HIV & AIDS programme as having limited or no impact on learners. Teachers experience a low level of confidence in the success of the programme, and regard the programme as ineffective;
- the responsibility for dealing with HIV & AIDS, sexuality and sensitive topics is regarded as being that of female teachers. In general male teachers are not responsible for the implementation of the programme, possibly because of cultural and gender stereotypes in society with regard to sexuality education;
- there is a lack of training opportunities and poor attendance of training sessions for teachers with regard to HIV & AIDS programmes and Life Orientation;
- teachers are not fully aware of what the HIV & AIDS programme within Life Orientation entails;
- the existence of sexual relationships between teachers and learners defeats the aim of the programme and presents challenges for the teachers who are responsible for the implementation of HIV & AIDS programmes.

5.3.3 Secondary Question 3: How do school management teams and teachers perceive their respective responsibilities with regard to the implementation of an HIV & AIDS programme in their schools?

I found that

- school managers are ignorant with regard to HIV & AIDS programmes and the implementation thereof;
- there is a lack of sound management practices with regard to the implementation of the Life Orientation curriculum (especially the implementation of HIV & AIDS programmes);
- school managers are uninvolved in the efforts that teachers make to initiate and implement programmes within the classroom and in the school as a whole;
- stakeholders such as parents, teachers, and the SGB are not involved in the implementation of HIV & AIDS programmes;
- school management have not developed functional and practicable HIV & AIDS school policies in order to facilitate the implementation of HIV & AIDS programmes;
- school management are well aware of the national policy, but have not studied and incorporated it within their school management practices;
- limited time for HIV & AIDS programme implementation has been allocated on school timetables by management;
- Life Orientation does not receive serious attention from school management, consequently the implementation of HIV & AIDS programmes is neglected;
- HIV & AIDS as a topic and a programme is not integrated within all school activities and subjects;

- no funds are allocated in the school budget to support the HIV & AIDS programme implementation and/or improvement;
- management are unaware of relevant documentation with regard to HIV & AIDS programmes and the implementation thereof.

5.3.4 Secondary Question 4: What are the attitudes and lived-experiences of teachers with regard to the practical implications of the HIV & AIDS programme in the classroom?

I found that

- there is a lack of parental involvement in the schools, and especially limited parental support and involvement with regard to HIV & AIDS programmes;
- cultural taboos in the community do not allow parents (especially fathers) to talk to learners about sex, sexuality and HIV & AIDS. The community therefore relies on the school to fulfil this role, but the school does not accept and fulfil this responsibility – consequently the HIV & AIDS programme does not reach the learners for whom it is intended;
- societal factors such as poverty, substance abuse and peer pressure in the community necessitate and influence the implementation of the HIV & AIDS programme in the school;
- myths with regard to HIV & AIDS in the school community negatively influence the rare implementation efforts of teachers with regard to HIV & AIDS programmes;
- teachers experience the low level of social morality in the community as a challenge regarding the implementation of the HIV & AIDS programme within the school;
- parents are not involved in school activities and regard HIV & AIDS education as the school's responsibility;

- the behaviours and statements of authority figures and politicians, within the school's community and in society at large, are defeating the aims of the HIV & AIDS programme, and negatively influence the efforts of teachers and school management with regard to the implementation of the programme.

5.3.5 Findings: a final conclusion

The Department of Education, in *The National Policy on HIV & AIDS for Teachers and Learners in public schools and students and teachers in further education and training institutions,* and, *The HIV & AIDS emergency: Department of Education guidelines for teachers*, stipulates that the HIV & AIDS programme, as part of the Life Orientation Learning Area, is compulsory in all schools in South Africa. Despite this mandatory obligation, I found that schools and other stakeholders do not adhere to this requirement, and view Life Orientation as of less importance. Adequate provision is not made on school timetables, and suitable venues and teaching resources are not available. Regarding the lived-experiences of teachers, they reported that they regarded the nature of the content of the HIV & AIDS programme as too sensitive and too demanding to deal with in the classroom, for example, how to deal with sexually active learners, how to change their behaviour, and how to transcend personal convictions, beliefs and cultural taboos surrounding the topic of human sexuality. This can possibly be ascribed to a lack of proper training, and the fact that human sexuality forms an integral and personal part of *being*, and of constituting *who I am*. Teachers further reported a low level of confidence in the programme and view it as of limited impact.

The research has further shown that a lack of sound management practices and lacking commitment restrain implementation efforts to such an extent that management ignore their responsibility regarding keeping abreast with relevant

documentation and policy, and continue with business as usual, thereby neglecting the implementation of the HIV & AIDS programme in totality.

Other than the above-mentioned contextual factors that negatively influence the implementation and status of the HIV & AIDS programme, are factors such as poverty, substance abuse, peer pressure, current myths, and the low level of social morality in the community (refer to Diagram 5.1 for a graphic presentation [that is self-explanatory] of the relation between the findings of the study and answering the primary and secondary questions).

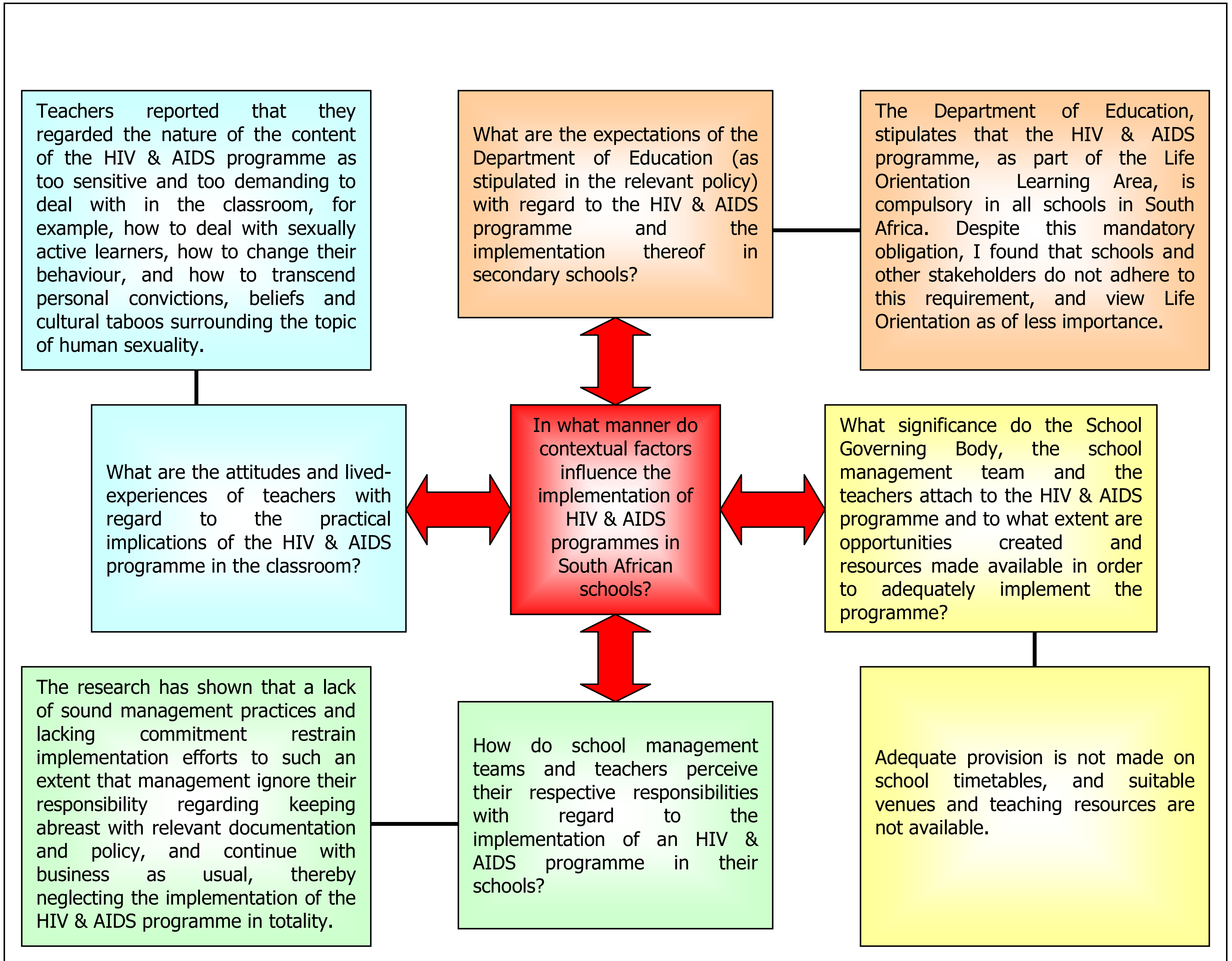


Diagram 5.1: A final conclusion on the relation between the findings and answering of the primary and secondary research questions

5.4 RECOMMENDATIONS

Based on my findings (discussed in paragraph 5.3) with regard to the four broadly identified themes that emerged from my empirical study (refer to Diagram 4.9 in Chapter 4), I now present my recommendations.

5.4.1 Recommendations for rectifying problems addressed in this study

During the analysis and interpretation of the data, the most prominent findings that answer the primary and secondary research questions point to the inadequate management of HIV & AIDS programmes, whether on macro, meso or micro level. The following diagram (Diagram 5.2 on the next page) indicates my recommendations for improving management practices.

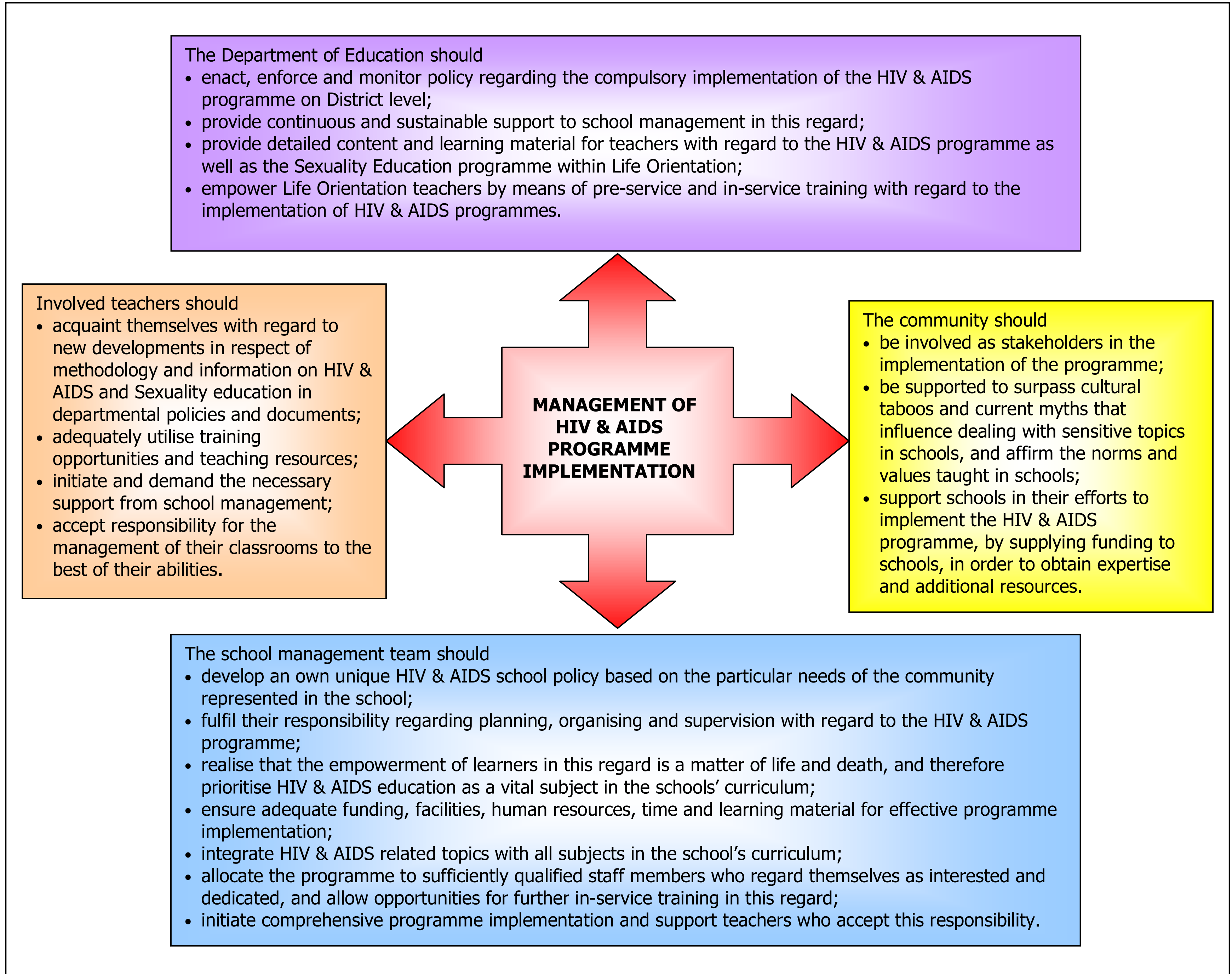


Diagram 5.2: Recommendations for improving HIV & AIDS programme implementation

5.4.2 Recommendations for further research

In the light of the findings in paragraph 5.3, and the recommendations in Diagram 5.2, I suggest that further research be undertaken with regard to the development of effective parent and community programmes that go beyond an HIV & AIDS or sexual health agenda, and empower parents, community members and other adults to overcome gender stereotypes and cultural taboos. This research may take the form of the development of family counselling programmes that promote open communication regarding issues such as sexuality, social stigma, and parental responsibility with regard to the sexual education of children in the family and community.

As this study involved schools as case studies, additional comparative studies can be undertaken, to explore the manner in which contextual factors within other communities influence the implementation of the HIV & AIDS programme in their respective schools.

Based on the exploration, identification and description of contextual factors that influence the implementation of HIV & AIDS programmes in schools, I also recommend a follow-up study on the sustainability and continuous innovation of programmes in schools and communities.

5.5 POSSIBLE CONTRIBUTIONS OF MY STUDY

The main contribution of my study is that contextual factors, that negatively influence the implementation of HIV & AIDS programmes in schools, were identified and investigated.

I believe that this study adds to the growing body of knowledge on the implementation of the school's curriculum with regard to HIV & AIDS programmes. My investigation of the manner in which contextual factors

influence the implementation of the programme contributes to current knowledge on curriculum implementation and management in schools.

This study further contributes to the realisation and optimising of educational policy in practice (schools). As such this study highlights the manner in which educational policy becomes a workable instrument in the hands of school managers, that empowers them and provides the parameters in which a unique, own school policy can be designed. I further believe that the identification and investigation of contextual factors, that influence the implementation of HIV & AIDS programmes in schools, will contribute to addressing the hindrances that negatively influence programme delivery to learners, and may direct an appeal to school management and teachers to embrace their responsibilities with regard to the implementation of the programme.

In addition to this, I am of the opinion that this study might contribute to the improvement of teacher training and the professional development of school managers. The exploration and description of the lived-experiences of teachers (such as being uncomfortable when dealing with sensitive topics) with regard to the implementation of HIV & AIDS programmes in schools may have significant value for the training of Life Orientation teachers and curriculum developers.

5.6 POSSIBLE LIMITATIONS OF MY STUDY

In this discussion I shall consider possible limitations of my study, which might be related to certain challenges that I faced whilst conducting the study (refer to paragraph 3.9 for detailed discussions on the challenges that I experienced).

On entering the research field as a white, Afrikaans speaking, graduate male, I was faced with the challenge of reporting research findings that were true to the reality that I investigated, and of avoiding personal and biased findings. However, I aimed to address the potential limitation of being influenced toward personal and biased findings, by constantly being aware of the likelihood thereof, and by reflecting, by asking myself: "Did I hear what the participants tried to tell me? Did I see what they wanted me to see?". In addition to a field journal and frequent debriefing sessions with my supervisor, I returned to the participants to confirm the outcomes of all interviews and observations, in order to limit my subjectivity and enhance the trustworthiness of the study.

Another challenge, and possibly a limitation with regard to the outcomes of my study, was that generalizations should not be made from a single or even three case studies. Despite this possible limitation, I believe that the outcomes of my study may relate to research findings from similar contexts. I also kept in mind that the aim of my research was not to generalize, but rather to gain an in-depth view of contextual factors that influence the implementation of HIV & AIDS programmes in schools, from an interpretivist and constructivist perspective.

5.7 A FINAL WORD (OR TWO)

Continuous efforts to combat the spread of the HIV & AIDS pandemic on a global scale presently rely on local initiatives in every community, especially in schools, to present education programmes, in order to curb the vigorous spread of the national epidemic. In this study I identified and investigated contextual factors that influence the implementation of HIV & AIDS programmes in schools, in an attempt to reduce the impact of the epidemic on a local level.

I utilised a qualitative research approach by means of an instrumental case study design with the aim of identifying and investigating the lived-experiences of teachers who are responsible for implementing HIV & AIDS programmes in schools. In doing so, I believe that this study contributes to existing knowledge with regard to HIV & AIDS prevention, and indicates factors that need to be considered when attempting to improve programme implementation in schools.

Based on the sound practising of science that I adhered to during this study I regard the findings that I obtained as the authentic truth for the context in which this study was conducted. Every thought and consideration, deliberations and actions were undertaken with the following principles in mind: non-discrimination, which is reflected in a commitment to a non-racial and non-sexist society; democratic values and implementation of the programme, taking the needs and interests of the learners as well as the community at large into account; a multi-sectoral approach which draws on the resources of other education support services; an awareness and implementation of human rights and responsibilities within a democratic society; contextualising relevant issues in terms of community concerns, changes in the working environment and global issues; respect for diversity and a commitment to the Bill of Rights and the Constitution of our country; the development of a national identity; basing the primary approach to teaching upon acknowledging and drawing from existing competencies and resources in the learners as well as the broader community; access to appropriate and innovative resource material; and classroom methodology that empowers the learners to participate at all levels in the school and society, demystifies social relations of power and promotes active, critical and dynamic learner-based education.

ADDENDUM G

COLLECTED VISUAL DATA

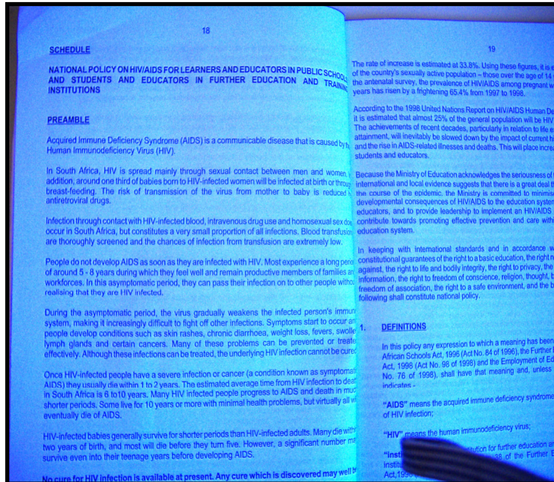
Figure 1: Examples of unutilised HIV & AIDS and Life Orientation resources

Figure 2: Example of a Life Orientation classroom

Figure 3: Examples of painted HIV & AIDS murals

Figure 4: Examples of love Life involvement in the schools and community

Figure 5: Library utilised as a staffroom



18

SCHEDULE

NATIONAL POLICY ON HIV/AIDS FOR LEARNERS AND EDUCATORS IN PUBLIC SCHOOLS AND STUDENTS AND EDUCATORS IN FURTHER EDUCATION AND TRAINING INSTITUTIONS

PREAMBLE

Acquired Immune Deficiency Syndrome (AIDS) is a communicable disease that is caused by th Human Immunodeficiency Virus (HIV).

In South Africa, HIV is spread mainly through sexual contact between men and women. addition, around one third of babies born to HIV-infected women will be infected at birth or throug breast-feeding. The risk of transmission of the virus from mother to baby is reduced antiretroviral drugs.

Infection through contact with HIV-infected blood, intravenous drug use and homosexual sex doe occur in South Africa, but constitutes a very small proportion of all infections. Blood transfusio are thoroughly screened and the chances of infection from transfusion are extremely low.

People do not develop AIDS as soon as they are infected with HIV. Most experience a long perio of around 5 - 8 years during which they feel well and remain productive members of families an workforces. In this asymptomatic period, they can pass their infection on to other people witho realising that they are HIV infected.

During the asymptomatic period, the virus gradually weakens the infected person's immun system, making it increasingly difficult to fight off other infections. Symptoms start to occur an people develop conditions such as skin rashes, chronic diarrhoea, weight loss, fevers, swolle lymph glands and certain cancers. Many of these problems can be prevented or treate effectively. Although these infections can be treated, the underlying HIV infection cannot be cure

Once HIV-infected people have a severe infection or cancer (a condition known as symptomat AIDS) they usually die within 1 to 2 years. The estimated average time from HIV infection to dea in South Africa is 6 to10 years. Many HIV infected people progress to AIDS and death in muc shorter periods. Some live for 10 years or more with minimal health problems, but virtually all w eventually die of AIDS.

HIV-infected babies generally survive for shorter periods than HIV-infected adults. Many die with two years of birth, and most will die before they turn five. However, a significant number m survive even into their teenage years before developing AIDS.

No cure for HIV infection is available at present. Any cure which is discovered may well b

19

The rate of increase is estimated at 33.8%. Using these figures, it is es of the country's sexually active population – those over the age of 14 y the antenatal survey, the prevalence of HIV/AIDS among pregnant wo years has risen by a frightening 65.4% from 1997 to 1998.

According to the 1998 United Nations Report on HIV/AIDS Human Dev it is estimated that almost 25% of the general population will be HIV The achievements of recent decades, particularly in relation to life ex attainment, will inevitably be slowed down by the impact of current hig and the rise in AIDS-related illnesses and deaths. This will place increa students and educators.

Because the Ministry of Education acknowledges the seriousness of th international and local evidence suggests that there is a great deal th the course of the epidemic. the Ministry is committed to minimise developmental consequences of HIV/AIDS to the education system educators, and to provide leadership to implement an HIV/AIDS p contribute towards promoting effective prevention and care within education system.

In keeping with international standards and in accordance wi constitutional guarantees of the right to a basic education, the right no against, the right to life and bodily integrity, the right to privacy, the r information, the right to freedom of conscience, religion, thought, be freedom of association, the right to a safe environment, and the be following shall constitute national policy.

1. **DEFINITIONS**

In this policy any expression to which a meaning has been a African Schools Act, 1996 (Act No. 84 of 1996), the Further E Act, 1998 (Act No. 98 of 1998) and the Employment of Edu No. 76 of 1998), shall have that meaning and, unless t indicates -

"AIDS" means the acquired immune deficiency syndrome, of HIV infection;

"HIV" means the human immunodeficiency virus;

"insti … titution for further education an … 38 of the Further E institu … Act,199 …

Figure 6: An example of a school's HIV & AIDS policy

Figure 7: Examples of the surroundings in Case Study 1

5.8 REFERENCES[18]

ABT ASSOCIATES. 2001. *Impacts of HIV/AIDS on the South African Education Sector*. Johannesburg: Abt Associates.

ADLER, P.A. & ADLER, P. 1994. Observational techniques. In: N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research*. Thousand Oaks: Sage Publications.

AINSA, P. 2002. *Teaching children with Aids*. New York: Edwin Mallen Press.

AIRHIHENBUWA, C.O., MAKINWA, B., FIRTH., M. & OBERGON, R. 1999. *Communication frameworks for HIV/AIDS: A new direction*. Geneva:UNAIDS. Available at www.unaids.org/publications.

AJENZEN, I. & FISHBEIN, M. 1980. *Understanding Attitudes and predicting social behaviour*. Englewood Cliffs New York: Prentice-Hall.

AJENZEN, I. & FISHBEIN, M. 1985. From Intentions to Action: A theory of planned behaviour. In: Kuhl, J. & Beckmann, J.(Eds.), *Action control: From cognition to behaviour*. New York: Springer.

BABBIE, E. & MOUTON, J. 2001. *The practice of social research (2nd ed)*. Cape Town: Oxford Press.

BADCOCK-WALTERS, P. & WHITESIDE, A. 2003. *HIV & AIDS and development in the Education Sector.* Geneva: USAID.

BANDURA, A. 1986. *Social Foundations of Thought and Action.* New Jersey: Prentice-Hall.

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[18] This list of references also includes National acts and Departmental policies.

BANDURA, A. 1989. Percieved Self-Efficacy in the Exercise of Control over AIDS infection. In: Mays, V.M., Albee, G.W. & Schneider, S.F. (Eds.), *Primary Prevention of AIDS*. California:Sage.

BASSET, M.T. & KAIM, B. 2000. *What they don't know can hurt them*. Zimbabwe: TARSC.

BATE, K. D. 2003. *Responsibility in a time of Aids. A pastoral response by Catholic Theologians and Aids Activists in Southern Africa*. Pietermaritzburg: Intrepid.

BERG, B.L. 2001. *Qualitative research methods for the Social Sciences*. Needham Heights: Allyn and Bacon.

BERGEN, A. & WHILE. 2000. A case for case studies: Exploring the use of case study design in community nursing research. *Journal of Advanced Nursing*, 31(4):1-14.

BEYER, L.E. 1988. *Knowing & Acting: Inquiry, Ideology & Educational studies*. London: The Falmer Press.

BLESS, C. & HIGSON-SMITH, C. 1995. *Social Research Methods: An African Perspective*. Cape Town: Juta.

BOGDAN, R.G. & BILKEN, S.K. 1992. *Qualitative Research for Education (second edition)*. Boston MA: Allyn & Bacon.

BROUARD, P., MARITZ, J., PIETERSE, J., VAN WYK, B. & ZUBERI, F. 2005. *Course companion to the CSA entry level course and general information source*. Pretoria: Centre for the study of AIDS, University of Pretoria.

BROOKES, H., SHISANA, O. & RICHTER, L. 2004. *The National Household HIV Survey prevalence and risk survey of South Africa*. Cape Town: HSRC Publishers.

BUSINESS REPORT. 2000. 17 July:16

CHAPIN, J.R. 2000. The third Person Perception and Optomistic Bias Among Urban Minority Alt-Risk Youth. *Communication Research*, 27(1):51-81.

CAREY, S. 1985. *Conceptual change in childhood*. Cambridge: The MIT Press.

CARTER, D.S.G. 1999. A Whole-school approach to adolescent peer-leader development for affective learning in health-related curricula. *Research Papers in Education*, 14(3):295-319.

CATANIA, J.A., KEGELES, S.M. & COATES, T.J. 1990. Towards and understanding of risk behaviour: An AIDS risk reduction model (ARRM), *Health Education Quarterly*, 17(1):53-72.

COHEN, D. 2002. HIV and education in Sub-Saharan Africa: Responding to the impact. *Perspectives in Education*, 20(2):13-23.

COHEN, L., MANION, L. & MORRISON, K. 2003. *Research methods in Education*. New York: Routledge Falmer.

COLLINS COBUILD ENGLISH DICTIONARY. 1998. London: HarperCollins Publishers.

COOMBE, C. 2000a. *HIV & AIDS and the education sector. The foundations of control and management strategies in South Africa*. Briefing paper commissioned by the United Nations Economic Commission for Africa.

COOMBE, C. 2000b. *Numbers and the AIDS effect*. Pretoria: University of Pretoria.

COOMBE, C. 2001a. *HIV/AIDS and trauma among learners: sexual violence and deprivation in South Africa*. Pretoria: University of Pretoria.

COOMBE, C. 2001b. *Mitigating the impact of HIV/AIDS on education supply, demand and quality: a global review*. Pretoria: University of Pretoria.

COOMBE, C. & KELLY, M.J. 2001. *Education as a vehicle for combating HIV/AIDS*. Pretoria: University of Pretoria.

COURT, S. 1999. *Curriculum planning guidelines for HIV & AIDS education*. Montana: Office of Public Instruction.

CRESWELL, J.W. 2003. *Research design. Qualitative, quantitative and mixed methods approaches.* California: Sage Publications.

CREWE, M. 2002. Reflections on the South Africa HIV/AIDS epidemic. *Society in Transition*, 33(3):446-454.

DAVISON, W. 1983. The Third Person Effect in Communication. *Public Opinion Quarterly*, 47:1-15.

DENZIN, N.K. 1989. *Interpretive Biography*. London: Sage Publications.

DENZIN, N.K. & LINCOLN, Y.S. (Eds.) 1998. *The landscape of Qualitative Research: Theories and Issues.* London: Sage Publications.

DENZIN, N.K. & LINCOLN, Y.S. (Eds.) 2000. *The handbook of Qualitative Research*. California: Sage Publications.

DEPARTMENT OF EDUCATION. 1996. *National Education Policy Act, 1996 (Act No. 27 of 1996). National Policy on HIV/AIDS for Learners and Educators in Public Schools*. Johannesburg: Department of Education.

DEPARTMENT OF EDUCATION. 1998. *Sexuality Education in Schools. Circular 485*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 1999. The National Policy on HIV/AIDS, for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions. *Government Gazette*, 410, 20372, August 10. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 2000. *The HIV & AIDS emergency: Department of Education's guidelines for Teachers*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 2001a. *Tirisano – working together*. [Online] Available at: http://education.pwv.gov.za

DEPARTMENT OF EDUCATION. 2001b. *Education in South Africa: Achievements since 1994*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 2001c. *Manifesto on Values, Education and Democracy*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 2002. *Revised National Curriculum Statement Grades R – 9 (Schools): Overview*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 2003a. *National Curriculum Statement Overview Grades 10-12 (General)*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 2003b. *National Curriculum Statement Grades 10-12 (General): Life Orientation*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 2003c. *Develop an HIV & AIDS plan for your school – A guide for school governing bodies and management teams*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 2003d. *HIV & AIDS Resource Guides*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 2004. *School Development Plan for School Governing Bodies*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 2005. *National Curriculum Statements grades 10-12 (General) – Life Orientation Programme Guidelines*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 2007. *National Curriculum Statement grades 10-12 (General) – Learning Programme Guidelines: Life Orientation*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION & DEPARTMENT OF HEALTH. 2000. *HIV & AIDS Life Skills Training Manual for Secondary and Primary Schools*. Pretoria: Department of Education.

DEPARTMENT OF HEALTH. 2001. *Draft HIV & AIDS/STD Strategic Plan for South Africa, 2000 – 2005*. Pretoria: Department of Health.

DEPARTMENT OF HEALTH. 2005. *South Africa National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005*. Pretoria: Department of Health.

DEPARTMENT OF SOCIAL DEVELOPMENT. 2002. *Documenting HIV & AIDS case studies in South Africa*. Pretoria: Department of Social Development.

DE VOS, A.S. (Ed.) 2000. *Research at grass roots. A primer for the caring professions*. Pretoria: Van Schaik.

DICKSON-TETTEH, K & LADHA, S. 2000. Youth Health. In: *South African Health Review 2000.* Durban: Health Systems Trust.

DONALD, D., LAZARUS, S., & LOLWANA, P. 2002. *Educational psychology in social context*. Cape Town: Oxford University Press.

DORRINGTON, R.E., JOHNSON, L.F., BRADSHAW, D. & DANIEL, T. 2006. *The demographic Impact of HIV/AIDS in South Africa. National and Provincial Indicators for 2006*. Cape Town: Centre for Actuarial Research.

DWADWA, L. 1997. Teachers learn about sex education. *The Teacher*, 2(11):9.

ERICSON, F. 1986. Qualitative methods in research on teaching. In: Wittrock, M. D. (Ed.), *Handbook of research on teaching.* New York: McMillian.

EZZY, D. 2002. *Qualitative analysis: Practice and innovation*. London: Routledge.

FARHANGPOUR, P., PRETORIUS, A. & SMIT, A. 2007. *Life Orientation – A teacher's guide*. Paarl: Heinemann.

FARYNA, E.L. & MORALES, E. 2000. Self-Efficacy and HIV-related Risk Behaviours Among Multi-ethnic Adolescents. *Cultural Diversity and Ethnic Minority Psychology*, 6(1):42-56.

FISHBEIN, M. & MIDDLESTADT, S.E. 1989. Using the theory of Reasoned Action as a Framework for Understanding and changing AIDS-Related Behaviours. In: Mays, V. M., Albee, G. W., & Schneider, S. F. (Eds.), *Primary Prevention of AIDS*. California: Sage.

FLICK, U., VON KARDORFF, E. & STEINEKE, I. 2004. *What is qualitative research? An Introduction to the field*. London: Sage Publications.

GARBERS, J.G. (Red.) 1996. *Doeltreffende geesteswetenskaplike navorsing*. Pretoria: J.L. van Schaik.

GAUTENG DEPARTMENT OF EDUCATION. 2004. *Life Orientation: HIV and AIDS*. Johannesburg: GDE-GIED.

GLESNE, C. & PESHKIN, A. 1992. *Becoming qualitative researchers: An introduction*. New York: Longman Publishers.

HADDON, C. & MOORE, J. 2006. *Shuter's Life Orientation Guide*. Cape Town: Shuter & Schooter.

HARTELL, C.G. & MAILE, S. 2004. HIV/AIDS and Education: a study on how a selection of school governing bodies in Mpumalanga understand, respond to and implement legislation and policies on HIV/AIDS. In: *International Journal of Educational Development*, 24(2004), p. 183-199.

HATCH, J.A. 2002. *Doing qualitative research in educational settings*. Albany: State University of New York Press.

HAYES, R.L. & OPPENHEIM, R. 1997. Constructivism: Reality is what you make it. In: Sexton, T.L. & Griffin, B.L. (Eds.), *Constructivist thinking in counselling practice, research and training*. New York: Teachers College Press.

HENNING, E., VAN RENSBURG, W. & SMIT, B. 2004. *Finding your way in qualitative research*. Pretoria: Van Schaik.

HOPE, K.R. 1999. *AIDS and Development in Africa: A social science perspective*. New York: The Haworth Press.

HUMAN RIGHTS WATCH. 2001. *Scared at school: Sexual violence against girls in South Africa*. New York: Human Rights Watch.

HUMAN SCIENCES RESEARCH COUNCIL. 2002. *Nelson Mandela/HSRC Study of HIV & AIDS*. HSRC: Cape Town.

JANESICK, V. J. 2000. The choreography of qualitative research design. In: DENZIN, N. K. & LINCOLN Y. S. (Eds.), *The handbook of qualitative research*. California: Sage Publications.

JOHNSON, B. & CHRISTENSEN, L. 2000. *Educational Research: Qualitative and Quantitative Approaches*. Needham Heights: Allyn & Bacon.

KELLY, K. 2000. *Communicating for Action: a contextual evaluation of youth responses to HIV & AIDS. Beyond Awareness Campaign*. Department of Health: South Africa.

KELLY, K., PARKER, W. & OYOSI, S. 2002. *Pathways to Action – HIV & AIDS prevention, Children and Young People in South Africa*. Pretoria: Cadre.

KELLY, M.J. 1999. *What HIV/AIDS Can Do to Education, and what Education can do to HIV/AIDS*. Paper presented to the All Sub-Saharan Africa Conference on Education for All 2000, University of Zambia, Lusaka, 6-10 December.

KELLY, M.J. 2000. *Planning for education in the context of HIV & AIDS*. Paris: UNESCO.

KELLY, M.J. 2001a. *Challenging the Challenger: Understanding and expanding the response of universities in Africa to HIV & AIDS*. Washington, DC: ADEA Working Group on Higher Education.

KELLY, M.J. 2001b. *Meeting the educational needs of orphans and vulnerable children (OVCs).* Presentation at the Eastern and Southern Africa regional workshop on orphans and vulnerable children (7 November 2001). Lusaka: Zambia.

KIRSCHT, P. & JOSEPH, J. G. 1989. The Health Believe Model: Some Implications for Behaviour Change, with Reference to Homosexual Males. In: Mays, V. M., Albee, G. W., & Schneider, S. F.(Eds.), *Primary Prevention of AIDS*. Califonia: Sage.

KISTNER, J.,EBERSTEIN, I.W., QUADNAGO, D., SLY, D., SITTIG, L., BALTHOZOR, M., CASTRO, R. & OSBORNE, M. 1997. Children's AIDS-Related Knowledge and Attitudes: variations by Grade, Race, Gender, Socio-Economic Status, and Size of Community. *AIDS Education and Prevention*, 9(3):285-298.

KWAZULU-NATAL DEPARTMENT OF EDUCATION AND CULTURE. 2002. *HIV & AIDS Plan for Education*. As Is report.

LARSON, H. & NARAIN, J. 2001. *Beyond 2000: Responding to HIV & AIDS in the New Millenium*. New Delhi: World Health Organisation

LEEDY, P.D. 1997. *Practical research: Planning and Design.* New Jersey: Prentice-Hall.

LINCOLN, Y.S. & CUBA, E.G. 1985. *Naturalistic Inquiry.* Beverly Hills: Sage Publications.

LOUW, N. 2006. *Interview on 11 November*. Private educational consultant and previous Superintendent of Education: Department of Education.

LOUW, N., EDWARDS, D. & ORR, J. 2001. *HIV/AIDS: Care and support to affected and infected learners. A guide for educators*. Pretoria: Formeset Printers.

MACMILLAN ENGLISH DICTIONARY. 2005. *Macmillan English Dictionary for Advanced Learners – International Edition*. Oxford: Macmillan Publishers.

MARAIS, H. 2000. *To the edge: AIDS review 2000*. Pretoria: Centre for the study of AIDS, University of Pretoria.

MARAIS, H. 2005. *Buckling: The Impact of AIDS in South Africa 2005.* Centre for the study of AIDS, Pretoria: University of Pretoria.

MATHEWS, C., BOON, H., FLISHER, J. & SCHAALMA, P. 2006. Factors associated with teachers' implementation of HIV & AIDS education in secondary schools in Cape Town, South Africa. In: *AIDS Care*, 18(4): 388-397.

MCMILLAN, J.H. & SCHUMACHER, S. 2001. *Research in Education: A conceptual introduction*. Harrisonburg: Longman.

MEEKS, L. & HEIT, P. 2001. *Sexuality and Character Education*. Chicago: Meeks&Heit Publishers

MELKOTE, S.R., MUPPIDI, S.R. & GOSWAMI, D. 2000. Social and economic factors in an integrated behavioural and societal approach to communication in HIV/AIDS. In: *Journal of Health Communication*, 5:17-27.

MERRIAM, S.B. 1998. *Qualitative Research and Case Study Applications in Education*. San Francisco: Josey-Bass Publishers.

MERTENS, D.M. 1998. *Research methods in Education and Psychology*. London: Sage Publications.

MICHEL, B. 2000. *Talking about life – HIV & AIDS and Life Skills Training Manual for Secondary and Primary Schools*. Johannesburg: Department of Education.

MOUTON, J. 2001. *How to succeed in your Master's and Doctoral Studies – a South African guide and resource book*. Pretoria: Van Schaik.

MONTEITH, M. 2006. *Oxford Successful Life Orientation – Teacher's Book*. Cape Town: Oxford University Press.

MUSSEN, P. H., CONGER, J. J., KAGAN, J. & HUSTIN, A. C. 1984. *Child Development and Personality*. New York: Harper and Row.

NEUMAN, W.L. 1997. *Social Research Methods: Qualitative and Quantitative approaches*. Boston: Alyn and Bacon.

O'DONOGHUE, T.A. & PUNCH, K.F. 2003. *Qualitative Educational Research in Action*. London: RoutledgeFarmer.

PAGE, J., LOUW, M. & PAKKIRI, D. 2006. *Working with HIV & AIDS.* Cape Town: Juta.

PALMER, D.A., BOARDMAN, B. & BAUCHNER, H. 1996. Sixth and Eight Graders and Acquired Immunodeficiency Syndrome: The results of Focus Group Analysis. In: *Journal of Adolescent Health*, 19(4):297-302.

PARKER, W. 1997. Action Media: Consultation, Collaboration and Empowerment in Health Promotion. In: *Africa Media Review*, 11(1):54-63.

PARKER, W. 2004. *Rethinking conceptual approaches to behaviour change: The importance of context*. Johannesburg: CADRE.

PARKER, W. 2005. *Claims and realities in HIV programme evaluation*. CADRE: Johannesburg.

PARKER, W., DALRYMPLE, L. & DURDEN, E. 2000. *Communication beyond AIDS awareness: A manual for South Africa*. Aucklandpark: Department of Health.

PATTERSON, G. 1996. *Love in a time of AIDS – Women, Health and the Challenge of HIV*. Geneva: WCC Publications.

PATTON, M.Q. 2002. *Qualitative research and evaluation methods.* California: Sage Publications.

POGGENPOEL, M. 1998. Data analysis in qualitative research. In: DE VOS, A.S. (Ed.), *Research at grass roots: A primer for the caring professions*. Pretoria: Van Schaik.

RADEMEYER, A. 2003. *Schools ignore prescribed sexuality programmes*. Johannesburg: Media24.

READER'S DIGEST. 1985. *The right word at the right time: A guide to the English Language and how to use it*. London: Reader's Digest Association Limited.

READER'S DIGEST UNIVERSAL DICTIONARY. 1989. London: Reader's Digest Association Limited.

REITMAN, D., St. LAWRENCE, J.S., JEFFERSON, A., ALLEYNE, E., BRASFIELD, T.L. & SHIRLEY, A. 1996. Predictors of African American Adolescents' Condom Use and HIV Risk Behaviour. In: *AIDS education and Prevention*, 8(6):499-515.

REPUBLIC OF SOUTH AFRICA. 1996a. South African Schools Act, Act 84 of 1996. *Government Gazette*, 377 (17579). Cape Town: Government Printer.

REPUBLIC OF SOUTH AFRICA. 1996b. The Constitution of the Republic of South Africa, Act 108 of 1996. *Government Gazette*, 378 (17678). Cape Town: Government Printer.

REPUBLIC OF SOUTH AFRICA. 1996c. National Education Policy Act, Act 27 of 1996. *Government Gazette*, 370 (17118). Cape Town: Government Printer.

RICHTER, L., MANEGOLD, J. & PATHER, R. 2004. *Family and Community interventions for children affected by AIDS*. Cape Town: HSRC Publishers.

SAAYMAN, W. & KRIEL, J. 1992. *The leprosy of our time?* Johannesburg: Orion Publishers.

SCHOEBERLEIN, D.R., WOOLSTON, L. & BRETT, J. 2000. School-based HIV Prevention: A Promising Model. In: *Child and Adolescent Psychiatric Clinics of North America*, 9(2):389-405.

SCHWANDT, T.A. 1998. Constructivist, interpretivist approaches to human inquiry. In: DENZIN, N.K. & LINCOLN, Y.S. (Eds.), *The landscape of qualitative research: Theories and issues*. London: Sage Publications.

SCHWANDT, T.A. 2000. Three epistemological stances for qualitative inquiry. In: DENZIN, N.K. & LINCOLN, Y.S. (Eds.), *The handbook of qualitative research*. California: Sage Publications.

SCHURINK, E.M. 1998. The methodology of unstructured face-to-face interviewing. In: DE VOS, A.S. (Ed), *Research at grass roots. A primer for the caring professions*. Pretoria: Van Schaik Publishers.

SEXTON, T.L. 1997. Constructivist thinking within the history of ideas: The challenge of a new paradigm. In: Sexton, T.L. & Griffin, B.L. (Eds.), *Constructivist thinking in counselling practice, research and training*. New York: Teachers College Press.

SHENTON, A.K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, 22: 63-75.

SHELL, R.C.H. 2000. *Halfway to the Holocaust the HIV & AIDS pandemic in South Africa*. Cape Town: Rhodes University.

SHISANA, O., REHLE, T., SIMBAYI, L.C., PARKER, W., ZUMA, K., BHANA, A., CONNOLLY, C., JOOSTE, S. & PILLAY, V. 2005. *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005*. Cape Town: HSRC Press.

SIGELMAN, C., DERENOWSKI, E., WOODS, T., MUKAI, T., ALFRED-LIRO, C., DURAZO, O. & MADDOCK, A. 1996. Mexican-American and Anglo-American Children's Responsiveness to a Theory-Centred AIDS Education Program. In: *Child Development*, 62(2):253-266.

SIMBAYI, L.C. 1999. AIDS awareness and sexual behaviour in South Africa. In: *AIDS and Development in Africa: A social science perspective*. New York: The Haworth Press.

SILVERMAN, D. 1994. *Interpreting qualitative data: Methods for analysing talk, text and interaction*. London: Sage Publications.

SILVERMAN, D. 2000. *Doing qualitative research: a practical handbook*. London: Sage Publications.

SMART, R. 2003a. *Policies for orphans and vulnerable children: A Framework for moving ahead*. South Africa: Futures Group International and the Centre for Development and Population activities.

SMART, R. 2003b. *Children affected by HIV/AIDS in South Africa: a rapid appraisal of priorities, policies and practices*. Pretoria: Save the Children (UK).

STANECKI, K.A. 2002. *The AIDS pandemic in the 21st Century*. Report on the XIV International Conference on AIDS (July 2002): Barcelona.

STATISTICS SOUTH AFRICA. 2006. *Mortality and causes of death in South Africa, 2003 and 2004*. Pretoria: Statistics South Africa.

STATISTICS SOUTH AFRICA. 2007. *Mid-year population estimates – 2007*. Pretoria: Statistics South Africa.

STAKE, R.E. 2000. Case studies. In: DENZIN, N.K. & LINCOLN, Y.S. (Eds), *The handbook of qualitative research*. California: Sage Publications.

STRYDOM, H. 1998. Ethical aspects of research in the caring professions. In: DE VOS, A.S. (Ed.), *Research at grass roots - A primer for the caring professions.* Pretoria: Van Schaik Publishers.

TERRE BLANCHE, M. & DURRHEIM, K. (Eds.) 2002. *Research in practice: Applied methods for the Social Sciences*. Cape Town: University of Cape Town Press.

TERRE BLANCE, M. & KELLY, K. 2002. Interpretive methods. In: Terre Blance, M. & Durrheim, K. (Eds.), *Research in practice: Applied methods for the Social Sciences*. Cape Town: University of Cape Town Press.

THE KAISER FAMILY FOUNDATION. 2001. *Youth: Report on South African youth*. Johannesburg: Kaiser Family Foundation.

TRAUTH, E. M. 2001. *Quantitative research in IS: issues and trends*. Hersey: Idea Group.

TRANSVAALSE ONDERWYS DEPARTEMENT. 1986. *Verslag van die Ad Hoc Komitee en Aanbevelings ten opsigte van die uitbouing en verdere verfyning van die Gesinsvoorligtingsprogram in T.O.D skole*. 2 Junie 1986. Pretoria: Departement van Onderwys.

UNAIDS. 1997. *Integrating HIV and STD prevention in the school setting*. Geneva: UNAIDS.

UNAIDS. 2000. *Report on the global HIV & AIDS epidemic*. Geneva: UNAIDS.

UNAIDS. 2001a. *Gender and AIDS Almanac*. Geneva: UNAIDS.

UNAIDS. 2001b. *World AIDS campaign: Men culture and HIV/AIDS*. Geneva: UNAIDS.

UNAIDS. 2002a. *Children on the brink*. Geneva: UNAIDS

UNAIDS. 2002b. *Report on the global HIV/AIDS epidemic (June 2002)*. Geneva: UNAIDS.

UNAIDS. 2004a. *AIDS epidemic update December 2004*. Geneva: UNAIDS.

UNAIDS. 2004b. *Report on the global HIV/AIDS epidemic*. Geneva: UNAIDS.

UNAIDS. 2006. *Report on the Global AIDS epidemic*. Geneva: UNAIDS.

UNAIDS. 2007. *AIDS epidemic update – 2007*. Geneva: UNAIDS.

UNESCO. 2003. *Living and learning in a WORLD with HIV/AIDS*. Paris: IEEP Publications.

UNESCO. 2004. *UNESCO'S strategy for HIV & AIDS prevention education*. Paris: IIEP Publications.

VAN ROOYEN, L. 1987. *Die beplanning van 'n opleidingsprogram vir onderwysers in Gesinsvoorligting*. Ongepubliseerde PhD proefskrif. Pretoria: Universitiet van Pretoria.

VAN ROOYEN, L. 1997. *Sexuality Education in the classroom*. Pretoria: Kagiso Pulishers.

VAN ROOYEN, L. 2001. *Interpretation of relevant policies on HIV & AIDS*. Pretoria: University of Pretoria.

VAN ROOYEN, L., & HARTELL, C. 2001. HIV and Education – Beyond 2000. In: Calitz, L., Fugelstad, O.L. & Lillejord, S. (Eds.), *Leadership in Education*. Cape Town: Heinemann.

VAN ROOYEN, L & LOUW, N. 1993. *Geslagsopvoeding: 'n Handleiding vir die opvoeder*. Pretoria: Academica.

VAN ROOYEN, L & LOUW, N. 1994. *Sexuality Education: a guide for teachers*. Pretoria: J.L. van Schaik.

VAN ROOYEN, L. 2006. *Interview on 14 October*. Professor in Curriculum Studies at the University of Pretoria.

WILLIG, C. 2001. *Introducing qualitative research in psychology: Adventures in theory and method*. Philadelphia: Open University Press.

WEINSTEIN, N.D. 1989. Perceptions of Personal Susceptibility to Harm. In: Mays, V.M., Albee, G.W. & Schneider, S.F.(Eds.), *Primary Prevention of AIDS*. California: Sage.

WORLD BANK. 1999. *Intensifying action against HIV & AIDS in Africa: Responding to a development crisis*. Africa Region: World Bank.

WORLD BANK. 2002. *Education and HIV & AIDS – a window of hope*. The World Bank: Washington.

WORLD HEALTH ORGANISATION. 1994. *School Health Education to prevent AIDS and STD*. Geneva: WHO.

WORLD HEALTH ORGANISATION. 2002. *Report on infectious diseases*. Geneva: WHO.

ADDENDUM A

CODE: ______

QUESTIONS FOR SEMI-STRUCTURED INTERVIEWS

RESEARCH TOPIC: CONTEXTUAL FACTORS INFLUENCING THE IMPLEMENTATION OF HIV & AIDS PROGRAMMES IN SCHOOLS

RESEARCH QUESTION: IN WHAT MANNER DO CONTEXTUAL FACTORS INFLUENCE THE IMPLEMENTATION OF HIV & AIDS PROGRAMMES IN SOUTH AFRICAN SCHOOLS?

Section A: Biographical information

Question 1: What is your position at the school?

Principal	
Deputy Principal	
Head of Department	
Master Trainer	
Teacher	

Question 2: What is your highest qualification?

____
____
____
____
____
____

Question 3: How long have you been a teacher?

0-5 years;	
5-10 years;	
10-20 years;	
20 years or more.	

Question 4: To what extent are you involved in HIV & AIDS programmes in your school?

Directly involved	Indirectly involved	Not involved at all

SECTION B: Training with regard to HIV & AIDS education

Question 5: Have you attended any training sessions, workshops or information sessions with regard to HIV & AIDS? If so, where, when and by whom were these services rendered?

Question 6: On a scale of 1 to 5, how high would you rate your knowledge with regard to HIV & AIDS?

1: Low	
2: Below average	
3: Moderate	
4: Above average	
5: Very high	

Question 7: Do you agree or disagree with the statement that HIV & AIDS can be prevented. If yes, how?

Question 8: What is your view with regard to the role of education in the prevention of HIV & AIDS infection? Does education have a role to fulfil in prevention?

Question 9: Which aspects do you regard as important when dealing with HIV & AIDS prevention?

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SECTION C: The school's HIV & AIDS programme

Question 10: Does your school present an HIV & AIDS programme to the learners? If not, ignore question 10 and please answer questions 11a to 11d.

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ALTERNATIVE QUESTIONS TO QUESTION 10, IN THE INSTANCE OF NON-PRESENTATION OF THE HIV & AIDS PROGRAMME.

Question 11a: With reference to question 10, why is your school not implementing the HIV & AIDS programme?

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Question 11b: Do you regard the implementation of the HIV & AIDS programme as important? If not, why?

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Question 11c: Do you think the implementation of such a programme can make a difference?

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Question 11d: How can these challenges be addressed in order to facilitate the implementation of such a programme in your school?

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Question 12: Are you aware of the fact that the implementation of the HIV & AIDS programme is compulsory?

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Question 13: Regarding your school's HIV & AIDS programme, answer the following questions.

When is the programme presented?	
Who is responsible for the programme?	
How long does the presentation take?	
Where is the programme presented?	
According to your opinion, what is the core message of the programme?	

Question 14: In your opinion, what is the impact of your school's HIV & AIDS programme?

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Question 15: Which resources for facilitating the implementation of the HIV & AIDS programme are available in your school?

RESOURCE	AVAILABLE	UNAVAILABLE
Teachers allocated to the HIV & AIDS programme.		
Teachers trained with regard to HIV & AIDS education.		
Classrooms dedicated to the HIV & AIDS programme.		
Textbooks.		
Posters, wall charts.		
Pamphlets, booklets.		
Video player and/or a DVD player.		
Videocassettes and/or DVD material related to HIV & AIDS education.		
First aid kit and supplies.		
Library.		
Internet.		
Computer access for teachers.		
Computer access for all learners.		
Budget allocation for HIV & AIDS education.		

Question 16: How is the HIV & AIDS programme accommodated within the school's timetable?

Question 17: Does your school have an own, unique school policy on how to deal with HIV & AIDS related issues in the school and on the playground?

Question 18: Can you describe the process that was followed for developing the school's HIV & AIDS policy?

Question 19: Are you aware of other sources that were consulted during the development of your school's HIV & AIDS policy, for example experts, departmental requirements, the Internet or books?

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Question 20: Who were the stake-holders that were involved in drafting your school's HIV & AIDS policy?

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Question 21: Does your school's HIV & AIDS policy deal with unforeseen incidences that may occur on the campus of the school (accidents which could lead to bleeding)?

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Question 22: Does your school make provision for/allow outsiders such as loveLife, Soul Buddyz, the Department of Health, community institutions, NGOs or the clergy to participate in or present HIV & AIDS programmes in your school?

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Question 23: Are you comfortable or uncomfortable about talking to learners about sensitive topics such as:

	Comfortable	Uncomfortable	Reasons
HIV & AIDS?			
HIV & AIDS transmission?			
HIV & AIDS prevention?			
HIV & AIDS testing?			
HIV & AIDS status?			
Caring for people living with HIV & AIDS?			
Sex?			
Sexual relationships?			
Sexual activities? (heterosexual; homosexual; bisexuality; oral; anal; group)			
Sexual orientation?			
Sexual reproductive development?			
Sexual abuse?			
Sexually Transmitted Infections?			
Condom availability and use?			
Unwanted pregnancies?			
Substance abuse?			
Prostitution?			

SECTION E: Reflection on the implementation of the HIV & AIDS programme at a participant's school

Question 24: According to you, what are the strengths and weaknesses of the implementation process followed by your school?

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Question 25: If you would be asked to advise the schools in Soshanguve with regard to improvement of the process of HIV & AIDS programme implementation, what would your advice be?

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ADDENDUM B

ETHICAL CLEARANCE CERTIFICATE FROM THE RESEARCH ETHICS COMMITTEE OF THE UNIVERSITY OF PRETORIA

UNIVERSITY OF PRETORIA

FACULTY OF EDUCATION

RESEARCH ETHICS COMMITTEE

CLEARANCE CERTIFICATE	CLEARANCE NUMBER : CS07/05/01
DEGREE AND PROJECT	PhD Curriculum Studies Contextual factors influencing the implementation of HIV and AIDS programmes in schools
INVESTIGATOR(S)	Dirk van den Berg - 9527889
DEPARTMENT	Curriculum Studies
DATE CONSIDERED	14 June 2007
DECISION OF THE COMMITTEE	APPROVED

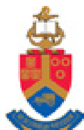
This ethical clearance is valid for 3 *years and may be renewed upon application*

CHAIRPERSON OF ETHICS COMMITTEE	Dr S Human-Vogel
DATE	14 June 2007
CC	Prof Linda van Rooyen (Supervisor) Dr Lojiso Jita (Departmental Ethics Representative) Ms Jeannie Beukes (Student Administration)

This ethical clearance certificate is issued subject to the following conditions:

1. A signed personal declaration of responsibility
2. If the research question changes significantly so as to alter the nature of the study, a new application for ethical clearance must be submitted
3. It remains the students' responsibility to ensure that all the necessary forms for informed consent are kept for future queries.

Please quote the clearance number in all enquiries.



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ADDENDUM C

PERMISSION FROM THE GAUTENG DEPARTMENT OF EDUCATION TO CONDUCT RESEARCH IN SCHOOLS

UMnyango WezeMfundo
Department of Education

Lefapha la Thuto
Departement van Onderwys

Date:	12 March 2007
Name of Researcher:	Van der Berg Dirk Nicolaas
Address of Researcher:	Visvangerstraat 250
	Montanapark
	0159
Telephone Number:	0125489682
Fax Number:	0127998564
Research Topic:	Contextual factors influencing the implementation of HIV and AIDS programmes in schools
Number and type of schools:	3 Secondary Schools
District/s/HO	Tshwane North

Re: Approval in Respect of Request to Conduct Research

This letter serves to indicate that approval is hereby granted to the above-mentioned researcher to proceed with research in respect of the study indicated above. The onus rests with the researcher to negotiate appropriate and relevant time schedules with the school/s and/or offices involved to conduct the research. A separate copy of this letter must be presented to both the School (both Principal and SGB) and the District/Head Office Senior Manager confirming that permission has been granted for the research to be conducted.

Permission has been granted to proceed with the above study subject to the conditions listed below being met, and may be withdrawn should any of these conditions be flouted:

1. *The District/Head Office Senior Manager/s concerned must be presented with a copy of this letter that would indicate that the said researcher/s has/have been granted permission from the Gauteng Department of Education to conduct the research study.*
2. *The District/Head Office Senior Manager/s must be approached separately, and in writing, for permission to involve District/Head Office Officials in the project.*
3. *A copy of this letter must be forwarded to the school principal and the chairperson of the School Governing Body (SGB) that would indicate that the researcher/s have been granted permission from the Gauteng Department of Education to conduct the research study.*

Director: Knowledge Management and Research
Room 525, 111 Commissioner Street, Johannesburg, 2001 P.O.Box 7710, Johannesburg, 2000
Tel: (011) 355-0488 Fax: (011) 355-0286

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4. *A letter / document that outlines the purpose of the research and the anticipated outcomes of such research must be made available to the principals, SGBs and District/Head Office Senior Managers of the schools and districts/offices concerned, respectively.*
5. *The Researcher will make every effort obtain the goodwill and co-operation of all the GDE officials, principals, and chairpersons of the SGBs, teachers and learners involved. Persons who offer their co-operation will not receive additional remuneration from the Department while those that opt not to participate will not be penalised in any way.*
6. *Research may only be conducted after school hours so that the normal school programme is not interrupted. The Principal (if at a school) and/or Senior Manager (if at a district/head office) must be consulted about an appropriate time when the researcher/s may carry out their research at the sites that they manage.*
7. *Research may only commence from the second week of February and must be concluded before the beginning of the last quarter of the academic year.*
8. *Items 6 and 7 will not apply to any research effort being undertaken on behalf of the GDE. Such research will have been commissioned and be paid for by the Gauteng Department of Education.*
9. *It is the researcher's responsibility to obtain written parental consent of all learners that are expected to participate in the study.*
10. *The researcher is responsible for supplying and utilising his/her own research resources, such as stationery, photocopies, transport, faxes and telephones and should not depend on the goodwill of the institutions and/or the offices visited for supplying such resources.*
11. *The names of the GDE officials, schools, principals, parents, teachers and learners that participate in the study may not appear in the research report without the written consent of each of these individuals and/or organisations.*
12. *On completion of the study the researcher must supply the Senior Manager: Strategic Policy Development, Management & Research Coordination with one Hard Cover bound and one Ring bound copy of the final, approved research report. The researcher would also provide the said manager with an electronic copy of the research abstract/summary and/or annotation.*
13. *The researcher may be expected to provide short presentations on the purpose, findings and recommendations of his/her research to both GDE officials and the schools concerned.*
14. *Should the researcher have been involved with research at a school and/or a district/head office level, the Senior Manager concerned must also be supplied with a brief summary of the purpose, findings and recommendations of the research study.*

The Gauteng Department of Education wishes you well in this important undertaking and looks forward to examining the findings of your research study.

Kind regards

ACTING CHIEF DIRECTOR: OFSTED

The contents of this letter has been read and understood by the researcher.	
Signature of Researcher:	
Date:	19/03/2007

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ADDENDUM D

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT THE SCHOOL

The Principal
Xxx Secondary School
Soshanguve

Dear Mr xxx

RE: PERMISSION FOR CONDUCTING RESEARCH AT xxx SCHOOL

I am a PhD student at the University of Pretoria and I am currently conducting a research project on contextual factors that influence the implementation of HIV & AIDS programmes in secondary schools. For this purpose, I have selected your school as participant in this study. The study will take place during the period April 2007 to June 2007 and the findings will be used to identify, explore, describe and explain the manner in which contextual factors in a secondary school influence the implementation of the HIV & AIDS programme.

For the purpose of the study, I kindly request your permission to conduct interviews and discussions with selected staff members of your school. The information provided will be treated confidentially and anonymously. Any participant will also be free to withdraw from the research project at any stage that he/she wishes to do so. The Gauteng Department of Education has granted permission to have the interviews conducted at selected schools. I have also been granted ethical clearance by the Research Ethics Committee of the University of Pretoria to conduct the research in schools.

If you are willing to assist me, please complete the form below and return it to me.

Kind regards

____

Dirk van den Berg

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YUNIBESITHI YA PRETORIA

Dear Mr Van den Berg

Having read your above letter, I hereby grant / do not grant you permission to do research at xxx Secondary School, by conducting interviews and facilitating discussions with selected members at my school.

Name and surname:___________________________________

Signature: ____

Date:_________________

ADDENDUM E

PARTICIPANT'S INFORMATION LETTER AND INFORMED CONSENT FORM

Researcher's name: DN van den Berg

Student number: 9527889

Department of Curriculum Studies

University of Pretoria

I, the undersigned, hereby declare that the researcher has sufficiently informed me about my role in the research, about what he will expect of me, as well as regarding the fact that there are no foreseen risks of participating in this research. I understand that the interview will take approximately one hour, and that I shall receive no remuneration for participating in this research.

I therefore wish to give my written informed consent regarding my participation in the research of the bearer hereof, Mr D N van den Berg. I acknowledge that the latter is an enrolled student in the Faculty of Education at the University of Pretoria. I understand that I shall be required to answer questions during an interview, which will be tape-recorded.

I understand that my participation is voluntary and that I may discontinue my participation at any time. I also understand that, should I wish to withdraw my participation, I shall not be discriminated against in any way. I am cognisant of the fact that the findings of this research project will be disseminated, for which I give my approval.

____________________ __________________

Participant Date

ADDENDUM F

FIELD OBSERVATIONS AND REFLECTIVE JOURNAL

1 August 2007: Case study 1 – School visit 1

Today I was extremely excited and anxious at the same time. I was to have my first two interviews for data collection, after the disappointment of being forced to postpone my interviews due to the national public servant strike action that continued for six weeks from May until July. I was very fortunate to be able to re-schedule my field visits and interviews for August and September. Although the three principals were very helpful in assisting me to rearrange all my interviews, I still could not help feeling a bit despondent because of the delay in my data collection, but most of all because of the effect that the strike had on the delivery of education to the learners who I felt needed it the most. Well, I had to move forward and put my personal feelings aside to focus on the aim of my study, that is to identify and investigate contextual factors that influence the implementation of HIV & AIDS programmes. Undoubtedly, the industrial action must have had a serious influence.

On entering the first school where I had the first two interviews scheduled with the school principal (C1:P) and the head of department for human and social sciences (C1:HOD), I suddenly felt very nervous – although I was well-prepared and well-organised, the uncertainty of how I would be received made me anxious. These feelings aside, I noticed that the school buildings appeared neat and tidy, characterized by red face-brick and small windows. I noticed a faded emblem of the school that had been painted on the wall of the administration block, indicating that once there was possible pride and a certain ethos in the school. The surroundings of the school were not the same though. The school premises were littered with paper, and the lawn

not mowed. I could see that the few plants and trees around the buildings desperately needed attention and water. It made me curious to see what the classrooms were like, as the surroundings were not very conducive to learning and created a negative and uncaring impression (refer to Figure 7 in Addendum G).

I met the principal, and he was indeed very friendly, which made me feel welcome and at ease. Our interview started on time and he shared a lot of information with me. In the office I noticed several trophies that the school had won in music and drama competitions, as well as photos of the president and the minister of education. I got the impression that this principal must be proud of his school's achievements, and apparently a proud South African. Even though the principal appeared to be well-informed with regard to HIV & AIDS, as he had attended departmental workshops, I got the impression that his knowledge with regard to the HIV & AIDS programme was limited, and that he reported positively regarding his school, in order to impress me. The school reportedly had an HIV & AIDS school policy, although the principal was unable to provide me with a copy. This would definitely have provided me with valuable information with regard to the implementation efforts of the school. In addition to this, I was sure that I would be able to collect information from the other participants at the school. The principal appeared to be unsettled when discussing sensitive issues such as sex and condoms, and ascribed this to his culture and his age. I considered the interview a success and was eager to listen to my first data recording. After the interview, I felt more confident, and looked forward to the next interview with the head of department.

The head of department (C1:HOD) was also an older male teacher with an apparent vast experience in education. He was also very friendly and welcomed me into his office where the interview was to be conducted. The office was cluttered with numerous text books and stacks of documents that

needed filing. The HOD apologised friendly that all the NCS (National Curriculum Statement) documents were overwhelming, and that he did not have enough files for everything. I also noticed musical instruments and sport equipment that were packed in the office. These apparently were resources intended for Life Orientation (LO), and the school still had to decide on how to utilize them (refer to Figure 1 in Addendum G). The interview went smoothly, and the HOD provided me with relevant information, although I found it interesting that he regarded himself as not directly involved in the HIV & AIDS programme at his school, even though he was teaching LO. This participant was clearly concerned about the continued sexual relationships between male educators and female learners, as well as the influence that the behaviour of political figures has on the message of prevention. Although he spoke openly about sensitive topics during the interview, he regarded it as unprofessional to discuss these topics with learners. I found it strange that the HOD was not aware of any HIV & AIDS school policy that had been drafted at their school, and I wondered if the other participants would be able to confirm my suspicion that no such policy existed. The interview was concluded, and I felt more confident about my questions and interview procedures.

Although only the first two interviews had been concluded, it seemed as though I had already gathered a lot of data, and I was looking forward to transcribing from my recordings. I met the two teachers that I was going to interview during the next field visit, and secured the time and venue for the interviews with them. They were two female teachers, and I was anxious to obtain a possible different perspective regarding the school. I was still not clear about the exact manner in which the school implemented the HIV & AIDS programme, but I was confident that, by listening to the recordings and obtaining more information from the teachers, I would be able to shed more light on the subject. I had to remind myself that this was only the first school

and the first two interviews, and that, although I could anticipate certain outcomes, I should guard against early interpretations and conclusions.

6 August 2007: Case study 1 – School Visit 2

Today I returned the transcripts to the principal and the HOD of the school. They verified the correctness thereof, which made me feel more confident and motivated for the interviews that followed. I then conducted interviews with the two teachers at school 1 (C1:T1 and C1:T2). I obtained a lot of valuable information from both teachers, and I was very fortunate to be able to conduct the interviews in their classrooms. I believe this gave me the opportunity to obtain a better picture of the set-up in which the HIV & AIDS programme was being implemented. I also managed to take photos of the loveLife billboards in the school and community which illustrates the possible involvement of the organisation in the schools and community (refer to Figure 4 in Addendum G).

The first interview was with an elderly female teacher who had several years of experience in education (C1:T1). She was very knowledgeable with regard to HIV & AIDS, although I sensed a lack of enthusiasm with regard to LO and the implementation of the HIV & AIDS programme. Even though the classroom was without any litter, I did not find it very clean, as the walls and learners' desks were covered with graffiti (slogans of how the learners hated school), and some window panes were broken. The room was only furnished with a teacher's desk, and a number of (+/- 50) desks and chairs for learners, as well as a steel cupboard for the teacher. There were no posters or educational material displayed; this made the room look impersonal, cold and empty. The teacher was teaching LO to grade 10 and 11 learners, as well as History and Geography to several classes up to grade 12 level (refer to Figure 2 in Addendum G). Her view was that LO did not to receive much attention, because it was not examinable, and therefore the management and learners

apparently did not focus on the subject that much. I also gained the impression that the parents of the school were not that much involved in the school's activities, as many of them reportedly did not even know in which class their child was, or who the subject teachers were.

The second interview was also conducted with a female teacher (C1:T2) who was teaching LO as well as a First Language for grades 10, 11 and 12 classes. The teacher had been trained as a "Master Trainer", and I could sense that she had a real interest in the topic of HIV & AIDS (especially with regard to the girls). The appearance of the classroom was quite similar to that of the previous teacher, except that I noticed some posters with regard to HIV & AIDS, puberty and physical development, on the one wall. Even though the teachers reported about several events that the school had organised in the past, I could not confirm any such events with the other participants, but I was delighted about the possibility that someone was at least trying to do more than what is expected according to the prescribed curriculum. I found it disturbing, that according to the teacher, LO and HIV & AIDS related issues at the school were regarded as the responsibility of the female teachers, and that the males of the school were not that involved. Only the females were apparently sent for workshops and training in this regard. I wondered if this phenomenon could be ascribed to some cultural taboo or to gender-stereotyping. I decided to include a question in this regard during informal discussions with the other participants.

Reflecting on the interviews that I had today, I felt more confident that my questions were focused on the real issue at hand, although I had to guard against early interpretations and conclusions. Despite the encouraging response of the participants, that their school was implementing the HIV & AIDS programme in LO, I pondered the questioned whether the programme extended beyond the classroom. The possibility may exist that the teachers mainly transferred factual knowledge to learners, in order to cover the scope

of the curriculum. This impression was also created by the two participants being unaware of any policy that had been developed by the school in respect of HIV & AIDS related issues.

13 August 2007: Case Study 2 – School visit 1

The school that I visited today was in the same vicinity or block as the previous school (the areas in the township have been divided into blocks, with no street or 'suburb' names). Although the building appeared to be much older than that of the previous school, I got the impression that it was well-maintained. There was no littering, the school had a fresh coat of paint, and the garden was neat and cared for. I also noticed a painting on the school entrance wall, depicting the red HIV & AIDS ribbon and a slogan "HIV kills" and "My friend with AIDS is still my friend" (refer to Figure 3 in Addendum G). This excited me, and I expected to obtain more data than just a reflection on LO requirements from this school.

Even though I planned to interview the principal first, I started with the HOD (C2:HOD), as the principal was occupied in an emergency meeting with some staff members. In the school library, it was apparent that they had prepared for my visit, as I was escorted there to find a table and two chairs ready. This made me feel most welcome and left a good impression, although I would have preferred conducting the interviews in a classroom, in order to be able to observe more of the surroundings. I found it extremely upsetting that, although it was not functional, due to shortage of teachers, the school library was piled with numerous stacks of books, and mainly served as a staff room.

The HOD was a female teacher with qualifications in psychology and counselling, and I got the impression that she was well-informed and spoke English very well. She appeared to be a very proud person, and spoke highly

of the teachers in her department, and the manner in which they worked together. She confirmed that the school presented HIV & AIDS education mainly as part of the LO curriculum, with an additional HIV & AIDS awareness day during the year, although such events were not supported by the management with regard to funds. The male teachers at the school apparently also regarded the implementation of HIV & AIDS programmes as a "woman's job", and the men who had been allocated to LO were not taking the subject seriously. I wondered whether the perceptions of other teachers might not have had a negative influence on the efforts of those who were aiming to implement the programme. I was disappointed to learn that the school did not have an HIV & AIDS policy, and that they were lacking resources for supporting the implementation thereof.

Eventually I got to interview the principal (C2:P) after his meeting, and I was concerned that he might be in a hurry and rush through the interview, as it was getting late. The principal was very friendly, and apologised for the delay, although he seemed to be a bit distant and troubled during the interview. I got the impression that he was not well-informed with regard to HIV & AIDS education, as he frequently referred to it as the responsibility of the HOD. I understood that an HIV & AIDS policy had been developed by the school, although the principal only provided me with a copy of the departmental requirements for a school's HIV & AIDS policy (refer to Figure 6 in Addendum G). This was the second principal to report the existence of such a policy, despite other teachers stating that they were not aware of the policy. This concerned me, and I wondered whether the principals were trying to impress me during the interview, or whether the policy had just not been communicated to other staff members. I was a bit disappointed, as the principal's responses to the questions were short and not very informative. I probed him for additional information, but he seemed unwilling to share too much.

Reflection on the two interviews that I conducted today, I am beginning to enjoy the different responses of the participants, that clearly provided me with various perspectives regarding implementation efforts at schools. I realised today that appearances can indeed be deceiving. . . I was looking forward to interviewing the two teachers from this school.

20 August 2007: Case Study 2 – School Visit 2

The principal and HOD of the school were satisfied with the transcripts of their interviews, and this assured the credibility of the data that I had collected from them. The interviews with the two teachers (C2:T1 and C2:T2) that I had today were extremely informative. Both of them were very friendly, and participated open-heartedly in the interviews.

I requested to conduct the interviews in their classrooms, but it was not possible. This disappointed me, as the teachers at the school did not have their own classrooms, due to a shortage thereof. The learners remained in the same classroom throughout the school day, and the subject teachers then rotated between the classrooms. I considered this as not conducive to learning, although I appreciated the manner in which the teachers apparently coped with this frustrating situation. The interviews were then conducted in the library, which also served as a staff room (refer to Figure 5 in Addendum G).

The one female teacher participant (C2:T:2) was very young and enthusiastic, and this made the interview dynamic and informative. Although she had received no training with regard to HIV & AIDS, she taught LO as a subject, and regarded HIV & AIDS as a serious problem. I got the impression that the management of the school were not very supportive regarding the efforts that the LO teachers were making to enhance the subject. The teacher was also unaware of any policy or programme that the school might have developed

with regard to HIV & AIDS, except for what was required in LO. I realised that the schools regarded LO as the only HIV & AIDS programme, and, even if this is the case, there appeared to be little effort at schools to involve other people or organisations, to assist with presenting the programme – the LO teachers "are undermined". The schools apparently wait for HIV & AIDS experts, organisations and events to be organised for them, with little or no initiative by the schools.

The other participant (C2:T1) was also a female teacher, whose interest in HIV & AIDS related issues was quite apparent. She had been trained as a counsellor and was involved in the community as a life-coach. Her contributions during the interview made me realise that HIV & AIDS was having an effect on the community and in their school. The school apparently had a number of AIDS orphans, and possibly learners who were living with HIV & AIDS. The teacher confirmed that the HIV & AIDS programme was limited to LO, and, although they made some efforts to have other people and institutions involved, the school management decided that these efforts were disrupting the school programme. The teacher also highlighted the fact that myths with regard to HIV & AIDS in the school and the community were confusing learners and causing them not to take LO (and HIV & AIDS) seriously.

The two interviews that I had today convinced me again of the dire need for HIV & AIDS education. I also felt disturbed about the apparent neglect of the HIV & AIDS programme by education managers, and about the unsupportive attitude of some teachers and learners towards the efforts of LO teachers. Could it be that LO as a replacement for Guidance as a subject has inherited the same inferior status as its predecessor? Today I have been convinced that contextual factors were definitely having an influence on the implementation of the HIV & AIDS programme. I have already started identifying some categories and themes for my data analysis.

27 August 2007: Case Study 3 – School Visit 1

Today I visited the third school to conduct my interviews, and was once again surprised at the different perspectives and experiences that teachers have with regard to the implementation of HIV & AIDS programmes in their schools. As I entered the school, it was obvious that the school was old, with buildings quite similar to those of the school in Case Study 2. Although the school appeared old and needed some renovation, it was neat and clean. I specifically looked for murals depicting "AIDS awareness" messages, but there was no sign of them.

The principal was an elder lady who welcomed me and invited me into her office, where the interview was conducted. My first impression was that this principal was strict, and it appeared as though she had everything under control. I was excited about obtaining the perspective of a lady principal, as the previous two principals were men. I was offered tea and sandwiches, and realised that this was an example of "a women's touch". Despite her being very candid and open in her perspectives and opinions on HIV & AIDS, she appeared uncomfortable when we discussed sensitive issues such as sexual relationships, condoms and teenage pregnancies. The interview was very insightful, as the principal clearly had strong religious convictions that made it challenging for her to discuss sensitive topics with learners and teachers. I wondered what possible influence this might have on the manner in which teachers perceive the HIV & AIDS programme. The principal (like the previous two principals) stated that the school had an HIV & AIDS policy and was implementing HIV & AIDS programmes as part of LO. I also decided to validate the existence of such as policy with the other participants from this school, as the principal was unable to provide me with a copy.

The interview with the HOD was conducted in her office, which was neat and tidy as well. The HOD was very welcoming, and shared her opinions without

hesitation. My impression was that the HOD had serious concerns with regard to the lack of involvement of parents who should be talking to their children about HIV & AIDS, and teachers who had not been trained with regard to HIV & AIDS. The HOD could not confirm that the school had developed an HIV & AIDS policy. Apparently the HIV & AIDS programme was dealt with as part of LO, and by means of occasional visits from the local clinic. I experienced the HOD as pessimistic with regard to the HIV & AIDS programme, and some of her responses displayed apathy towards the implementation of the programme, for example I would expect an HOD to be aware of the number of periods that had been allocated to LO. In this school, the learners also remained in the same classroom for the whole day, while teachers rotated from classroom to classroom. I was really concerned about the effect that this might have on teaching and on the creation of an appropriate atmosphere, especially when dealing with sensitive topics in LO. This was definitely a contextual factor to keep in mind during my data analysis.

I felt quite satisfied with the data that I collected today, even though I expected the HOD to be more enthusiastic and up to date with regard to the programme and the implementation thereof. I have to remind myself that these are my personal, subjective expectations. The participants were willing to share and express their personal opinions, and this gave me a general idea of the context in which the HIV & AIDS programme is perceived and implemented. I also started considering the influence of the perceptions and attitudes of the community (parents) towards HIV & AIDS education, and came to regard this as a possible contextual factor that influences the implementation of the programme.

3 September 2007: Case Study 3 – School Visit 2

Today I conducted my last two interviews, and, after returning the transcripts to the previous two participants for verification, I realised that, except for some unfortunate re-scheduling at the start of my data collection process, all had gone well and I had enjoyed the interviews tremendously. Although I felt a bit tired of all the listening and transcribing in an effort to return transcripts to the participants on time, the excitement of completing this crucial part of my data collection invigorated me.

My last two participants (C3:T1 and C3:T2) were again both ladies, and I got the impression that HIV & AIDS related issues and LO as a subject may be viewed in schools as the responsibility of only female teachers. Is this possibly because of a cultural perception that the responsibility of discussing sexuality with learners lies with women, or is this about a possible societal stereotype that influences education as well? Nevertheless, the interviews were conducted in the staff room that was shared by all the teachers in the school. This resulted in a few interruptions during the interviews, as other teachers entered or left the room. I was still amazed at the manner in which teachers coped with not having their own classrooms and moving about from classroom to classroom. Was this arrangement due to a lack of classrooms, or an excuse to avoid certain classroom management responsibilities?

The one participant (C3:T1) appeared to be slightly inhibited at the start of the interview, but later on relaxed and shared valuable information with me. The participant appeared to be frustrated that parents and some male educators were not involved in HIV & AIDS related issues, and regarded them as someone else's problem. Several issues, such as a lack of trained LO teachers, insufficient resources, a shortage of classrooms, and learners not being serious about the programme, were discussed. The participant was also unaware of any school policy with regard to HIV & AIDS.

The other participant (C3:T2) was also a young lady who had specialised in LO at a tertiary institution. I was surprised that during the last interview I would come across a participant with specialised training, and I was looking forward to informative responses. The participant shared some interesting myths with regard to HIV & AIDS, condom use and sexual practices with me. We enjoyed the laugh, but realised the serious consequences of these myths for the school, and considered the possible influence thereof on the implementation of HIV & AIDS programmes. I found the enthusiasm of the participant, with regard to the role that education might fulfil in the prevention of HIV & AIDS, encouraging. I realised that, despite the apparent negative influence that contextual factors might have on the implementation of HIV & AIDS programmes, there are also positive factors (motivated teachers) that influence the implementation of programmes. I regard these teachers as the "jewels" in schools, that need continuous support. Cultural taboos, such as talking to children about sex, and that men were not supposed to discuss such a topic with children, were of great concern for this participant, and I believe that this might be a critical contextual factor the influences the implementation of the programme in schools.

Reflecting on the interviews that I conducted during the past weeks, I must admit that I would never have imagined them to be such a learning experience. My initial anxiety and uncertainty grew into confidence and fulfilment as a researcher, and this was a wonderful experience. It was a journey filled with surprises. The views, perspectives and opinions of different participants sometimes frustrated me, but always provided me with something to learn, not only about others, but also about myself and the way that I perceive reality. This has indeed been a lived-experience, in which I was able to construct a fresh view of reality, by means of interpreting the lived-experiences of others.