

**HOW HIV/AIDS EDUCATION IS FOSTERED IN THE INTERMEDIATE
PHASE IN A SCHOOL**

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the degree of Masters of Education**

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DECLARATION

I declare that this research project is my own original work; it has not been submitted before for any degree or examination at any other University.

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ABSTRACT

Intermediate Phase learners represent our “window of opportunity” since children in the middle childhood years are in the process of acquiring knowledge and forming attitudes and beliefs which will have long-term implications in the fight against HIV/AIDS. This is an in depth study to examine how HIV/AIDS education is fostered in the Intermediate Phase in a school. The focus is to examine the level of knowledge and understanding of HIV/AIDS of the learners and Life-skills educators and how it is managed in the school.

The study used a mixed methodology design employing both quantitative (learners’ questionnaires) and qualitative (educators’ and manager’s interviews) methods of data collection. The questionnaire embodied both open-ended and closed questions which were further categorized into dominant themes: level of knowledge and understanding of HIV/AIDS, sources of information, learners’ attitudes and myths/misconceptions about HIV/AIDS. The data produced was triangulated with the responses from the educators’ and manager’s interviews. Analysis of the data was carried out in the Microsoft Excel program by using the programs graph wizard to generate bar graphs for easier interpretation of the open-ended questions. The findings of the questionnaire showed positive results and left me with a sense of optimism for the future, although there were areas of concern as in the findings of the grade four learners.

The educators’ responses to the interviews revealed the reasons for the concern which are attributed to lack of training in life-skills and sexuality education, unavailability of resources and poor knowledge about policy documents. The management response also revealed lack of focus and commitment from all stakeholders to give impetus to the fight against HIV/AIDS. The role of the school and religious and civic organisations cannot be underestimated in the fight against AIDS. We should empower our children with education and life skills - not only so that they can prevent themselves from being infected, but also so that they can have the opportunity to learn to become compassionate caring members of a society that will be struggling with the aftermath of HIV/AIDS for a long time to come.

CHAPTER ONE

INTRODUCTION

1.1. INTRODUCTION

This chapter is divided into three sections, the preamble, the rationale and the methodological considerations. The preamble locates the HIV/AIDS pandemic globally and nationally; the rationale highlights the awareness and education campaigns initiated in an effort to combat the spread of HIV/AIDS and includes the motivation for the study and the critical questions; the methodology briefly explains the sample characteristics and instruments used in the study and concludes with a structure of the report.

1.2. PREAMBLE

The HIV/AIDS pandemic is one of the greatest humanitarian and developmental challenges facing the global community. At present 45 million people worldwide have been infected with HIV with Sub-Saharan Africa being the worst infected region, having around 85 percent of the global total of HIV-positive people (UNAIDS, 2001).

South Africa has one of the highest levels of HIV prevalence in the world and, with an estimated 4,2 million infections in 1999, it is estimated by UNAIDS to have more HIV-positive citizens than any other country (UNAIDS, 2000). According to the Department of Health (2001), the figure for 2000 is 4,7 million in South Africa, but for various reasons, this is probably an underestimate. According to the ASSA model (a component population projection model that models the demographic impact of the epidemic and which provides the most reliable estimate to date) this figure is closer to 5,3 million (Dorington and Johnson, 2002 as cited in Gow & Desmond, 2002).

Despite the South African epidemic having a late start to the epidemic in other African countries such as Uganda and Zimbabwe, the epidemic has reached catastrophic proportions especially in Kwazulu Natal, with the rate of prevalence at ante-natal clinics exceeding 40 percent and a nation wide prevalence rate in excess of the critical 20 % level. Kwazulu Natal is now regarded as the epicentre of the HIV/AIDS pandemic and it has been estimated that at the current rate of infection,

half of all South Africans currently 15 years or younger could die of HIV/AIDS (Lovelife, 2001).

HIV/AIDS is our continent's greatest social and human catastrophe in history and its profoundly grave implications on economic and political stability are already evident. Families are devastated, communities are decimated and hospitals are overwhelmed. Teacher attrition is becoming a problem, and learners are being forced to drop out of school because of lack of funds and to run households with no breadwinners (Gow & Desmond, 2002).

1.3. RATIONALE

HIV/AIDS also represents the largest, single threat to the education process. Infection rates have not decreased in spite of the rigorous HIV/AIDS awareness campaigns by the media (Sunday Times 2001, Lovelife and Soul City booklets), multilingual leaflets, resource guides, Readright supplements (Sunday Times, 2002) and radio and television campaigns, as well as the inclusion of HIV/AIDS education in schools, there seems to be a general lack of recognition of the seriousness of the problem. In spite of the plethora of information available the infection rates continue to soar in South Africa, and especially in Kwazulu Natal.

The spectre of HIV/AIDS is upon us. What are we, as educators and the school community doing about it? Are we addressing the issues through our HIV/AIDS life-skills programmes? Does the school have a clear-cut policy on HIV/AIDS? Is there commitment among the various stakeholders in addressing the problem of HIV/AIDS in our society? Are all the stakeholders, the educators, the principal, the school governing body and the greater community working together to empower our youth to fight this scourge? These were the questions that came to mind as an educator teaching in a primary school. The dissident views expressed by our leaders and the silence surrounding HIV/AIDS compelled me to find answers within the school community. There is acknowledgement from all quarters that there must be a sustained effort to combat the problem about HIV/AIDS. The Departmental and National policy is clearly spelt out, but are we doing enough at grassroots level in empowering the learners and educators in the fight against HIV/AIDS.

According to the findings by UNESCO (2002), ignorance is a major reason why the epidemic is out of control. Preventive education must make people aware that they are at risk, and why – and how prevalence can be reduced. However, knowledge is often not enough to change behaviour. Preventive education must address mentalities and the cultures within which they are embedded in order to generate the attitudes, provide the skills and sustain the motivation necessary for changing behaviour to reduce risk. Education is the most effective strategy because prevention is not only the cheapest response; it is the most potent response. It seems legitimate to expect schools as a teaching-learning institution to play a very active role in the communication of messages about HIV/AIDS.

Literature has shown that schools have grave problems in communicating messages about HIV/AIDS. An appreciation of these problems is possible to be more realistic about what schools can and cannot accomplish in the field of HIV prevention (Kelly, 2000). These were some of the motivating factors that drove the researcher to seek some of the answers that she was looking for and which are examined by the critical questions of this study.

1.4. KEY RESEARCH QUESTIONS

The critical questions that will guide this study are:

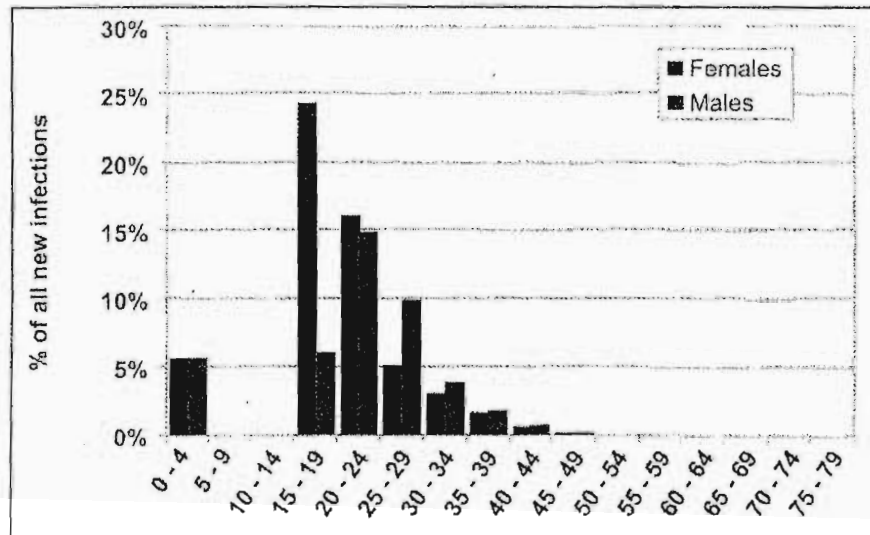
1. What is the level of knowledge and understanding of HIV-AIDS of learners in the Intermediate Phase?
2. What is the level of knowledge and understanding of HIV/AIDS of the educators in the Intermediate Phase?
3. How is HIV/AIDS education managed in the Intermediate Phase in a school?

Cecilia Braslavsky, Director of IBE and distinguished education specialist from Argentina, shared her view that second to lack of information on basic HIV prevention, there is also a lack of capacity in educational establishments to locate and interpret this information and to develop new attitudes and behaviours through its use (cited in Innovations, 2002).

1.5. Why Intermediate Phase learners? - Our Window of Hope

The researchers motivation for selecting Intermediate Phase learners was two-fold: one, there is a paucity of research on children in this crucial stage of development and two, they represent a window of opportunity for us educators to make a difference in the fight against HIV/AIDS.

Figure 1: Incidence of HIV by gender and age group



(Impending Catastrophe Revisited, H.J. Kaiser Family Foundation, 2001)

Age related data regularly show AIDS cases being at their lowest for boys and girls below the ages 5 and 14. (Henry J Kaiser Family Foundation, 2001) Because of mother to child transmission they are higher in children below the age of 5, and after the age of 15 they increase very rapidly, especially for girls. According to Kelly (2000), the low occurrence of AIDS amongst those aged 5 - 14 has led to children being regarded as constituting a “window of hope”. Programmes targeted at this group are seen as providing a special opportunity to prevent infections and reduce the transmission of the disease.

The researcher believed that the school has a vital role to play in prevention activities as HIV/AIDS prevention messages and attitude change must begin at an early age. These messages and skills are most effective when they reach primary school learners. One of the most cost effective ways is to include these messages in the curriculum. The present HIV/AIDS Life-skills programme together with the in-

service training of educators is an effective tool if used properly and can reverse the high infection rates. However, there is no 'quick fix' process, and there will have to be a sustained effort over a period of time. We need to revisit the effectiveness of our life-skills campaigns.

1.6. THE METHODOLOGICAL CONSIDERATIONS

The researcher used a mix of qualitative and quantitative methods in the data collection and analysis. Cresswell (1994), cited in de Vos, 1998) maintains that the mixed methodology design represents the highest degree of mixing paradigms since the researcher would mix aspects of the qualitative and quantitative approaches at all or many of the methodological steps in the design. The sample consists of learners in the Intermediate Phase, the Life skills educators as well as a school manager in a public school. The instruments employed are questionnaires for the learners and semi-structured interview schedules for the educators and manager. The research process thus requires working back and forth between inductive and deductive models of thinking, especially in the data analysis.

1.7. THE STRUCTURE OF THE REPORT

This report is divided into five chapters. Chapter one (this section) provides a general overview of HIV/AIDS infection rates globally and in South Africa. It also discusses the motivation for the study, the aims of the study, key research questions and the methodological considerations.

Chapter two examines the related literature which includes the biomedical aspects of HIV/AIDS and sexuality education. It also sheds some light on the complexities and challenges facing the education sector regarding HIV/AIDS education and the knowledge and perceptions of Intermediate Phase learners.

Chapter three describes the research methodology that was employed in the conduction of this study. It also includes the ethical considerations and the limitations of the study.

Chapter four (Part One) presents and analyses the findings of the learners' questionnaires that were employed to answer the first critical question. Part Two of

the same chapter presents and analyses the findings of the semi-structured interview schedules which answered the second critical question. Part Three of the chapter focuses on answering the third critical question which relates to the management of HIV/AIDS in the Intermediate Phase of a school. In each of the parts, the findings of the study are discussed in relation to views drawn from academic literature and related theories.

Chapter five of the report is concluded by making recommendations, with implications for further study and the conclusion.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1. INTRODUCTION

This chapter reviews literature relating to the biomedical aspects of HIV/AIDS, Life-skills and sexuality education, and examines the HIV/AIDS education initiatives in the South African Education System. It also explores the problems experienced with policy implementation and reviews literature relating to programme implementation and knowledge of HIV/AIDS as well as the perceptions and knowledge of HIV/AIDS of learners in the middle childhood years (Intermediate Phase).

2.2. THE BIOMEDICAL ASPECTS OF HIV/AIDS

AIDS is the acronym for “acquired immunodeficiency syndrome” and is the end-stage disease manifestation with a virus called the human immunodeficiency virus (HIV). The virus infects mainly two systems of the body, the immune system and the central nervous system, and disease manifestations are consequent on damage to these two systems (Schoub, 1999).

HIV infection and AIDS thus really refer to two different aspects of the same process. According to Schoub (1999), the cardinal feature of HIV infection and its subsequent diseases is its inexorable progression in the majority of cases. Also once an individual is infected, he or she remains infectious for a lifetime. The average time from initial infection to AIDS for an adult is about 8 – 13 years, sometimes longer in certain individuals, whereas in children and babies, the incubation period can be less than five years or as short as two years. During this time, individuals may show no signs of HIV infection. Such individuals are said to be asymptomatic seropositives. Following infection with HIV, a person is likely to remain well for a variable length of time. A person is likely to develop symptoms when the virus is actively replicating, or when the damage caused to the immune system is such that the opportunistic infections develop (Rogers, 1989). Persistence of symptoms over several weeks or longer is indicative of the presence of AIDS. Kaus and Reed (1987) lists the symptoms as follows: fever or sweating at night (chills); long fits of coughing; rapid weight loss for no apparent reason; chronic fatigue; diarrhoea; swollen lymph nodes (usually in neck,

armpits or groin); white spots or other unusual blemishes in the mouth; and discoloured blotches on the skin or in the mouth, nose and eyes. Recovery from AIDS is not known to occur and the disease is almost always fatal.

Transmission of the virus depends to a large extent on individuals engaging in risk behaviours that expose them to the virus. HIV may be transmitted in three principal ways: unprotected vaginal or anal sexual intercourse; direct exposure of bodily fluid, to semen, blood or blood products (mainly involving reuse of or accidental injury with, inadequately sterilized needles or syringes); by blood transfusion; or from a mother to her unborn child. While the pattern varies geographically it has been estimated that 70% of global infections are via vaginal intercourse (UNAIDS, 2002). HIV cannot be transmitted through the following: through touching, hugging, or dry kissing; from toilets ;by sharing cups, knives and forks, cooking bowls etcetera; from head lice, mosquitoes, or other biting insects; and from swimming water (Harvey & Reiss, 1991).

2.3. LIFE-SKILLS AND SEXUALITY EDUCATION

Sexuality education is a key component of HIV/AIDS education and should be appropriate to the learners' age and phase of development and should not be confused with sex education. Sexuality education is a lifelong process of acquiring information and forming attitudes, beliefs and values about identity, relationships and intimacy. It encompasses sexual development, reproductive health, interpersonal relations, affection, intimacy, body image and gender roles (Louw, Weetsz and Radebe, 1996).

It is mainly a matter of education in guiding the child to responsible adulthood and encompasses values, norms and education. Life skills are a key component of sexuality education. Even if learners have the necessary values and information to make responsible decisions they still need skills to implement the decisions. Through life-skills learners become empowered. According to Rooth (1999) learners are empowered when:

- They believe in themselves
- Take control of themselves
- Can cope with life

- Feel in charge of what is happening around them
- Feel motivated
- Feel confident to face the challenges of life
- Achieve the best that they are able to

This results in a positive self-concept. Gillis (1996) suggests that parents and educators can enhance a child's self-concept since a child with a positive self-concept has psychological strengths such as self-efficiency and assertiveness which may help children to avoid child abuse, drugs, premature or unwanted sex and HIV infection.

Van Dyk (2001) maintains that HIV/AIDS should never concentrate on the dissemination of information on HIV and AIDS alone. A child can only make responsible decisions if the knowledge that he or she obtains is firmly based on healthy values, norms and attitudes and if he or she has the necessary skills to implement these decisions. Thus, for an HIV/AIDS education to be successful there should be a balance between knowledge, life skills, values and attitudes.

Basic knowledge, attitudes, values and skills (which are not exclusively HIV/AIDS – related) should be established, promoted, and reinforced in all the phases of a child's primary and secondary school career. The content and the way in which this knowledge, attitudes and skills are taught, should be adapted to the child's age and developmental phase (Edwards & Louw, 1998; Pilot project on Life skills, 1999).

Having outlined the basis of the HIV/AIDS life-skills programmes, the following section will examine education initiatives in South Africa.

2.4. AIDS INITIATIVES IN SOUTH AFRICA

Education is one of the most powerful weapons against HIV/AIDS. Kelly (2000a) argues, "Education in a world with AIDS must be different in an AIDS free world. The context, process, methodology, role and organization of school education in a world with HIV/AIDS must be radically altered."

The school therefore becomes a crucial site for the battle against HIV/AIDS since it is most appropriate for the following reasons:

- Daily contact with learners
- Staffed by skilled professionals

- It is the area with the fastest growing infection rate and houses the most vulnerable in society
- The position of the teacher in the community, especially in rural areas, is influential
- Schools have the opportunity to reach young children

If we are to use the potential of the education sector to defeat HIV/AIDS, it is important that we base our initiatives on some understanding of what has gone wrong, why the AIDS pandemic has got out of hand and why, in particular, the response from the education sector has been so limited.

School based interventions have taken place since the mid '80s against a backdrop of media messages about AIDS. The success of these multi-media public awareness campaigns is evidenced by high levels of general awareness of AIDS, its modes of transmission and methods of prevention.

Life skills programmes targeted at young people in and out of school represent one of the identified key priority strategies of the South African government's National AIDS Programme since 1995. In the last 10 years, South African schools have been inundated with interventions targeting HIV/AIDS. The purpose of these interventions, broadly speaking, has been to increase knowledge about HIV/AIDS and its transmission, on assumption that this would in turn change behaviour, thereby preventing HIV transmission (Morrell et al, 2002).

Morrell, Moletsane, Abdool Karrim, Epstein & Unterhalter (2002) maintain that by far the most important of the school based interventions have been in terms of the formal curriculum. The life-skills component of Curriculum 2005 is considered to be the logical place where AIDS, sexuality and safe sex are discussed. While a state initiative into education via the curriculum was long ago considered the most logical, comprehensive and wide reaching type of intervention which targeted those most at risk, it was equally recognised that teachers could not be expected, without training, to fulfil this new role. As a result, in 1999 European Union funding was made available for the purpose of teacher training. The vast scale of the challenge dictated that a

cascading model was used with just under one thousand teachers in Kwazulu Natal out of a total teacher population of seventy thousand in the province receiving training. They were then expected to “cascade” their knowledge to colleagues at their schools. The schools that were targeted were secondary schools while not much was being addressed at primary schools. Subsequent evaluations of its impact suggest that it was not successful and is inline with evidence from other countries that cascade models of professional development are rarely effective, particularly in difficult or sensitive areas (McBride, 1989; Epstein, 1991).

Recent findings by Gopal (2003) in one rural area of Jozini in Kwazulu Natal show that despite the Minister of Education’s focus on HIV/AIDS in the school curriculum, there appears to be non-deliverance. Although the curriculum has roles through all learning areas activities in equipping and sensitizing learners and educators and in enlightening learners and educators on the importance of HIV/AIDS, this is clearly not followed through.

The following documents will be used to reflect on educators and managers responses to HIV/AIDS education in a primary school.

2.5. HIV/AIDS DOCUMENT REVIEW

2.5.1. The HIV/AIDS Education Policy

The Department of Education has developed a National Policy for Learners and Educators in Public Schools (Department of Education, 1999) which is consistent with the Department of Health’s strategic plan but goes further to provide guidance on advocacy and sensitization, and sports safety. It specifies that:

- Learners and students must receive education about HIV/AIDS and abstinence in the context of life-skills education on an ongoing basis.
- Life-skills and HIV/AIDS education should be integrated in the whole curriculum and not be presented as isolated learning content. This places the responsibility for AIDS education on all educators.
- The purpose of education about HIV/AIDS is “to prevent the spread of HIV infection, to allay excessive fears of the epidemic, to reduce the stigma

attached to it and to instil non-discriminatory attitudes towards persons with HIV/AIDS”.

- Programmes should include age-and context appropriate knowledge and skills in order that learners may adopt and maintain behaviour that will protect them from HIV infection.
- In the primary grades, the regular educator should provide education about HIV/AIDS, while in secondary grades the guidance counsellor would ideally be the appropriate educator. Because of the sensitive nature of the learning content, the educators selected to offer this education should be specifically trained and supported by the support staff responsible for life-skills and HIV/AIDS education in the school and province.
- The educators should feel at ease with the content and should be a role model with whom learners and students can easily identify.
- All educators should be trained to give guidance on HIV/AIDS. Educators should respect their position of trust and the constitutional rights of all learners and students in the context of HIV/AIDS.

In schools, principals are responsible for plan implementation, and school governing bodies are expected to work in partnership to promote HIV/AIDS education. Thus, the South African National Education Policy Act, 1996 (Act 27 of 1996) on HIV/AIDS for learners in public schools makes it compulsory for a continuing HIV/AIDS programme to be implemented at all schools for all learners. Accordingly, the age-appropriate education on HIV/AIDS forms part of a compulsory curriculum for all learners and should be integrated in the life skills education programme for pre-primary, primary and secondary school learners.

2.5.2. The Department of Education Strategy: TIRISANO (2000 – 2004)

The National Department of Education’s Strategy and Work Plan: Tirisano, states that, ‘We must deal urgently and purposefully with the HIV/AIDS emergency in and through the education and training system. This is the priority that underlies all priorities, for unless we succeed, we face a future full of suffering and loss, with untold consequences for our communities and the education institutions that serve them.’”

This national policy document addresses both the health of the learners and educators. TIRISANO focuses on

- Raising awareness about HIV/AIDS among educators and learners
- Integrating HIV/AIDS education into the curriculum

2.5.3. The Life Skills Programme

The Life-skills Programme was compiled by the Departments of Health and Education who began to design curricula in 1995. Each provincial department was supposed to apply the curriculum and train teachers in its use, but implementation has been slow. This lack of success was revealed in a provincial survey, when only 18% of schools were found to be offering any form of life-skills training, let alone training on Sexuality and HIV/AIDS prevention (Data Research Africa, 2000).

The present HIV/AIDS Life-skills Programme for grades 1 to 7 was piloted in 1999 and has been available in schools in KZN since 2002. Training of Intermediate Phase educators was undertaken in 2002 and 2003. According to Ncgobo (2002), the emphasis of the DOE Life-skills Programme is on facilitating behavioural change through providing life-enhancing (life-saving) skills within the curriculum.

2.5.4. The HIV/AIDS Emergency Guidelines for Educators (2000)

The Departmental Guidelines insist that educators exemplify responsible sexual behaviour and create a working environment which supports those infected or affected by HIV/AIDS, thereby making the school a centre of hope and care in the community.

2.5.5. KwaZulu Natal Master Strategic Plan 2003 – 2006 (June 2003)

The strategic goals and associated objectives includes among others,
Goal 6: Deal urgently and purposefully with the HIV and AIDS pandemic and other health and social threats/hazards.

Strategic Objectives:

- To develop programmes to counter the negative effects of HIV and AIDS in schools

- To ensure the integration of life-skills across the curriculum to combat HIV and AIDS and other health and social threats/hazards
- To develop a management plan to deal with infected and affected.

The above initiatives had problems relating to the implementation of HIV/AIDS education in schools.

2.6. BARRIERS IN THE IMPLEMENTATION HIV/AIDS EDUCATION PROGRAMMES

Ncgobo (2002) claims that the co-ordination of the HIV/AIDS programmes is being improved both within districts and within departments. There have been problems with intra-departmental co-ordination as good planning appears to have been neglected. There are no environmentally appropriate responses to local barriers to the programme, and the learning support material does not take into account local contexts. To make the programme more responsive to local needs, more responsibility needs to be given to districts and regions. Discussing learning support material with parents to reflect local needs has been crucial to programme success in some regions.

Ncgobo (2002) further maintains that educators are expected to teach 'life skills' to learners, but this is problematic. The educators themselves went through a school system that did not offer Life Skills. Educators may hold conservative values, and some educators have also been implicated in gender-based abuse. Educators must first grapple with their own issues, before they can facilitate 'life skills' for learners. She advocates that a Life Skills, HIV/AIDS specific Care and Support Counselling Programme for educators is needed, and might increase implementation by 100 percent.

Van Dyk (2001) maintains that HIV/AIDS should never concentrate on the dissemination of information on HIV and AIDS alone. A child can only make responsible decisions if the knowledge that he or she obtains is firmly based on healthy values, norms and attitudes and if he or she has the necessary skills to implement these decisions. Thus, for an HIV/AIDS education to be successful there should be a balance between knowledge, life skills, values and attitudes.

Ncgobo (2002) further argues that a great majority of educators teach matters pertaining to sexuality in communities to which they do not belong. The 'values and norms' bias of the programme raises some awkward questions in the minds of many community members who do not yet understand the life skills context of Sexuality and HIV/AIDS education, and who feel that something other than community values is being discussed. Some ordinary people, including educated ones, equate Life Skills and sexuality to sex talk. This poses problems for educators who become suspected of ulterior motives, or misinterpreted to suit pre-conceived perceptions. Educators have to work in communities where gender values are extremely conservative and where gender malpractices are common. No one supports the educator when he/she returns to school after training, and some school principals are opposed to the programme. Educators feel helpless and demotivated to continue. Also, there is a chronic shortage of staff trained in Life Skills (Ncgobo, 2002).

Teachers assigned to teach courses on sexuality, HIV/AIDS and relationship skills clearly need special training to increase their knowledge and comfort levels. In Thailand, prior to training, many teachers in a study reported that they found it difficult to lead a discussion on sexual health, but after attending a four day training session, they felt more comfortable in discussing such sensitive topics. In addition to intensive training courses, teachers need ongoing support as they teach the course so that they are able to handle such situations as student embarrassment or parental objections. Furthermore, teachers need to know they have school and community support for teaching the subject and they will not be criticized for doing so (cited in Horizons Report, 2001).

Morrell et al., (2002) concur that school –based interventions are tackled without any attention being paid to the social context in which they are implemented, particularly the gender regimes of schools and communities where learners reside. Moletsane (2002) argues that it is important in school based interventions to consider not only what is general about schools, but what is specific to particular schools and classes. Thus, developing a particular and nuanced intervention for each situation is a key factor in the success of attempts to reduce the spread of HIV and change sexual behaviours (Moletsane, et al., 2002). This is also suggested by Schaalma, et al (2002),

who acknowledge that research is also required on how widespread implementation and maintenance of programmes can be achieved and how individual, institutional, political, religious and cultural barriers to implementing effective sex education and AIDS education can be overcome. There is a need to know how to effectively support educators with in-service training to enhance the delivery of programmes that have proven to be effective. Research into implementation barriers could have a powerful impact in spelling out the effectiveness of the programmes.

Previous research which provides us with the level of knowledge and understanding of HIV/AIDS follows:

2.7. INTERMEDIATE PHASE LEARNERS' KNOWLEDGE AND UNDERSTANDING OF HIV/AIDS

Much research has concentrated on adolescents since they are regarded as high risk. However, learners in the middle childhood years are in the process of acquiring knowledge and forming attitudes and beliefs. Interventions made at this stage will therefore be valuable and have long term implications for the formation of these attitudes and beliefs.

In a study on grade 6 and 7 learners' knowledge, perceptions and attitudes on HIV/AIDS, Buhr's (2001) findings indicate that the majority of participants (38,7%) felt that the age group 6 – 10 years is the appropriate age to target. Providing HIV/AIDS information to such a young age group would enable educators to have a reasonable chance of influencing children prior to their entering into sexual activities. In the same study approximately 42% of learners indicated that they would like their class teacher to provide HIV/AIDS education, and 30,7% an AIDS sufferer. A Health Monitor Report (Volume 18, No.2, 2001) of HIV/AIDS field work conducted in two black working class township schools shows a relatively small portion (9%) of the learners learned about HIV/AIDS from the teachers.

On the type of information which participants considered to be important for inclusion in an HIV/AIDS programme, an overwhelming number of participants (82%) indicated that HIV/AIDS education should include information about the virus and its

effects on the human body, whilst a significant 66% would like information on how people get infected by HIV/AIDS. Battaracharya et al., (2000) found that scientific knowledge pertaining to the transmission modes of HIV and AIDS was the most wanted item and second to that was information dispelling misconceptions and myths about HIV/AIDS. This is in accordance with the Minister of Education, Professor Kader Asmal's (2001) address at a conference on Sexuality Education held at Gallagher Estate, Midrand on the 20th August 2001. He emphasised the importance of such education and mentioned that it (Sexuality Education) should include sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. Various agents impact upon the above education. Some of these are: parents, peers, schools, religion, media and friends. This again highlights the need to look at HIV/AIDS education holistically.

Children in this phase are able to distinguish between the causes and effects (or symptoms) of disease. They define illnesses in terms of specific symptoms experienced by the body. While they describe the symptoms of AIDS as externally observable when they are younger, older children are able to realise that symptoms can also be internal (i.e. that they do not also affect the 'inside' of the body) (Walsh & Bibace, 1990) .

When they are asked to explain what causes AIDS, children in this age group will often offer a long list of causes from what they have heard in the media, from what other people have said, or from what they imagine to be the causes of AIDS (Walsh & Bibace, 1990).

Although their understanding is still largely concrete and non-specific, children in this phase know that HIV can be transmitted through sex, blood, from mother-to-baby, and by using drugs (Montauk & Scoggin, 1989). They are also able to make basic distinctions such as that 'not all kinds of sex' or 'not all drugs' lead to AIDS (Walsh & Bibace, 1990).

Montauk and Scoggin (1989) found that the questions grade 4 and grade 5 children ask are mainly dominated by their own everyday frame of reference. For example, when asked about the safety of blood, their questions were about blood from their

own or their friends' wounds. They also wanted to know if HIV can be transmitted through 'blood rituals' between friends, and by using pins as 'pea shooters'. Children at this age also had a lot of questions about the 'French kiss' – not really because they were practising it, but because of curiosity.

Children between the ages of 10 and 12 years are very prone to the acquisition of myths. They get confused between fact and fantasy and between hypotheses and reality (Davidson, 1988 as cited in Van Dyk, 2001).

Most of the questions asked by children in grades 5 and 6 in Montauk and Scoggin's (1989) study suggest the existence of myths. They asked questions about the transmission of HIV through toilet seats, swimming pools, food, coughing, playing with friends, and through animals, mosquitoes, rats and flies. Brown, Nassau and Barone (1990) found that 54% of the grade 5 children in their study believed that one can get HIV by using a friend's hair comb, yet 84% of them did not know that HIV cannot be transmitted by touch.

It is extremely important to eradicate myths and misconceptions because they may lead to severe anxiety in children. People who believe in myths also tend to have more prejudices or negative attitudes towards people with HIV/AIDS. For instance, Siegel et al. (1991) found that children with misconceptions about the transmission of HIV believed that children with HIV should not be allowed to attend school. The older child usually associates HIV/AIDS with specific groups of people such as 'drug users', 'adults' or 'naughty teenagers'. Children in this phase tend to dissociate themselves from groups that they identify as vulnerable to HIV/AIDS. This is, of course, a defence mechanism because it helps them cope with their own fear of HIV/AIDS. Sexuality based myths are often central to the stigmatization of specific cultural groups. Negative misinformation about the sexuality of women, gay men, and blacks in general are often barriers to effective prevention efforts (Buhr, 2001).

The researcher's study examined the level of knowledge and understanding of the intermediate phase learners in order to eradicate myths and misconceptions.

2.8. CONCLUSION

Much of this chapter has been devoted to examining the biomedical aspects of HIV/AIDS; life-skills and sexuality education; past and current education initiatives in our schools; and barriers in the implementation of programmes. Literature related to the learners' understanding and perceptions of HIV/AIDS was also examined. Because of the complex nature of HIV/AIDS, a coherent overall strategy is crucial from all levels of society. In the following chapter, the methodology that was engaged in data collection will be defined.

CHAPTER 3

METHODOLOGY

3.1. INTRODUCTION

In the previous chapter, the literature related to this study was reviewed. This was done with the purpose of exploring various issues surrounding HIV/AIDS education and what previous researchers had discovered on HIV/AIDS education with the emphasis on Intermediate Phase learners who are in the formative stage of development. This chapter defines the methodological approach that was employed in the data collection. The researcher then proceeded to detail the sampling procedure, sampling criteria and the ethical considerations. The researcher then described the different research instruments employed. She also tabulated the methodology plan used in the study which includes the research procedure and an outline of the methods of analysis. The chapter concludes with the shortcomings of the study.

3.2. METHODOLOGICAL APPROACH

The researcher used a mix of quantitative and qualitative methods of data collection and analysis. The analysis of the responses to 120 learner questionnaires was conducted using a quantitative method since it allowed for the comparison and statistical aggregation of the data (Patton, 1990; 14). According to Cohen (2000), quantitative data analysis “involves organising, accounting for and explaining the data, in short making sense of the data.” The respondents’ responses were organised and fitted in tables and charts under different headings, in doing this the different themes of the data were observed, and this helped me to put the responses in different categories according to their themes. The quantitative data analysis also involved the use of percentages and frequencies which were presented in tables and graphs.

Interviews were conducted with a purposively selected sample of four educators on the basis of them being Life Orientation educators in the Intermediate Phase. Their responses were analysed using qualitative methods which typically produce a wealth of detailed information about a much smaller number of people. Furthermore, the qualitative research design is more flexible and allowed a closer relationship between those being researched and the researcher. The aim of using interviews and the

outcomes of the responses focussed on understanding rather than on predicting general patterns of behaviour (Neuman, 1997).

The term 'triangulation' was originally coined by Denzin (1978) and referred to the use of multiple methods of data collection with a view to increasing the reliability of observation. In this study, the interviews with the educators and manager served to validate the responses of the learners' questionnaires. Since the learners' knowledge and understanding of HIV/AIDS is as a result of the knowledge, understanding and teaching of HIV/AIDS.

3.3. THE RESEARCH DESIGN

3.3.1. Sampling and sample criteria

The school is an English medium public school with an Islamic ethos as the majority of learners are Muslim. The senior management, that is, the principal, deputy principal and Heads of Department (HOD's) are all Muslim males. The staff composition is a mix of Muslim, Hindu and Christian educators. The day to day running of the school is shaped by its Islamic ethos.

The respondents were studied in their natural environment, which was the school. The sample consisted of the three Life-skills educators in the Intermediate Phase at this school. The religious composition of the educators in the sample comprised of two Muslim males and a Muslim female educator, and a Hindu male educator. All the educators were employed by the Department of Education and Culture (DOE). The average age of the educators was 38 years.

The research was conducted in the form of an in depth analysis intended to examine how HIV/AIDS education is fostered in the Intermediate Phase in a primary school. In order to do this the researcher had to use the three Life-skills Educators in the respective Intermediate Phase grades, that is, grades four, five and six as well as the learners in the respective grades.

3.3.2. Ethical considerations

Strydom (1996, cited in de Vos, 1998) states that the fact that human beings are the objects of study in the social sciences brings unique ethical problems to the fore that

would never be relevant in the pure clinical settings of the natural sciences. For researchers in the social sciences, the ethical aspects are pervasive and complex especially when researching social phenomena such as HIV/AIDS.

Ethical guidelines serve as standards and as the basis on which each researcher ought to evaluate his own conduct. Ethical principles should thus be internalised in the personality of the researcher to such an extent that ethically guided decision-making becomes part of his total lifestyle (Botha, 1993: Bulmer& Warwick, 1983: Corey et al.,1993 cited in de Vos,1998) The following aspects which relate to this study were considered: harm to subjects/respondents; consent of the respondents; and violation of privacy/ anonymity / confidentiality.

On the first issue, respondents were thoroughly informed beforehand about the potential impact of the investigation. This involved getting informed consent from the DOE prior to the commencement of the study. During the research process, informed consent was also sought from the principal prior to the administration of the questionnaire to the learners. Since the learners are minors, the principal acted as *loco parentis*, and prior to the commencement of the test a copy of the questionnaire was handed to him. The researcher administered the test herself informing the learners that there was no need to provide their names or their gender to guard against their privacy.

Prior to the entire research process, the Life-skills educators and manager were informed about the confidential/private nature of the study and asked whether they would like to participate. The anonymity of the subjects was assured at every level. Thus, pseudonyms were used for the respondents as well as the institution of the study.

3.3.3. The Educators

Since the school has a policy of specialisation in respect of learning areas, my task was made simple as there was no problem in the choice of a sample as this consisted of the three Life-skills educators currently teaching Life Orientation in the three grades in the Intermediate Phase.

3.3.3.1. Biographical Details of Intermediate Phase Educators

The following table is a representation which provides the biographical details of the Intermediate Phase educators. The sample comprised four Life-skills educators, three male and one female. Their teaching experience ranged from six to twenty years. Their average age was thirty eight years. They are all Indian with three of the educators coming from the same religious faith, that is, Islam, while Perumal comes from the Hindu faith. All educators are state employed. The manager, Mr Omar, teaches Life Orientation in grade six as well as being the manager (Deputy Principal), member of the school Governing Body and a religious leader in the community.

Table 3.1. Life-skills educators' profile

Educator	Age	Gender	Religion	Teaching Experience	Qualifications
Perumal	38	Male	Hindu	16 years	JP.ED & FDE
Ayesha	40	Female	Muslim	18 years	B. Paed & B.Ed
Ismail	29	Male	Muslim	6 years	B. Paed
Omar (Deputy Principal)	42	Male	Muslim	20 years	BA. UHDE, B.Ed

3.3.4. The Learners

The total learner population of the Intermediate Phase learners comprised of 250 learners, the majority (96%) coming from one cultural group, that is Muslim. Approximately 4% were either Hindu or Christian learners. One class of 40 learners was selected from grade 4 (age group 9 – 10 years), one class of 40 learners was selected from the grade 5 class (age group 10 – 11 years) and the third group comprised of one class of 40 learners from the grade 6 class (age group 11 – 12 years). The sample thus comprised of 40 learners from each of the three grades with a total of 120 learners to whom the questionnaire was administered and who were representative of the Intermediate Phase learners.

3.5. INSTRUMENTS:

3.5.1. The Questionnaire

① Questionnaires are used widely in research to obtain facts and opinions about a phenomenon from people on a particular issue (Fouche 1996, cited in de Vos, 1998). In this study the purpose of the questionnaire was to explore the level of understanding and awareness of HIV/AIDS of the Intermediate Phase learners. The questions were itemised and categorized into the four main areas of concern, namely, knowledge about HIV/AIDS; learners' information and support base; attitudes towards people infected or affected by HIV/AIDS, sexuality education and the myths and prejudices that are prevalent in the school community. Categorizing the questions in this manner was useful for effective analysis of the responses. When designing the questionnaire for the Intermediate Phase learners, the researcher had to ensure that the language was suitable for all learners from grade 4 to grade 6 in that phase.

Both open-ended and closed questions were used by me since open-ended questions encouraged the learners to give more information. The closed questions could be answered by one or two words e.g. Yes or no.

The researcher tried to balance the factual with the thought provoking questions. A pilot questionnaire was first designed and discussed with the supervisor of the study. It was decided that to guarantee the anonymity of the learners, they would only be asked to write their age and grade on the questionnaire. This also gave the learners the freedom to respond honestly to the questions. The questionnaire was then used for a pilot study on a grade six class who would not be part of the study. The pilot questionnaire was used to explore the range and suitability of the questions. The researcher also established whether the time allocated for completion of the questionnaire was reasonable. The learners' responses in certain grades showed a lack of understanding and misconceptions about HIV/AIDS.

In the following section, the researcher intended to analyse the results of the questionnaires administered to the learners. By analysing the data from 120 respondents, it would show what the level of knowledge and awareness of HIV/AIDS the learners have in the 9 – 10 age cohort, the 10 -11 age cohort and the 11 – 12 age

cohort. The use of open-ended questions was used to capture the learners' insights into the categories of knowledge, learner support, attitudes and myths or prejudices.

3.5.2. The Interview Schedule

2 The interview schedule according to Kerlinger (1992) can be used for three main purposes.

- It can be an exploration device to help identify variables and relations and to guide other phases of the research. In the case of this study, the researcher wanted to know whether there was a positive correlation between learner's responses and the educators own knowledge about HIV and AIDS, the Department of Education Policy on HIV/AIDS and the teaching and learning.
- It can be the main instrument of the research. In this case the question design to measure the variables of the research was included in the interview schedule.
- The interview can supplement the other methods. Here the interview responses of the manager (deputy principal) were used to validate the responses of the three Life-skills educators and went deeper into the motivations of the respondents and the reasons for such responses.

The interview schedule was drawn up in collaboration with a fellow researcher, who was conducting a study on Foundation Phase educators. Since the interviews were semi-structured, it gave me ample opportunity to probe for clarity especially where responses were ambiguous and unclear.

3.6. DATA COLLECTION PLAN

The data collection plan included three groups of participants, namely, the Life-skills educators, the manager, and the learners. This allowed for triangulation of data produced.

Table 3.2 Administration of Interviews

Educator	Grade	Date of Interview
Perumal	4	30/07/2003
Ayesha	5	31/07/2003
Ismail	6	01/08/2003
Omar (Deputy Principal)	6	05/08/2003

Table 3.3 Administration of Questionnaires:

Grade	Age Group	Number of Learners	Date of Test
Grade 6	11 – 12 years	40	18/08/2003
Grade 5	10 – 11 years	40	19/08/2003
Grade 4	9 – 10 years	40	20/08/2003

3.7. PROCEDURE:

3.7.1. Questionnaire

Before administering the questionnaire to the learners, the researcher informed the principal and gave him a copy of the questionnaire. The entire questionnaire took approximately thirty minutes to complete. The researcher had made prior arrangements with the educators in the three grades so that she would be present with the learners when administering the questionnaire. Her reasons for this were:

- The researcher gave the instructions for completion of the questionnaire verbally. She also informed them of its confidentiality.
- Any concerns of the learners were attended to immediately. For example in the grade four class a few learners wanted words spelt out for them in completing the items or if they did not understand a question, the researcher was available to explain briefly what was required.
- Finally, because of sensitive information, questionnaires need to be self-administered.

3.7.2. Interview with Ismail

At the beginning of the interview with the first of the four respondents, the researcher conducted a trial run where she practised the use of the recording device (audio tape-recorder). The researcher had made prior arrangement with the interviewee and he was waiting for her to begin the interview. The interview was conducted after school hours, that is, after 14h30 because the staff members were involved in a workshop. The first interview was conducted in the HOD's office.

The purpose of the interview was made clear prior to the interview proper itself, but again the researcher reiterated the reasons for the research and tried to put the interviewee at ease. The respondent was quiet excited to be part of the research. The researcher also explained to the participant that since the HIV/AIDS subject was a

sensitive topic, strict confidentiality will be maintained and a pseudonym will be used to guard against identification.

The responses given by the interviewee were in depth and since the grade six classes were learning about HIV and AIDS in Life Orientation, the interviewee responded with confidence. There was little need for probing because the interviewee answered the questions in detail. At the end of the interview, the respondent was grateful for being given the opportunity to participate and mentioned that he had a better understanding of the enormity of the HIV/AIDS pandemic and that he also felt empowered.

3.7.3. Interview with Ayesha

However, the second interview did not go on so well. Ayesha firstly did not want to be interviewed. The researcher did not press the issue and after a few days the educator agreed to be interviewed but not with an audio recorder (reason: did not like her voice to be recorded). She agreed to a face- to- face interview in the staff- room after school. Her responses were direct and to the point. Certain responses were non-committal. The researcher tried to use probes but these were not very successful. Her responses were brief and to the point. Since the topic is of a sensitive nature, the researcher did not insist. It was, however, surprising because this particular educator was the only one on the staff who had attended the Life-skills HIV/AIDS Workshop for grade five the previous year (2002). After the interview was over the researcher thanked the interviewee for granting the interview and assured her of the strict confidentiality undertaken due to the sensitive nature of the subject.

3.7.4. Interview with Perumal

The third interview with Perumal was also conducted after school. The researcher was met by the interviewee at the appointed time and place. However, the respondent was quite nervous due to the fact that it was the first time he was a participant in a research project. The researcher deemed it necessary to allay his fears and create a rapport so that he would be able to speak freely. This, the researcher managed to do, judging from the responses. The respondent was relaxed and took time to answer the questions. He was also assured of confidentiality.

3.7.5. Interview with School Manager

This interview took place at the appointed time after school which was suitable for the interviewee. Prior to the interview, the confidentiality of the respondent was assured. The interview was audio-recorded and took approximately thirty minutes. The interviewee showed interest in the interview and provided a very candid response.

3.8. SHORTCOMINGS/LIMITATIONS

One of the main shortcomings of the present study was that the sample was confined to a learner population of middle class learners who were drawn from a public school with ninety six percent of the learners coming from one religious group. One of the implications of not having a very diverse group in terms of race, religion, social status, etc., is that the results are generalisable to a limited segment of the population.

However, this study was conducted in a public school and as such, it could be replicated in any other public school in the country, since every school community has its own unique characteristics and cultural boundaries.

Another limitation was the use of questionnaires for eliciting responses from learners. The nature of questionnaire of not permitting the researcher to probe the respondents has led to some information being left uncovered. Usually such information arises from the verbal responses that can be elicited through probing. The information is important in clarifying some issues that may not be clear when given a written response.

Finally, the learners' gender was not established on the questionnaires. This could have yielded gendered responses which could have enhanced the quality of the data produced.

3.9. CONCLUSION

In this chapter, the methodology that was employed in gathering data was described. The following components were discussed: population and sample, the ethical considerations that guided the study, the methodological approach, research instruments used, the methodology plan and the research procedure. This chapter

concluded with the limitations of the study. Chapter four will present and analyze the findings of the data produced.

CHAPTER 4

RESULTS AND ANALYSIS

4.1. INTRODUCTION

This chapter presents the findings and discussion and is divided into three parts.

Part One will focus on the learners' questionnaires in an attempt to answer the first critical question of the study. Part Two intends to present and discuss the results of the interviews of the Life skills educators in the Intermediate Phase based on the second critical question of the study. Part Three will focus on the third critical question and intends to analyze and discuss the interview with the manager in order to examine how HIV/AIDS is managed in the Intermediate Phase in a school.

4.2. PART ONE: RESPONSES OF LEARNERS' QUESTIONNAIRES

These are the responses to the first critical question of the study:

What is the level of knowledge and understanding of HIV/AIDS of learners in the Intermediate Phase?

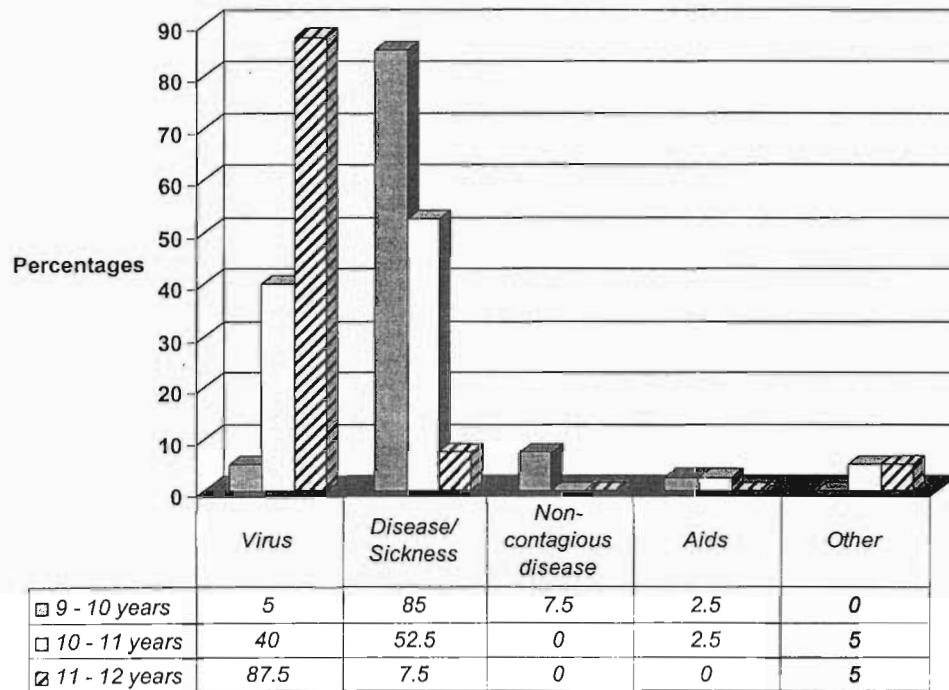
The questions are coded into the different dominant themes that surfaced in order to capture the nuances or silences of every learner. The frequencies and percentages of the closed questions are also given and this is again analysed within age cohorts and grades. Analysis of the data was carried out in the Microsoft Excel, a spreadsheet program which organises data into rows and columns on which various calculations can be carried out. The resulting data is then further analysed by using the program's graph wizard to generate bar graphs for easier interpretation of the open-ended questions (See Appendix E).

4.2.1. KNOWLEDGE BASED QUESTIONS

4.2.1.1. What is HIV?

Figure 4.1 Graphical representation of learners' responses to question:

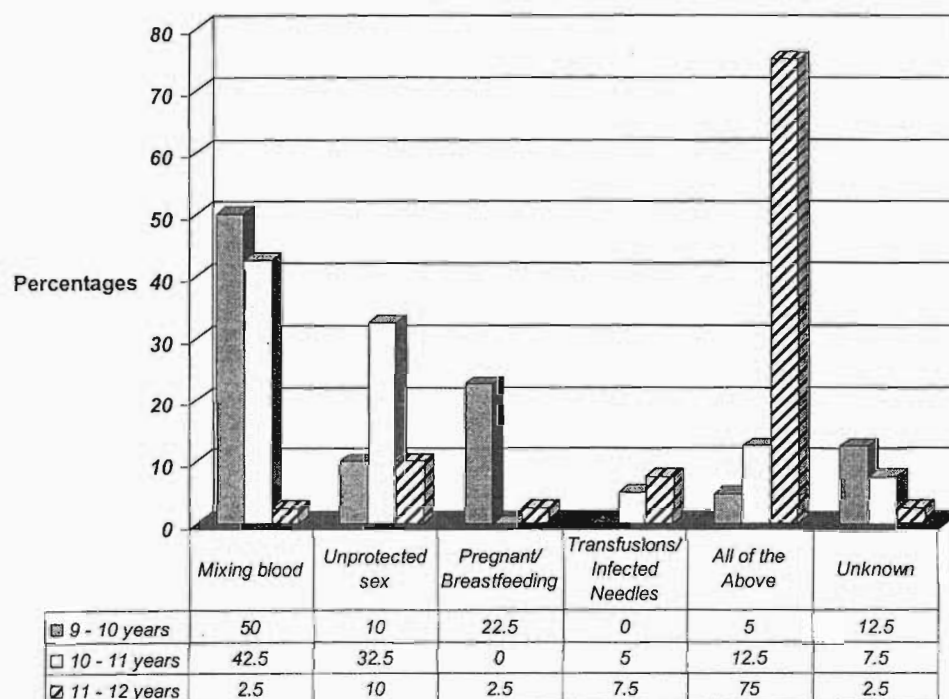
What is HIV?



This was an open-ended question with varied responses as seen on graph 4.1. Only 2 (5%) of 9 – 10 year olds knew that it was a virus as compared to 16 (40%) of 10 – 11 year olds and a significant 35 (87.5%) of 11 – 12 year olds. However, a significantly high percentage of 9 – 10 year olds and 10 – 11 year olds with frequencies of 34 (85%) and 21 (52,5%) respectively were still uncertain and saw HIV as a sickness or disease. The same groups also indicated that HIV and AIDS was one and the same thing. Three (7,5%) of 9 – 10 year olds also claimed that it was a non-contagious disease.

4.2.1.2. Name the ways in which HIV/AIDS are spread.

Figure 4.2 Graphical representation of learners' responses to question concerning the spread of HIV/AIDS



The responses were varied and the dominant themes were mixing of blood, unprotected sex, pregnant women or breast feeding mothers, transfusions or infected needles, all of the above and unknown. Twenty (50%) of the 9 – 10 year olds indicated that by mixing of blood (infected or otherwise) caused HIV to spread, only 4 (10%) showed that unprotected sex caused HIV/AIDS to spread, 9 (22%) indicated that infected pregnant women or breast feeding mothers could pass on the virus with only 2 (5%) having a very good understanding of how the virus was spread and 5 (12.5%) of learners had no knowledge of how HIV/AIDS is spread. Thus the majority of the learners indicated that mixing of blood was the main way that the virus was spread. The grade four learners were the group who had had no formal lessons on HIV/AIDS for the year.

In the 10 – 11 year age group 17 (42.5%) also indicated that mixing of blood caused the spread of HIV/AIDS while 13 (33%) of learners felt that it was unprotected sex.

Two (5%) of learners in grade 5 regarded transfusions or infected needles the cause of the spread of HIV/AIDS, while only 5 (13%) had a very good understanding of how HIV/AIDS is spread. Learners who did not know or did not answer comprised 3 (7%) of the total of 40 learners.

In the 11 – 12 year group only 1 (2%) indicated that mixing of blood as a possible cause of its spread with 4 (10%) indicated unprotected sex while 1 (2%) regarded pregnant women or breast feeding women as transmitting the virus with 3 (8%) showing the use of infected needles or transfusions causing the virus to spread and 30 (75%) of learners having an excellent understanding of how HIV/AIDS is spread. Only 1 (2%) did not know in this group.

4.2.1.3. Can HIV/AIDS be cured?

Table 4.1: Knowledge based questions

Questions	Responses	YES	NO	MAYBE
Q3. Can HIV/AIDS be cured?	Grade 4	20 (50%)	19 (48%)	1 (2%)
	Grade 5	1 (2%)	38 (95%)	1 (2%)
	Grade 6	2 (5%)	38 (95%)	-
Q4. HIV – positive person can live a long time if they follow a healthy lifestyle.	Grade 4	34 (85%)	6 (15%)	-
	Grade 5	25 (63%)	15 (38%)	-
	Grade 6	33 (83%)	7 (17%)	-
Q5. Breast-fed babies of HIV infected mothers also get HIV/AIDS.	Grade 4	34 (85%)	6 (15%)	-
	Grade 5	33 (83%)	7 (17%)	-
	Grade 6	38 (95%)	2 (5%)	-

The knowledge of whether HIV/AIDS could be cured was not well understood by the 9-10 age group where approximately half or 19(48%) indicated that it could not while the rest indicated that it could while only one learner was not sure as in the case of the 10-11 age group. The 10-11 age groups and 11-12 age groups showed that the majority 38(95%) knew that it was incurable. One learner in the 10-11 age group believed that HIV/AIDS could be cured and one learner indicated that a cure would be found.

4.2.1.4. A HIV –positive person can live a long time if they follow a healthy lifestyle.

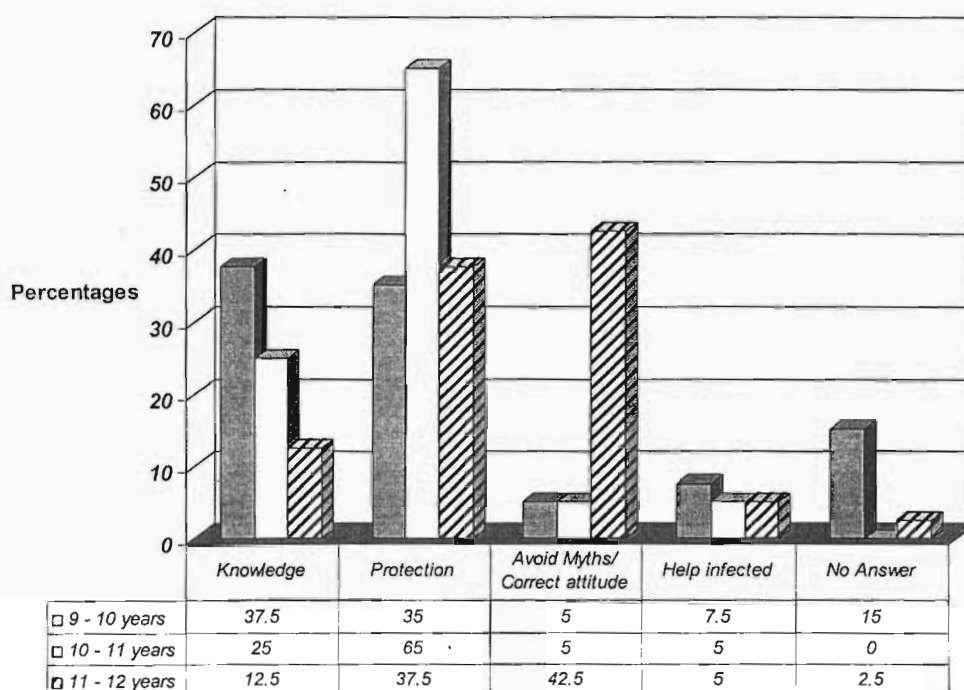
In the 9-10 age group 34(85%) of learners agreed with the statement, while 6(15%) disagreed. In the 10-11 age group 25(63%) agreed while 15(17.5%) disagreed. In the 11-12 age group 33(82.5%) had a good idea while 7(17.5%) did not. These responses show that the learners are aware that healthy living is one way of slowing down the progression from HIV to clinical AIDS.

4.2.1.5. Breast-fed babies of HIV infected mothers also get HIV/AIDS.

All three cohorts of learners from ages nine to twelve had significantly high frequencies of 34 (82,5%) and 38 (95%) with a total correct score of approximately 88% knowing that breastfed babies can get infected. Learners' knowledge concerning mother to child transmission of HIV is very good and may be attributed to a sound knowledge of how HIV/AIDS is transmitted.

4.2.1.6. Why is it important for all learners to learn the right information about HIV/AIDS?

Figure 4.3 Graphical representations of responses to question concerning the importance of correct HIV/AIDS information



The dominant themes in this knowledge category were the following: gaining knowledge; for protection and caring for oneself; avoiding myths and having the correct attitude towards people suffering from HIV/AIDS; knowing how to help infected persons and a few learners who did not answer.

In the 9-10 year cohort 15 (38%) indicated that knowledge about HIV/AIDS empowered them, 14 (35%) learners response was they needed to protect themselves, 2 (5%) felt that it was important to have the correct attitude, 3 (8%) felt that they could help someone suffering from HIV/AIDS and avoid myths while 6 (15%) left the question unanswered.

In the 10 – 11 year cohort, out of 40 learners 12 (25%) regarded the knowledge as important, a significant number 26 (65%) indicated that the knowledge gave them protection, 2 (5%) indicated that the correct information empowered them to have the

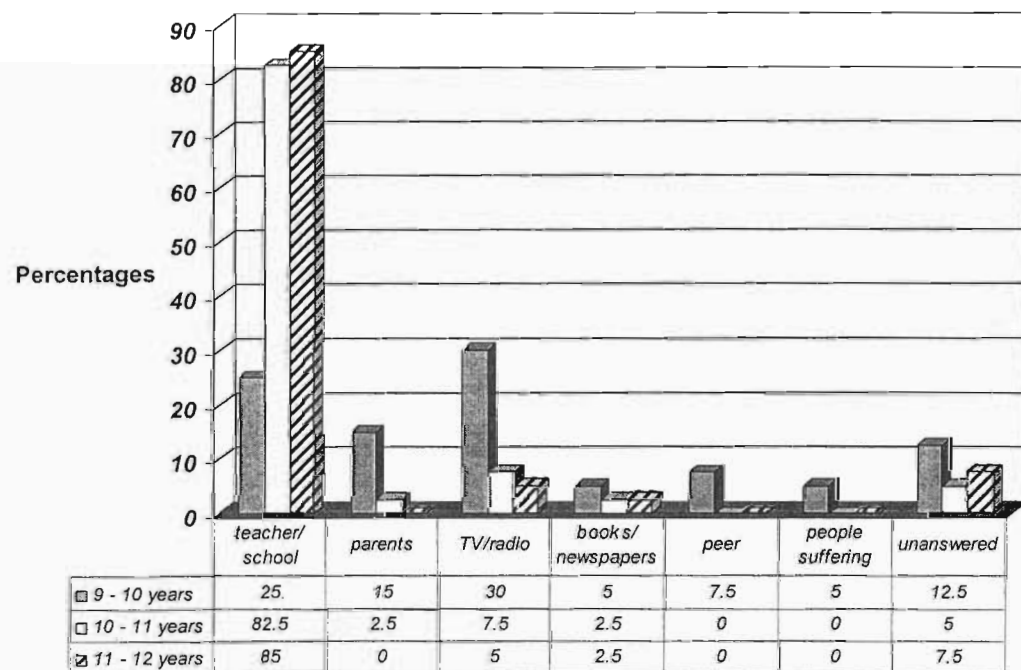
correct attitude and avoid myths associated with HIV/AIDS while another 2 (5%) indicated that they could help an infected person if they had the right information.

In the 11 – 12 year cohort 9 (12.5%) indicated the right information was empowering, while 15 (37%) showed that correct information helped them to protect themselves. A significant number of learners in grade 6 regarded the correct information about HIV/AIDS important in order to avoid myths and have correct attitudes towards infected people while 2 (5%) felt they could help infected people with the knowledge while only 1 (2.5%) left the question unanswered.

4.2.2. SOURCES OF HIV/AIDS KNOWLEDGE

4.2.2.1. Where did you learn about HIV/AIDS?

Figure 4.4 Graphical representation of responses to question concerning the learners' sources of HIV/AIDS related information



This question was used to elicit information about the learners' sources of information. There was a variety of responses which were then categorized in the dominant themes as shown in the graph.

In the 9 – 10 age cohort only 12 (25%) of learners regarded the school/teacher as their source of information while the 10 – 11 age cohort and 11 – 12 age cohorts regarded

the school as their main source of information with 33 (82.5%) and 34 (85%) responding. This is very significant since the school should play a major role in the education of HIV/AIDS education.

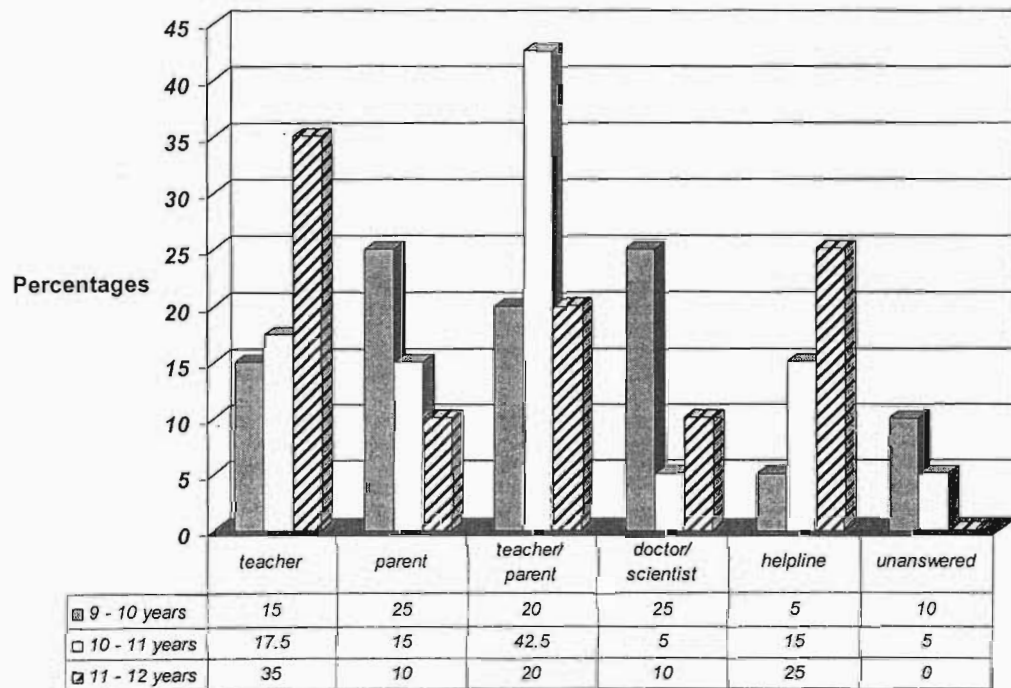
In the 9 – 10 age cohort, 10 (15%) learners showed that parents teach them about HIV/AIDS, while 12 (30%) received their education about HIV/AIDS from the TV/radio with another 2 (5%) from reading books and newspapers. Three (8%) of learners learnt something about HIV/AIDS from their peers while another 2 (5%) learnt about it from people suffering. Five (2%) left the question unanswered.

In the 10 – 11 age cohort, one (2.5%) learnt it from a parent, 3 (7.5%) from the TV/radio, 1 (2.5%) read it in books and newspapers while 2 (5%) left it unanswered

In the 11 – 12 year cohort parents did not play a role in imparting HIV/AIDS information with only 2 (5%) of learners regarding the TV/radio as a source of information and only 1 (2.5%) reading up books or newspapers. Three (7.5%) left the question unanswered. This seems to establish that learners look towards their peers to establish social norms at this age.

4.2.2.2. If you want to know more about HIV/AIDS, who would you ask?

Figure 4.5 Graphical representations of learners' responses to question concerning sources of HIV/AIDS help



This was an open-ended question which again elicited varied responses from the learners. The responses were categorized into six dominant themes/sources (see graph above).

In the 9 – 10 age cohort 6 (15%) could talk to the educator about HIV/AIDS while 10 (25%) responded that the parent was the person to turn to while 10 (25%) regarded the doctors or scientists as knowledgeable about HIV/AIDS and 2 (5%) of the learners indicated the AIDS helpline as a source of information while 4 (10%) left the question unanswered.

In the 10 – 11 year cohort 7 (17.5%) could talk to the educators, 6 (15%) of learners could talk to the parent while 17 (42.5%) of the respondents felt that both the teacher and parent could be approached. Six (15%) of the 5th graders indicated that the AIDS helpline could provide them with information while 2 (5%) left the question unanswered.

In the 11 – 12 age cohort 14 (35%) regarded the educator as a source of information with 4 (10%) looking to the parent to provide the information on HIV/AIDS while 8 (20%) showed that both educator and parent played a significant role in providing information about HIV/AIDS. Four (10%) of grade six learners indicated that someone in the medical profession would be the source of information while a quarter of the class thought that the AIDS helpline would be helpful.

Table 4.2 Sources of HIV/AIDS Knowledge

Questions	Responses	YES	NO	UNKNOWN
Q9. My parents teach me about my body and how to take care of myself.	Grade 4	40(100%)	-	-
	Grade 5	39 (98%)	1 (2%)	-
	Grade 6	38 (95%)	2 (5%)	-
Q10. I think people suffering from HIV/AIDS should come to talk to us about their experiences.	Grade 4	37 (93%)	2 (5%)	1 (2%)
	Grade 5	36 (90%)	4 (10%)	-
	Grade 6	38 (95%)	2 (5%)	-

4.2.2.3. My parents teach me about my body and how to take care of myself.

Here the frequencies were 40 (100%) in the 9 – 10 cohort, 38 (97,5%) in the 10 -11 cohort and 38 (95%) in the 11 – 12 cohort. This shows that the parental care and nurturance was strong. Only 1 (2,5%) in the 10 – 11 cohort felt that the parent did not teach him about his body and how to take care of himself. These answers are culturally linked to the emphasis placed on family life and the role of the mother.

4.2.2.4. I think people suffering from HIV/AIDS should come to talk to us about their experiences.

In the 9 – 10 cohort 37 (92,5%) agreed with the above statement, 2 (5%) did not agree and 1 (2,5%) was uncertain. However in the 10 – 11 cohort 36 (90%) agreed while 4 (10%) felt it was not a good idea. The impression we get here is that some learners are afraid of persons suffering from HIV/AIDS. In the 11 – 12 cohort 2 (5%) of learners also answered in the negative. Learners in this age group are more mature, yet discriminatory attitudes still persist.

4.2.3. ATTITUDES OF LEARNERS

Table 4.3 Attitudes

Questions	Responses	YES	NO	UNKNOWN
Q11. Can you hug/kiss a person who is HIV-positive?	Grade 4	30 (75%)	10 (25%)	-
	Grade 5	18 (45%)	22 (55%)	-
	Grade 6	38 (95%)	2 (5%)	-
Q12. If your best friend was HIV-positive, will you still be friends with her?	Grade 4	36 (90%)	4 (10%)	-
	Grade 5	33 (83%)	7 (17%)	-
	Grade 6	39 (98%)	1 (2%)	-
Q13. One of your teachers is HIV-positive. Would you be happy to be in his/her class?	Grade 4	31 (78%)	9 (22%)	-
	Grade 5	26 (65%)	14 (35%)	-
	Grade 6	31 (78%)	9 (22%)	-
Q14. Do you feel shy/ashamed to talk about HIV/AIDS?	Grade 4	14 (35%)	26 (65%)	-
	Grade 5	16 (40%)	24 (60%)	-
	Grade 6	4 (10%)	36 (90%)	-
Q15. Do you feel shy/ashamed to talk about sexuality education?	Grade 4	21 (52%)	19 (48%)	-
	Grade 5	22 (55%)	18 (45%)	-
	Grade 6	14 (35%)	26 (65%)	-
Q16. Do you think that girls and boys should be taught separately about Sexuality Education?	Grade 4	17 (42%)	23 (58%)	-
	Grade 5	30 (75%)	10 (25%)	-
	Grade 6	24 (60%)	16 (40%)	-
Q17. If a learner is HIV-positive, has the learner the same rights to education as a HIV-negative learner?	Grade 4	32 (80%)	5 (13%)	3 (7%)
	Grade 5	36 (90%)	4 (10%)	-
	Grade 6	39 (98%)	1 (2%)	-
Q18. Your teacher/principal may not tell anybody that a learner has HIV/AIDS without asking the learner first.	Grade 4	22 (55%)	5 (13%)	13 (32%)
	Grade 5	30 (75%)	5 (13%)	5 (13%)
	Grade 6	32 (80%)	6 (15%)	2 (5%)

4.2.3.1. Can you hug/kiss a person who is HIV-positive?

The 11 – 12 cohort had the most positive attitude against infected people with 38 (95%) agreeing with the statement and only 2 (5%) disagreeing. However, in the 10 – 11 age cohort only 18 (45%) agreed with the statement while a significant 22 (55%) disagreed. In the 9 – 10 age cohort 30 (75%) agreed while 10 (25%) disagreed. This indicates that a significant number of learners still have poor attitudes against HIV-infected persons.

4.2.3.2. If your best friend was HIV-positive, will you still be friends with her?

In response to the above question the frequency was 36 (90%) for the 9 – 10 age cohort while 4 (10%) of learners did not want to associate with persons with HIV/AIDS. In the 10 – 11 age cohort 33 (82,5%) also answered positively while 7 (17,5%) learners felt negative or strongly about friends who were HIV infected. However, in the 11 – 12 age cohort 39 (97,5%) of learners showed that they would remain friends with the infected person with only 1 (2%) learner who did not. It appears that with the higher level of maturity of the learners, a more positive attitude towards HIV infected persons is shown.

4.2.3.3. One of your teachers is HIV-positive. Would you be happy to be in his/her class?

Thirty one learners (77%) in the 9 – 10 age cohort felt uncomfortable being taught by a HIV-infected educator while 9 (22.5%) did not. However, in the 10 – 11 age cohort there were 26 (65%) learners who were comfortable but a significant 14 (35%) of learners who were not happy to be taught by a HIV-infected educator. Even in the age cohort 11 – 12 years, 31 (77%) were comfortable but 9 (22.5%) learners were unhappy. Overall 87 (73%) had a positive attitude towards HIV-infected educators whereas a significant 33 (27%) of learners were not agreeable to being taught by such an educator.

4.2.3.4. Do you feel shy/ashamed to talk about HIV/AIDS?

In the cohort 9 – 10 years, 26 (65%) showed a positive response while 14 (35%) showed a negative response. The 10 – 11 year cohort also showed a positive response with 24 (60%) learners feeling comfortable learning about HIV/AIDS. However, the 11 – 12 age cohort were the most positive with 36 (90%) of learners feeling comfortable about the subject while only 4 (10%) of learners not feeling comfortable. Overall, for the one hundred and twenty learners, 86 (72%) were comfortable when learning about HIV/AIDS.

4.2.3.5. Do you feel shy/ashamed to talk about sexuality education?

The response to the above question showed approximately half, 19 (48%), of the learners felt shy to talk about sexuality education in the 9 – 10 age cohort while 21 (52%) learners did not. The 10 – 11 age cohort showed similar results with 18 (45%)

responding positively to sexuality education while 22 (55%) saying they did not feel comfortable.

Interestingly, the 11 – 12 age cohort showed better results with 26 (65%) responding positively to sexuality education while 14 (35%) were not very comfortable about the subject. Overall 64 (53%) were comfortable while 56 (47%) of the one hundred and twenty learners were not. This response clearly indicates that when one enters into discussion on the above topic, one touches the child on a personal level.

4.2.3.6. Do you think that girls and boys should be taught separately about Sexuality Education?

In the 9 – 10 age cohort, the frequency was 23 (58%) who felt that boys and girls should not be taught separately while 17 (42%) felt they should. Only 10 (25%) of grade 5 learners did not think that boys and girls should be taught separately while the majority 30 (75%) agreed that they should.

Sixteen (40%) of grade 6 learners did not agree while 24 (60%) agreed that both girls and boys could be present together. Again this shows that when one presents extremely personal topics regarding sexuality education, it would be preferable to separate the boys and girls.

Approximately 48 (40%) of the one hundred and twenty learners in the Intermediate Phase indicated that boys and girls should not be taught Sexuality Education together while approximately 72 (60%) agreed that they should. It seems that this is culturally linked and there needs to be consultations with parents before these aspects are presented to the class.

4.2.3.7. If a learner is HIV-positive, learner has the same rights to education as a HIV-negative learner.

Here the frequency was high with 32 (80%), 36 (90%) and 39 (97,5%) in the different cohorts responding with an overall 90% agreement that no child should be deprived of education since education is the basic right of every child. Here we can see that children's attitudes towards peers are positive irrespective of whether the learner is

infected or not. Five learners from grade 4, four from grade 5 and one from grade 6 did not know that every child has a right to education.

4.2.3.8. Your teacher/principal may not tell anybody that a learner has HIV/AIDS without asking the learner first.

Though this was an open-ended question, the learners answered with a 'yes' or 'no' or 'did not know' answer. Some of them clarified their responses. The learners felt that it was discriminatory and would hurt the person's feelings.

In the 9 – 10 year age cohort 22 (55%) said yes while 5 (13%) answered no. however, a significant number 13 (32%) were unsure about their rights as learners. In the 10 – 11 age cohort 30 (75%) answered in the affirmative while 5 (13%) indicated negatively with another 5 (12%) who did not know. In the 11 – 12 age cohort 32 (80%) learners agreed with the statement while 6 (15%) disagreed and 2 (5%) of learners left the question unanswered.

4.2.4. MYTHS AND MISCONCEPTIONS REGARDING HIV/AIDS

Table 4.4 Myths/Misconceptions

Questions	Responses	YES	NO	UNKNOWN
Q19. Do you think that HIV/AIDS is a punishment from God?	Grade 4	4 (10%)	33 (83%)	3 (7%)
	Grade 5	8 (20%)	32 (80%)	-
	Grade 6	12 (30%)	28 (70%)	-
Q20. Do you think that only gay people get HIV/AIDS?	Grade 4	6 (15%)	34 (85%)	-
	Grade 5	-	40(100%)	-
	Grade 6	1 (2%)	39 (98%)	-

4.2.4.1. Do you think that HIV/AIDS is a punishment from God?

In response to the above question and in order to find out if learners have any myths or misconceptions about HIV/AIDS, the above question elicited interesting results.

The 9 – 10 age cohort responded with a 34 (85%) negative response with only 4 (10%) of learners indicating that they thought it was a punishment from God. However 3 (8%) did not answer or wrote "I do not know."

In the 10 – 11 age cohort 32 (80%) of learners indicated that it was not a punishment from God while 8 (20%) regarded it as a punishment. In the 11 – 12 age cohort 28 (70%) also responded in the negative and a significant number 12 (30%) believe that it is a punishment from God.

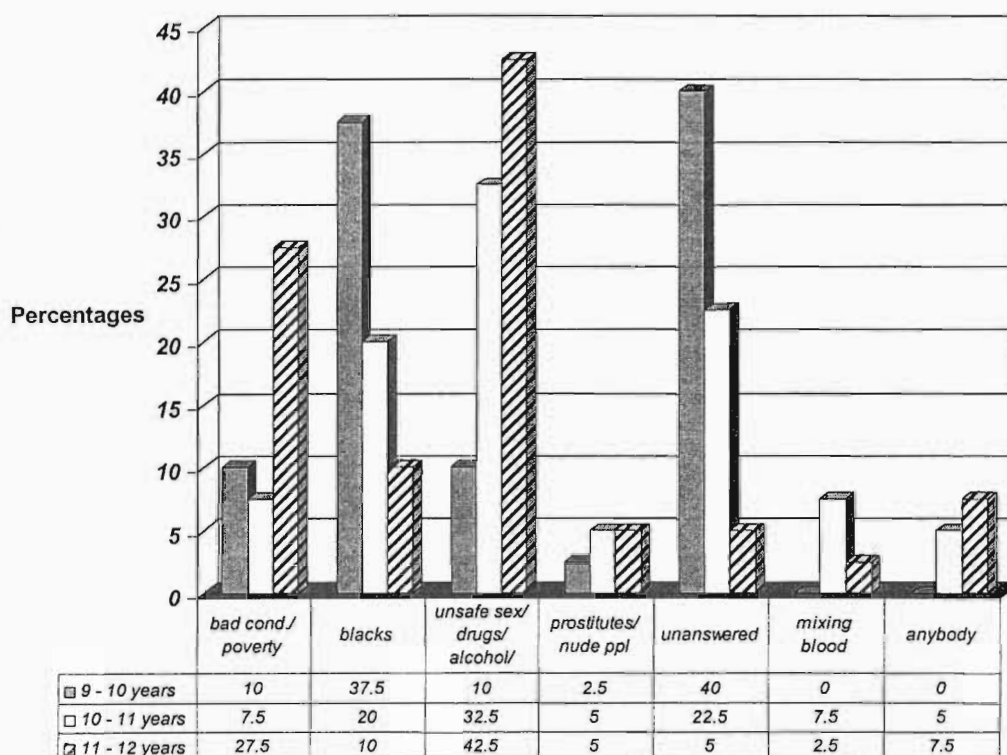
Overall about 24 (20%) of the one hundred and twenty learners in the Intermediate Phase indicated that it was a punishment from God. This can be linked to the cultural and religious beliefs of the learners. The cultural and religious beliefs of the Life Orientation educators in the grades five and six have also influenced the learners' responses.

4.2.4.2. Do you think that only gay people get HIV/AIDS?

The frequency to this question was 34 (85%) in the 9 – 10 age cohort, 40 (100%) in the 10 – 11 age cohort and 39 (97,5%) in the 11 – 12 age cohort who said no. Overall the frequency was a high 113 (94%). This shows that the learners' awareness is high and they do not feel that only gay people are affected by HIV/AIDS. It shows that learners do not discriminate against homosexuals. However, in the 9 – 10 age cohort 6 (15%) believed that HIV was contracted by gay people. This shows misinformation which has caused the prejudice against a certain group of people. In the 10 – 11 age cohort there were no learners who believed it, while in the 11 -12 group only one learner who believed that only gay people get HIV/AIDS.

4.2.4.3. Who are the people most likely to get HIV/AIDS?

Figure 4.6 Graphical representation of learners' responses to question concerning the most likely victims of HIV/AIDS



This was an open-ended question which elicited varied responses from the learners. The dominant themes that emerged were people living in bad conditions (shacks) and poverty, blacks, unsafe sex, use of drugs, prostitutes and nude people, unanswered, the mixing of blood when getting hurt or cut and anybody.

In the 9 – 10 age cohort, four (10%) of learners indicated that people living in poor conditions are most likely to get AIDS while a significant number 15 (38%) indicated that blacks were most likely to get HIV/AIDS. People who indulge in unsafe sex and use drugs was regarded by 4 (10%) of the learners as the most likely to get HIV/AIDS, while 1 learner indicated that prostitutes are most susceptible. A significant number 16 (40%) left the question unanswered. It seems that a lack of knowledge and awareness makes the learners feel that HIV/AIDS does not happen in their own community but happens to other people in other communities.

In the 10 -11 age cohort 3 (7.5%) of learners regarded poor living conditions the cause of HIV/AIDS with 8 (20%) believing that only blacks get HIV/AIDS. Unsafe sex and the use of drugs was the response of 13 (32.5%) of the grade 5 learners while 2 (5%) felt that prostitutes were most likely to get it. Nine (22.5%) did not answer the question while 3 (7.5%) felt that when there is a mixing of blood people get HIV/AIDS. Only 2 (5%) responded positively that HIV/AIDS can be contracted by anybody.

In the 11 – 12 age cohort 11 (27.5%) of learners again felt that people who live in poor conditions were most likely to get HIV/AIDS. Four (10%) of sixth graders also thought that only blacks get HIV/AIDS while a significant number 17 (42.5%) responded by saying that people who indulge in unsafe sex or people who use drugs or infected needles are most likely to get HIV/AIDS. However, 2 (5%) indicated that prostitutes could also get infected with 2 (5%) of learners leaving the question unanswered. One learner (2%) indicated that people who are HIV-infected can pass the virus through mixing of blood. Only 3 (7.5%) of learners responded without any prejudice and stated that anybody could get HIV/AIDS.

These answers clearly illustrate that many myths about HIV/AIDS are still prevalent in the school community as well as the community at large.

4.3. SUMMARY OF FINDINGS FROM QUESTIONNAIRE (PART ONE)

This chapter focussed on the responses of the learners to the questionnaire that embodied a mix of open-ended and closed questions relating to their level of knowledge and their attitudes regarding HIV/AIDS and explored some of the myths and prejudices that are still prevalent today. It also examined respondents' sources of information about HIV/AIDS. The main findings are summarized under the following headings: basic knowledge about HIV/AIDS; pedagogy; peer education and role-models.

4.3.1. BASIC KNOWLEDGE ABOUT HIV/AIDS

The responses of the learners in the 9-10 cohort indicate that these learners have a poorer understanding of HIV/AIDS than the other two groups. This can be attributed to the fact that they did not have any formal lessons on HIV/AIDS in the current year.

Much of their knowledge about HIV/AIDS is derived from other sources such as the media. Three of the educators admitted to having a very basic knowledge. From the interviews with the educators it is clearly evident that there is a need for more workshops to capacitate the educators and drive HIV/AIDS education forward. This study has shown that the educators who have undergone skills- training on HIV/AIDS DOE workshops or at workshops held at school have implemented the Life-skills programme quite effectively and it impacted positively on the learners.

Though the knowledge and awareness level of the Intermediate Phase learners increased with the level of their maturity from nine to twelve years, learners who have been deprived of HIV/AIDS education cannot be overlooked. The gaps in the learners' knowledge represent missed opportunities to guide and equip learners in the fight against HIV/AIDS.

4.3.2. PEDAGOGY

One of the basic principles underlying OBE is that children learn best when they are actively involved. By unobtrusive observation when visiting a Life-skills educator who was conducting a lesson on HIV/AIDS, it was noted that the learners were involved in play-acting showing how discrimination can affect people infected by the virus. The results in this study revealed that 17(43%) of learners felt that HIV/AIDS knowledge helped them to have a positive attitude and thereby help those that are infected.

4.3.3. PEER EDUCATION AND ROLE-MODELS

It was also significant that three learners in the 9-10 age group (the group that had not received any formal lessons on HIV/AIDS for the current year) indicated that they had learnt about HIV/AIDS from a girl who had read a story to them in class. The importance of peer education cannot be underestimated. In the pre-puberty stage of development, that is, in the Intermediate Phase, peers are frequently used as role-models. According to Erikson (1965) cited in Papalia & Olds (1988), the fourth crisis of psychosocial development occurs in middle childhood between the ages of ten and thirteen. Children must learn the skills of their culture, either in school or from adults or older children. Kolberg (1982) maintains that learners in the ages 10-13 now want to please other people and they observe the standards of others and internalise it to

some extent. They thus model their behaviour on adults or significant others (educator or peer). This is evident from the responses to the question:

My parents teach me about my body and how to care for myself.

The majority of the learners gave affirmation to the statement showing that the parent as a nurturing role-model is the person the learners turn to in this age group. This finding also indicates that culturally there are strong links between the parents and children in the community.

The findings in this study also established that out of one hundred and twenty learners 27 (22.5%) indicated that the educator was the person too who they could turn to on matters pertaining to HIV/AIDS and less than one third, 27.5%, would approach the parent/educator for help. The findings in this study established that out of one hundred and twenty learners 27 (22.5%) indicated that the educator was the person too who they could turn to on matters pertaining to HIV/AIDS and less than one third, 27.5%, would approach the parent/educator for help. These were the highest frequencies for the question and again reflect the powerful influence of significant caring adults who speak the same language.

During the Intermediate Phase, the process of clarifying values should be repeated as often as possible and should be related to concrete situations. Children in this phase are concerned about issues of justice as seen in the response to the question:

Your teacher/principal may not tell anybody that the learner has HIV, without asking the learner first.

Ninety four learners out of one hundred and twenty (78%) agreed with the statement and clarified their answer with the following statements:

- He would feel bad/hurt
- People won't want to be his friend
- They would treat him like dirt
- People won't keep it private

These responses not only show the values of the learners but their level of compassion for an infected person. It further illustrates that if HIV/AIDS education is presented

properly, the next generation of learners could have the correct attitudes about HIV prevention and about living socially with infected individuals. These were the highest frequencies for the question and again reflect the powerful influence of significant caring adults who speak the same language.

4.4. CONCLUSION

This concludes Part One of the data analysis of the questionnaire.

The following section (Part Two) of the report verifies the data obtained by means of the questionnaire and is used to triangulate the data produced in the interviews of the Life-skills educators and the school manager.

CHAPTER 4

4.5. PART TWO: ANALYSES OF INTERVIEWS

4.5.1. INTRODUCTION

This section intends to present and analyze the results of the interviews of the Life-skills educators in the Intermediate Phase. By analyzing the data from the four interviews, it would also be used as a means of validating the responses of the learners which were elicited by means of the questionnaire. The main purpose of administering the interviews was to capture the educators' concerns about HIV/AIDS education and to gain insights into their learners' responses as it was used as a method of triangulation. The interviews answered the second critical question.

4.5.2. ANALYSIS OF INTERVIEWS

The purpose of the interviews was to elicit responses to the second critical question:

What is the level of knowledge and understanding of HIV/AIDS education of the Life-skills educators in the Intermediate Phase?

The data was categorized according to the dominant themes that emerged from the interviews, namely, knowledge and understanding, sexuality education, pedagogy, educators' prejudices, learner support/resource materials, training of educators and cultural/religious aspects.

4.5.2.1. Knowledge and Understanding

In response to their knowledge about HIV/AIDS, both Omar and Perumal indicated that they had very basic knowledge while Ayesha maintained that as she had attended a HIV/AIDS skills workshop in the previous year (2002), she felt competent. Ismail's response was that because of his Biology background and orientation in the Natural Sciences, he had theoretical knowledge. Perumal further clarified his statement saying that he had no formal training regarding HIV/AIDS, since his knowledge was derived from the media and discussion with peers.

4.5.2.2. Sexuality Education

The question: "What is your understanding of Sexuality Education?" elicited the following responses:

- Perumal: *I would say teaching children how AIDS is sexually transmitted ...and it is something new if I have to teach them about sex.*
- Ayesha: *Teaching them about different bodily changes, nature of sex and development through to human beings... looking at it from educational perspectives.*
- Ismail: *... being from a strong religious background ... training the individual to be responsible about sex.
In every culture and religion there are certain guidelines such as no sex before marriage.
... when we speak about sexuality education, the child/learner has to be conscientized.
... if we go beyond the bounds of marriage, we'll be running a higher risk of contracting the disease.*
- Omar: *I have some difficulty so I try to neutralize the terms that I use. In the past we have had it separate for boys and girls.*

All three educators stressed the need for training. Perumal felt uncomfortable when posed the question and it was apparent that he was unaware of the National Policy (1999) which stated that HIV/AIDS education must be 'age appropriate'. Furthermore, Perumal was not aware that sexuality education was different from sex education. The learners in grade four are coming from the foundation phase where topics such as family relationships; issues regarding friends; liking, respecting, caring for and protecting their bodies; protecting against child abuse should have been focussed on (Vernani & Palmer, 1998).

Learners in the Intermediate Phase receive many confusing messages regarding sexual issues that it becomes difficult for them to make decisions. The aim of sexuality education is also to teach values and assist learners to understand and to clarify what they believe in. It is important that that sexuality education is done since learners should be guided through knowledge to understand and internalise core/common values in order to make responsible decisions about sexuality.

These findings resonate with the findings of the CMEC-Aids Survey (2000) which claims that educators are not covering some topics thoroughly.

4.5.2.3. Pedagogy

When asked if the educator felt competent to teach the learners about HIV/AIDS, the following responses were given:

- Perumal: *On teaching the topic I'll be uncomfortable... in my culture we don't talk about sex ... very uncomfortable especially in an Islamic school... I'm very hesitant.*
- Ayesha: *Very comfortable and very competent.*
- Ismail: *I start with the disease and virus as a starting point... how the virus causes the disease AIDS – children have misconceptions, it is the same thing... then I move to the social implications.*
- Omar: *... definitely we need guidance on how to present it. I have taught it to the grade six learners.
... learners are on the brink of puberty and they need to know – and some have attained puberty.*

The grade five educator, Ayesha, feels competent and comfortable in teaching the learners about HIV/AIDS because of the training she received in 2002, whereas the other three educators stress the need for training on the dissemination of HIV/AIDS knowledge, because of the sensitive nature of the content. Perumal's responses reflect his concerns that teaching content and activities may conflict with community, cultural and religious practices, norms and values.

On teaching and learning the grade four Life-skills educator, Perumal admitted that he had not attempted to teach the subject. The school has an Islamic ethos and because he comes from a different religious background, he was apprehensive about presenting the subject to the learners. He stated that he would therefore ask a Muslim teacher to assist him or ask him/her to teach the topic.

The DOE Policy states clearly because of the sensitive nature of the learning content, the educator selected to offer this education should be specifically trained and supported by the support staff responsible for Life-skills and HIV/AIDS education in the school and province. Furthermore, the educator should feel at ease with the content and should be a role model to whom the learners could easily identify. Children in the primary school look to the educator as a role model. Though the educator is not of the same religious background, this would not matter but it would be preferable if an educator of the same religious faith would be the one to teach the

subject. Social learning theorists such as Bandura (1986) consider identification a result of copying a model who may be a parent, teacher or celebrity. Thus a competent model should be available since children choose their models largely on the basis of two main characteristics – power and nurturance (Bandura & Huston, 1961).

4.5.2.4. Educators' prejudices

All the respondents show that they have their own misconceptions regarding HIV/AIDS, as can be seen from their responses:

- Perumal: *To be honest with you, no, I do not have any prejudices.
AIDS is not prevalent among my culture as it is among other cultures.*
- Ayesha: *Yes, it is a homosexual disease and I believe that if you are not following God's natural order of things, then you contract the disease.
It is a punishment from God.*
- Ismail: *From a religious and cultural point of view there must be no sex before marriage.*
- Omar: *Almighty has set certain guidelines for man to live by ... once you follow the guidelines then you're okay, but as soon as you transgress these guidelines then you have problems.
I see AIDS... and the spread of AIDS as man's own problem as he transgressed these guidelines given by the Almighty.*

It is important that educators do not impose their values and views on learners, but should guide them to develop their own attitudes and values with regard to what is right and wrong. However, from the responses of the learner questionnaire, it is evident that learners also have similar misconceptions about HIV/AIDS. It seems that some of the value judgements of the educators have impinged on the values of the learners.

The DOE Policy of HIV/AIDS states clearly:

Parent of learners and students must be informed about all Life-skills and HIV/AIDS education offered at the school or institution, the learning content and methodology to be used as well as values to be imparted. They should be invited to participate in parental guidance sessions and should be made aware of the role of sexuality education and importers of values at home.

4.5.2.5. HIV/AIDS Policy

The educators were asked about the HIV/AIDS Policy. All four educators indicated that the HIV/AIDS Policy was very important and it would be what gives impetus to the teaching and learning of HIV/AIDS education.

When asked about the National DOE policy on HIV/AIDS, three of the four educators replied that they knew about it, but were not too familiar with the contents. The manager felt that it was not too loaded because the information was meant for the educators. Only Ayesha who had attended the HIV/AIDS Life-skills workshop indicated that she had extensive knowledge of it.

On teaching and learning materials, one educator said there were some materials available while two educators indicated that there was a need for more teaching resources.

4.5.2.6. Learner Support

It was apparent from all the responses that there were no known cases of HIV/AIDS in the school. However, all agreed that should there be a child who is infected, there was a need to support the child by contacting the parent/guardians and putting them in touch with organisations that could help them. Ismail and Omar named an orphanage where orphans could go for help, while Perumal did not know of any such organisations.

On ways to help learners infected/affected by HIV/AIDS, Perumal suggested that the school set up a resource centre regarding the HIV/AIDS education while Ismail indicated that responsible adults need to be aware of the child's condition, because AIDS is not only a sexually transmitted disease but can be contracted from the blood or injury of another child.

4.5.2.7. Training of Educators

From the responses of the educators it is evident that all the educators except one were reluctant to teach the learners about sexuality education. The National DOE Policy on HIV/AIDS (1999) clearly states that in the primary school the regular

educator should provide education about HIV/AIDS, while in the secondary grades, the guidance counsellor would ideally be the appropriate educator.

Because HIV/AIDS is mainly spread through sexual contact, HIV/AIDS education should always be presented in the context of sexuality education. The content of sexuality education is different from any other content presented at school since as soon as one moves into the area of sexuality education, one is touching the learner personally. All three educators who did not undergo HIV/AIDS skills training held by the DOE expressed concerns about sexuality education which they felt required a special approach. From the analysis of the data, it is evident that Perumal's reluctance to teach HIV/AIDS education to the grade four learners is as a result of lack of training as well as his own prejudices due to his ignorance about HIV/AIDS. Furthermore, when the educator comes from a different religious background as the majority of the learners, the situation is further exacerbated due to fear of reprisals from parents. Though the DOE policy states that HIV/AIDS education must be "age appropriate," the highly personal and sensitive nature of the content shows that there is an urgent need for capacity building and skills-training of all primary school educators, and not only those who are teaching in the Intermediate Phase.

Results have also shown that overall only 25% of learners in the Intermediate Phase are getting their information on HIV/AIDS from the school while the media (TV/radio) is playing a greater role in dissemination of HIV/AIDS knowledge and awareness. It seems that the school is falling short. In the 9-10 age group only 6(15%) learners had indicated that the school was their primary source of information. However, the results from the grade five and six learners established that when HIV/AIDS education is presented effectively, the frequency rose to 33 (82.5%) and 34 (85%) respectively. This shows that education in school is crucial and currently an essential element in society's armoury against HIV transmission. The most effective vaccine against HIV/AIDS is definitely the "education vaccine."

4.5.2.8. Cultural/Religious Aspects

The responses of the interviewees (Life-skills educators) indicate that sexuality education should not be presented to learners in the 9-10 age group since they are too young, yet from the responses of the learners, albeit confused, show that many

learners are aware of HIV transmission. Though they are only nine year olds, the enormity of HIV/AIDS has struck home. Furthermore, this study has shown that the electronic media (radio/TV) has made a big impact in its awareness campaigns. Furthermore, of the one hundred and twenty responses, a significant percentage advocated the use of condoms for protection. This shows that many of the children from this religious background have more in common with children throughout the world. In spite of the adults view (both Ismail and Omar's views about sex within the bounds of marriage), learners have different views.

4.6. SUMMARY OF EDUCATORS' INTERVIEWS

Standing out profoundly in these responses are that all educators are not trained to disseminate HIV/AIDS education to Intermediate Phase learners. Educators' responses suggest that they do not feel equipped to teach the learners, especially on sensitive issues such as sexuality education and cultural values, which may be in conflict with the educators' own values. They are also faced with problems of unavailability of resources needed in classrooms and of greater concern is that some of them are not aware of the National Policy on HIV/AIDS. Furthermore, there is a need for all stakeholders (school governors, school managers, parents and educators) to give effect to the policy. According to the TIRISANO document, HIV/AIDS education is mandatory in all schools in South Africa but data obtained in this study suggest that the media (TV /radio) is more effective in disseminating knowledge and awareness about HIV/AIDS.

4.7. CONCLUSION

Much more needs to be done by educational institutions to counteract the effects of the HIV/AIDS pandemic.

Part Three follows with the responses and discussion from the school management.

CHAPTER 4

4.8. PART THREE: Management Response

4.8.1. INTERVIEW WITH OMAR

The interview with Omar, the school manager, was also used to expand on and validate the responses of the educators and answered the following critical question:

How is HIV/AIDS education managed in the Intermediate Phase in a school?

Discussion from the interview has resulted in the following dominant themes emerging from the data: curriculum responses, workshops and training, school policy on HIV/AIDS, and parental/community involvement.

4.8.1.1. Curriculum responses

On integration of HIV/AIDS across the curriculum, the manager admitted that this was not being done and there was a need to present the different aspects about AIDS education in other learning areas. He explained that HIV/AIDS education should thus not be confined to the Arts and Culture or Life Orientation lessons but could be included in subject areas like Human and Social Sciences.

On support from the management, Perumal responded that there was none, while Ayesha gave the comment: “Non-committal.” This comment speaks volumes since she had attended the DOE Life-skills workshop. It validates what the manager stated: “Ayesha had spoken of having a school policy on HIV/AIDS.” However this was not translated into action. The manager, Omar, represents a very vital link between the school and the community at large. Besides being a Life-skills educator and a school manager, he is also a member of the SGB (school governing body) and a religious leader in the community.

4.8.1.2. Workshops and training

Only one educator out of the four had attended the DOE Life-skills workshop on HIV/AIDS conducted by the department. Two others had attended a workshop presented at school by a religious organisation. However, Perumal was the one who had not attended any and therefore he was very apprehensive about teaching the grade four learners about HIV/AIDS.

To date, the grade four learners had had no instruction on HIV/AIDS for the current year. Gaps in teaching and learning represent missed opportunities in consolidating knowledge and changing behaviours regarding HIV/AIDS. This is apparent when the educator admits that he is not equipped to teach the learners about HIV/AIDS because of lack of training.

The manager agreed that there was a need to work together and there was a need for Life-skills educators to attend workshops to equip themselves with the knowledge about HIV/AIDS since “knowledge is a weapon.”

4.8.1.3. School Policy on HIV/AIDS

Omar admitted that there was a need to draw up a school policy on HIV/AIDS which would then give impetus to HIV/AIDS education at the school. The manager when asked about the school policy on HIV/AIDS remarked that he was reminded of it by the Life-skills educator, Ayesha, at one of the learning area meetings but the school had not drawn up a policy as yet. The same sentiments were echoed by the other educators when asked about the TIRISANO Policy.

The DOE Policy also states that within the terms of its functions under the South African Schools Act (1996) the governing body of a school may develop and adopt its own implementation plan to give operational effect to the national policy. This should act as a catalyst to drive the campaign forward and bring all parents in the community on board so that they are aware of what is being done to counter the effects of the HIV/AIDS pandemic in KwaZulu Natal. The policy further states that major role players in the wider school or institution such as religious and traditional leaders and representatives of the medical or health care professionals should be involved in developing an implementation plan for the school or institution.

The importance of parental involvement in family and community level approaches to HIV prevention cannot be underestimated since much of the beliefs about HIV and AIDS are embedded in the cultures of communities. This partnership needs to be developed in order to make the most impact and encourage behavioural changes since educational programmes must address the personal and cultural issues that motivate individual behaviour. Some parents may resist HIV/AIDS education programmes

because sex is a taboo subject in most homes and adults believe that children in the primary school do not need to know about “adult stuff.” Parents need to know how sexuality education is being addressed at primary school level. Some parents may feel that it is too early or not the responsibility of the educator but of the parent (Educational Innovation, 2002). These issues need to be spoken about at a forum where the managers and Life-skills educators can communicate their feelings on HIV/AIDS education.

4.8.1.4. Parental/community involvement

Omar’s response relating to the question about parental support was that “the governing body had discussed it, but nothing practical has been done about it.” This clearly illustrates the need for the establishment of a coalition of partners that involves the various stakeholders, that is, the parents, community leaders and health professionals. The SGB should liaise between the management and parents since educators need the support of parents and communities and the assurance that they approve of the contents and methods of what they teach. They do not want to be in uneasy conflict with them or with their cultural or religious perceptions. The reasons for this are two-fold:

Parents will make what is incorporated in HIV/AIDS education more real and relevant to life outside of school and secondly to ensure that everybody speaks with one voice, no matter what its source, since the message to the young is always the same.

The need for a partnership would also empower the community since much of the problems in society are endemic. Educators cannot take the place of parents in the community or impose their own values on what is right or wrong, but should rather assist learners to interpret, discuss and understand messages, values and attitudes that have been brought from home, culture and communities (Louw, 1994; Vergani & Frank, 1998).

4.9. SUMMARY OF FINDINGS: MANAGEMENT RESPONSES

Though much has been done at national, departmental and school levels, much still needs to be done at management level to give effect to policies which give the

impetus to drive the Life-skills education programme forward. Though school managers are proactive in managing schools, when it comes to Life-skills education, there seems to be hesitation and vacillation on the part of the DOE, the school and governors in making HIV/AIDS education the top priority. As can be seen from this report, there are grave problems in the implementation of the policies at grassroots level. This lack must be addressed urgently and systematically, especially by managers and leaders since their silence and denial at various levels is at the expense of the countless lives that are being lost every day.

4.10. CONCLUSION

Part One of this chapter presented a detailed analysis of the learners' understanding of HIV/AIDS in the Intermediate Phase. It provided some insights into their knowledge and uncertainties, attitudes and values, sources of information and myths and misconceptions surrounding HIV and AIDS. It also confirms that when HIV/AIDS Life-skills programmes are effectively implemented, positive changes can and will occur. Education can be an effective "vaccine" in the fight against HIV/AIDS.

Part Two presented an analysis of the key findings of the educators' interviews which highlighted the complex nature of HIV/AIDS education and which have led to a somewhat restrained response from certain Life-skills educators.

Part Three presented the interview responses of the school manager and indicated that when HIV/AIDS education is not adequately managed, it impacts on both the educators' performance in the classroom as well as the learners' understanding of HIV/AIDS.

In the next chapter, a brief synopsis of the findings will be presented, followed by the recommendations, implications for future research and the conclusion.

CHAPTER FIVE

REFLECTIONS AND CONCLUSION OF STUDY

5.1. INTRODUCTION

Discussion pertaining to the findings of the study was presented in the previous chapter. This chapter will give a brief summary of the present study and provide some recommendations regarding HIV/AIDS education in the primary school. This study also has implications for further research. A brief conclusion will be provided.

5.2. LEARNINGS FROM THE STUDY

Overall the sample exhibited average to good knowledge of HIV/AIDS though there are areas of concern as in the evidence provided by the grade four learners. While this is a start, and filled the researcher with some optimism for the future, more is required in the way of appropriate education to increase the levels of knowledge and awareness in the primary school. Whilst knowledge provides a base on which to build HIV/AIDS awareness and change in behaviour, it is not alone adequate to bring about change in behaviour. Changes in beliefs and increased awareness of personal risk to HIV/AIDS and attitude change are necessary. The positive responses of the learners' attitudes need to be enhanced to facilitate the adoption of health-promoting behaviour.

Regarding the educators' knowledge and perceptions of HIV/AIDS education, it would be advisable that future education efforts take their thoughts into account. With regards to management of the life-skills HIV/AIDS programme, a focussed school policy which is mandatory should be put into place to give impetus to the deliverance of the HIV/AIDS life-skills programme. Various domains of information provision such as communal bodies, religious groups and parents can facilitate school-based education programmes. Once support is garnered from these sources, optimal intake of information would be facilitated, which will hopefully lead to health-behaviour adoption and a slowing down of HIV/AIDS.

In the light of the above the following recommendations are being made.

5.3. RECOMMENDATIONS

The findings of this study confirm that Life-skills educators need ongoing training, support and guidance to be effective in the classroom. Training of all educators must be given top priority by skilled life orientation practitioners rather than by trained facilitators.

Educators need to learn additional skills, instructional methods and perhaps change some of their old ways of teaching in order to effectively deliver AIDS education using many different channels. Both learners and educators could be utilised in the design and implementation of HIV/AIDS education learning programmes and by fostering the development of learning support materials. This would encourage both educators and learners to assume ownership of the Life-skills and HIV/AIDS programmes. Resource materials must be made available to all learners to complement the Life-skills HIV/AIDS programmes currently being used in schools. The silence and misconceptions about HIV and AIDS could be addressed by bringing in HIV-infected persons to give talks to learners and educators.

Sexuality education must be specifically addressed in the context of the cultural and traditional norms and values of the communities in which the schools are situated. It is therefore imperative that all stakeholders should be involved in HIV/AIDS education. Collaborative efforts by the educators, school management teams (SMT), and school governing body (SGB) should give impetus to the programmes in schools. The SMT and SGB must be work-shopped and trained to provide the support required to implement the life-skills curriculum effectively.

Community based organisations such as non-governmental organisations, cultural societies, religious groups, medical workers and teacher unions can also provide support, information and practical assistance to schools on HIV/AIDS prevention.

5.4. IMPLICATIONS FOR FURTHER RESEARCH

As a consequence of this study, two areas need further investigation:

In HIV/AIDS education, the format of teaching should be taken into account. Teaching strategies employed to disseminate HIV/AIDS knowledge and awareness about risk factors and preventative measures will stimulate attitudinal changes such as

avoidance of risky behaviour, practising decision-making skills, and communication skills including assertive skills training. These skills should foster a positive self-concept and the adoption of safe sex practices in the future.

A longitudinal study could be undertaken on the present sample of learners over a period of two or three years. The findings of this study can serve to form the basis of future evaluation of changes in the level of knowledge, awareness and attitude change.

Finally, this study was conducted in an English medium public school and as such can be replicated in any other primary school/s to investigate how HIV/AIDS education is fostered since each school has its own cultural boundaries.

5.5. CONCLUSION

Reaching out to all children and young people represent our “window of opportunity” since to enable them to protect themselves from HIV-infection is at the core of reducing risk and promoting healthy development. Since schools reach further into communities than any other institution, HIV/AIDS prevention efforts delivered through schools are an important vehicle for reaching and enabling children and young people to protect themselves. As long as no vaccine exists and treatments are unaffordable, education is the most effective strategy. Time and ignorance are the real enemies in the fight against HIV/AIDS.

We invest heavily in the multilevel preparation of teachers of mathematics, science and literacy subject areas that prepare children for *life*, we must invest in the multilevel preparation of educators for HIV/AIDS and Life-skills that enhance the likelihood that young people will *live*.

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APPENDIX A
SEMI-STRUCTURED INTERVIEW SCHEDULE: DEPUTY PRINCIPAL

Topic: Fostering an Awareness of HIV/AIDS in the Intermediate Phase in the Primary School

Section One:

Biographical Details:

1. Name of School:
2. Gender:
3. Age:
4. Qualifications:
5. Total number of years in teaching:
6. Areas of specialisation:

Section Two:

1. Personal Knowledge of HIV/AIDS:

- 1.1. What is your personal knowledge about HIV/AIDS?
- 1.2. What is your most memorable/significant moments in your experience of HIV/AIDS?
- 1.3. What are the feelings
- 1.4. Have you attended workshops on HIV/AIDS?

2. The HIV/AIDS Policy:

- 2.1. Have you seen the Department of Education Policy on HIV/AIDS?
- 2.2. Do you think that the Departmental Policy is addressing the issue of HIV/AIDS adequately, or is the policy too loaded?

In the Policy (probe)

- 2.3. Are you familiar with TIRISANO and its underlying principles?
- 2.4. Has the school a policy on HIV/AIDS?

2.5. Why do you think it is important to have one?

3. Workshops:

3.1. How important is it to you that the Life-skills educators attend workshops on HIV/AIDS regularly?

3.2. When was the last time that Life-skills educators attended workshops on HIV/AIDS?

3.3. How many educators in your school have attended departmental workshops regarding HIV/AIDS?

Have the educators attended HIV/AIDS workshop held by other organizations
– Give details.

4. Implementation:

4.1. Is the HIV/AIDS Life-skills programme an ongoing programme in your school?

4.2. Is there integration of HIV/AIDS with other learning areas of the curriculum?

4.3. Sexuality education is part of the HIV/AIDS Life-skills programme. How does the educator handle this aspect of the programme?

4.4. Do you think that sexuality education as part of the HIV/AIDS programme should be addressed at Primary School level?

4.5. If yes, why?

If no, why not?

Learner Infection:

4.6. Have you any knowledge of learners who are HIV-positive in your school?

4.7. Are there any identifiable cases?

4.8. How does your school support learners who are affected/infected by HIV/AIDS?

4.9. Are there any HIV/AIDS orphans in your school and how are they supported by the school?

5. SGB/Networking:

5.1. How is the SGB facing the challenge of HIV/AIDS education in your school?

5.2. What is being done about HIV/AIDS in your school community?

- 5.3. What are the views of parents with regard to Sexuality Education being part of the Life-skills programme?
- 5.4. Did you have a special form/meeting where Sexuality Education was discussed with the parents?
- 5.5. If yes, what kind of feedback did you get from your parents?
- 5.6. Are there any organizations who are working with your school to assist learners/parents who are affected/infected by HIV/AIDS?
- 5.7. If YES, name the organisation.

APPENDIX B
SAMPLE TRANSCRIPT SEMI-STRUCTURED INTERVIEW: DEPUTY PRINCIPAL

Topic: Fostering an Awareness of HIV/AIDS in the Intermediate Phase in the Primary School

Section One:

Biographical Details:

1. Name of School: *MOD Primary School*
2. Name of Manager: *Omar (Deputy Principal)*
3. Gender: *Male*
4. Age: *42*
5. Qualifications: *BA, UHDE, B.Ed*
6. Total number of years in teaching: *20 years*
7. Areas of specialisation: *History and Afrikaans*

Section Two:

1. Personal Knowledge of HIV/AIDS:

1.1. What is your personal knowledge about HIV/AIDS?

Basically what those acronyms stand for, and how it is transmitted.

1.2. What are your most memorable/significant moments in your experience of HIV/AIDS?

No. I haven't met a person suffering from HIV or contracting the AIDS virus. I think the only first experience that I had of AIDS is when we had that course done in school. The HIV/AIDS course that Mrs Khan came as a facilitator and then I had to also do after that the Grade 7 HIV/AIDS programme with the boys. That was my, I'd say, first exposure to HIV/AIDS.

1.3. What are the feelings about HIV/AIDS?

I think that, you know, firstly I really sympathize with those who have got HIV/AIDS. However, generally when I look at the world, you know, Almighty has kept, naturally, certain guidelines for man to live by. Now notice, once you follow these guidelines then you're ok but as soon as you transgress the guidelines, then we land in difficulties and problems. I see AIDS, the spread of AIDS as, I mean man's own problem as he transgressed those guidelines as given by the Almighty.

1.4. Have you attended workshops on HIV/AIDS?

Yes

2. The HIV/AIDS Policy:

2.1. Have you seen the Department of Education Policy on HIV/AIDS?

Yes, I have seen it.

2.2. Do you think that the Departmental Policy is addressing the issue of HIV/AIDS adequately, or is the policy too loaded?

I think here and there it can be simplified, but obviously this is a guide for educators. So I read through it and I think it was fairly simple and easy to understand so I don't think it was loaded. It is clear for the teachers. It should be simplified for learners.

2.3. Are you familiar with TIRISANO and its underlying principles?

*Working with the community and parents etc.? Yes.
To be honest, you know, I know about it briefly but I haven't studied in-depth etc. so I haven't, I'd say no.*

2.4. Has the school a policy on HIV/AIDS?

No – in fact in our last AC/LO meeting I think Ayesha brought that up. I think we need to draw up a policy on AIDS and HIV, as we don't have a policy as such.

2.5. Why do you think it is important to have one?

I think so you need that. It is important to have one so that you know what to teach the learners, which are the things they shouldn't tread upon, guidelines. So that it's important to have one. Important to have direction and how to present it.

3. Workshops:

3.1. How important is it to you that the Life-skills educators attend workshops on HIV/AIDS regularly?

I think it's very important because I mean like Thabo Mbeki said in his speech, "we all need to work together" and knowledge is a weapon. I think Life skills educators need to regularly attend workshops to update themselves etc., so I think it is important. Learning is ongoing so you need to equip yourself with knowledge of these things.

3.2. When was the last time that Life-skills educators attended workshops on HIV/AIDS?

I remember that Ayesha attended one last year and she brought some material back from there.

- 3.3. How many educators in your school have attended departmental workshops regarding HIV/AIDS?

Two educators .Ayesha and the principal

Have the educators attended HIV/AIDS workshop held by other organizations – Give details.

No – not that I'm aware of.

4. Implementation:

- 4.1. Is the HIV/AIDS Life-skills programme an ongoing programme in your school?

No. We are covering the topic this term in the grade fives and sixes.

- 4.2. Is there integration of HIV/AIDS with other learning areas of the curriculum?

I don't know how I'll be able to answer that. Whenever we do AC/LO I suppose. I don't know if the other educators are doing that so I'm not sure so I can't answer that one. Yes it must cross the other learning areas. I'm not aware if it's being done. Because I think with HIV/AIDS, basically from any learning area you can present the different aspects of it. So it's important, it should not only be confined to AC/LO but the languages, HSS. It impacts on all those learning areas but whether it's being done, that I can't answer.

- 4.3. Sexuality education is part of the HIV/AIDS Life-skills programme. How does the educator handle this aspect of the programme?

Yes, that's a difficulty especially if you have boys and girls. To be honest I had some difficulty so I try to neutralize my terms that I use with them but I know in the past we usually have it separate for the boys and separate from the girls. But I think definitely that we need guidance on how to actually present that.

Boys and girls should be separate. There are certain things you can have them together but I feel they should be separated.

- 4.4. Do you think that sexuality education as part of the HIV/AIDS programme should be addressed at Primary School level?

Yes, I think so definitely.

- 4.5. If yes, why?

Because they're entering into primary school. They are in grades 6, 7 – most of them are like 12, 13 years, they are on the brink of puberty, some of them attained puberty etc. so they need to know definitely. And while they're young it's better for them to know.

If no, why not? *N/A*

Learner Infection:

4.6. Have you any knowledge of learners who are HIV-positive in your school?

No

4.7. Are there any identifiable cases? *N/A*

4.8. How does your school support learners who are affected/infected by HIV/AIDS? *N/A*

4.9. Are there any HIV/AIDS orphans in your school and how are they supported by the school?

Not that I know of.

5. SGB/Networking:

5.1. How is the SGB facing the challenge of HIV/AIDS education in your school?

They have discussed the issue but nothing practical has been done so far.

5.2. What is being done about HIV/AIDS in your school community?

Nothing really significant at the moment.

5.3. What are the views of parents with regard to Sexuality Education being part of the Life-skills programme?

Parents realize that it is important as long as it's done appropriately and discretely.

5.4. Did you have a special form/meeting where Sexuality Education was discussed with the parents?

No

5.5. If yes, what kind of feedback did you get from your parents? *N/A*

5.6. Are there any organizations who are working with your school to assist learners/parents who are affected/infected by HIV/AIDS?

No, but I do know of an orphanage called Bietal Noor.

5.7. If YES, name the organisation.

Bietal Noor – but they offer other forms of support as well.

... End of Interview...

APPENDIX C
A SEMI STRUCTURED INTERVIEW FOR INTERMEDIATE PHASE
EDUCATORS

A. Biographical Details:

1. Name of school:
2. Sex:
3. Age:
4. Race:
5. Qualifications:
6. How many years have you taught in this phase?
7. Have you attended any training programmes?
8. Which schooling phase are you trained to teach?
9. What intermediate phase grades are you trained to teach?
10. Is there any other information you would like to share?

B. Interview Schedule:

1. Personal Knowledge:

- 1.1. What is it you know about HIV/AIDS? If NO knowledge, do you wish to gain some or obtain formal training regarding HIV/AIDS?
- 1.2. What is your understanding of Sexuality Education?
- 1.3. How does your culture impact on HIV/AIDS knowledge?
- 1.4. Do you have any prejudices?
- 1.5. How comfortable do you feel teaching this topic?
- 1.6. Do you think you would be able to support an HIV/AIDS learner?
- 1.7. Do you know of any AIDS victim? Have you been in contact with an AIDS victim?
- 1.8. Being male/female impact on teaching HIV/AIDS?

2. The HIV/AIDS Policy

- 2.1. How important is it to you that this topic be part of an AIDS programme?
- 2.2. What is your knowledge of the Department of Education Policy regarding HIV/AIDS?

- 2.3. Are you familiar with the Department of Education Policy on HIV/AIDS eg. TIRISANO?
- 2.4. How supportive is your principal/HOD regarding teaching this topic?
- 2.5. Is the school well equipped eg. Charts, etc.

3. Teaching and Learning

- 3.1. Is there a specific way that you teach HIV/AIDS awareness to learners – if so why is it being taught in this way? Which do you think is the best way/medium?
- 3.2. How thoroughly do you cover this topic?
- 3.3. How competent do you feel teaching this topic?
- 3.4. What is the most difficult thing about sharing this information?
- 3.5. How do you contextualise HIV/AIDS?
- 3.6. What do you think learners preconceptions are?
- 3.7. Are you aware of the myths that surround learners knowledge of HIV/AIDS?
- 3.8. Do you think that learners are too young to be aware of this knowledge? If so, then whose decision is this?
- 3.9. Any reactions from parents?

4. Learner Support

- 4.1. Are you aware of any learners who are infected/affected by HIV/AIDS?
- 4.2. Are there any AIDS orphans in the grades that you teach?
- 4.3. How would you support them if this was the case?
- 4.4. Are there any NGO's who you know of who you could consult?
- 4.5. What are the ways in which the school can help/support learners who are infected/affected by HIV/AIDS?

APPENDIX D
QUESTIONNAIRE: LEARNERS IN THE INTERMEDIATE PHASE

Age: _____

Grade: _____

A.

1. What is HIV?

2. Name the ways how HIV/AIDS is spread?

3. Can HIV/AIDS be cured?

4. A HIV-positive person can live a long time if they follow a healthy lifestyle:

YES ☐ NO ☐

5. Breast fed babies of HIV infected mothers also get HIV/AIDS.

YES ☐ NO ☐

6. Why is it important for all learners to learn the right information about HIV/AIDS?

B.

1. Where did you learn about HIV/AIDS?

2. If you want to know more about HIV/AIDS, who would you ask?

3. My parents teach me about my body and how to take care of myself:

YES ☐ NO ☐

4. I think people who are suffering from HIV/AIDS should come to talk to us about their experiences:

YES ☐ NO ☐

C.

1. Can you hug/kiss a person who is HIV-positive?
YES ☐ NO ☐
2. If your best friend is HIV-positive, would you still be friends with him/her?
YES ☐ NO ☐
3. One of your teachers is HIV-positive. Would you be happy to be in his/her class?
YES ☐ NO ☐
4. Do you feel shy/ashamed to talk about HIV/AIDS?
YES ☐ NO ☐
5. Do you feel shy/ashamed to talk about Sexuality Education in the class?
YES ☐ NO ☐
6. Do you think that girls and boys should be taught separately about Sexuality Education?
YES ☐ NO ☐
7. If a learner is HIV-positive, he has the same rights to education as a HIV-negative learner?
YES ☐ NO ☐
8. Your teacher/principal may not tell anybody that a learner has HIV, without asking the learner first?

D.

1. Do you think that HIV is a punishment from God?
YES ☐ NO ☐
2. Do you think that only gay people get HIV?
YES ☐ NO ☐
3. Who are the people most likely to get HIV?

Thank you for completing the questionnaire.

 **AIDS HELPLINE: 0800 012 322** 

APPENDIX E - EXCEL DATA ANALYSIS

Analysis per Grade

Q1	Virus	Disease/ Sickness	Non-contagious disease	Aids	Other
A	5	85	7.5	2.5	0
B	40	52.5	0	2.5	5
C	87.5	7.5	0	0	5

Q2	Mixing blood	Unprotected sex	Pregnant/ Breastfeeding	Transfusions/ Infected Needles	All of the Above	Unknown
A	50	10	22.5	0	5	12.5
B	42.5	32.5	0	5	12.5	7.5
C	2.5	10	2.5	7.5	75	2.5

	% YES	% NO	% CONFUSED
Q3			
A	50	47.5	2.5
B	2.5	95	2.5
C	5	95	0
Q4			
A	85	15	0
B	62.5	37.5	0
C	82.5	17.5	0
Q5			
A	85	15	0
B	82.5	17.5	0
C	95	5	0

Q6	Knowledge	Protection	Avoid Myths/ Correct attitude	Help infected	No Answer
A	37.5	35	5	7.5	15
B	25	65	5	5	0
C	12.5	37.5	42.5	5	2.5

Analysis of Intermediate Phase

Virus	Disease/Sickness	Non-contagious disease	Aids	Other
44.17	48.33	2.50	1.67	3.33

Mixing blood	Unprotected sex	Pregnant/Breastfeeding	Transfusions/Infected Needles	All of the Above	Unknown
31.67	17.50	8.33	4.17	30.83	7.50

% YES	% NO	% CONFUSED
19.17	79.17	1.67
76.67	23.33	0.00
87.50	12.50	0.00

Knowledge	Protection	Avoid Myths/ Correct attitude	Help infected	No Answer
25.00	45.83	17.50	5.83	5.83

Q7	teacher/ school	parents	TV/radio	books/ newspapers	peer	people suffering	unanswered	teacher/school	parents	TV/radio	books/newspapers	peer	people suffering	unanswered
A	25	15	30	5	7.5	5	12.5	64.17	5.83	14.17	3.33	2.50	1.67	8.33
B	82.5	2.5	7.5	2.5	0	0	5							
C	85	0	5	2.5	0	0	7.5							

Q8	teacher	parent	teacher/ parent	doctor/ scientist	helpline	unanswered
A	15	25	20	25	5	10
B	17.5	15	42.5	5	15	5
C	35	10	20	10	25	0

teacher	parent	teacher/parent	doctor/scientist	helpline	unanswered
22.50	16.67	27.50	13.33	15.00	5.00

	% YES	% NO	% UNKNOWN
Q9			
A	100	0	0
B	97.5	2.5	0
C	95	5	0
Q10			
A	92.5	5	2.5
B	90	10	0
C	95	5	0
Q11			
A	75	25	0
B	45	55	0
C	95	5	0
Q12			
A	90	10	0
B	82.5	17.5	0
C	97.5	2.5	0
Q13			
A	77.5	22.5	0
B	65	35	0
C	77.5	22.5	0
Q14			
A	35	65	0
B	40	60	0
C	10	90	0
Q15			
A	52.5	47.5	0
B	55	45	0
C	35	65	0
Q16			
A	42.5	57.5	0
B	75	25	0
C	60	40	0

% YES	% NO	% UNKNOWN
97.50	2.50	0.00
92.50	6.67	0.83
71.67	28.33	0.00
90.00	10.00	0.00
73.33	26.67	0.00
28.33	71.67	0.00
47.50	52.50	0.00
59.17	40.83	0.00

	% YES	% NO	% UNKNOWN
Q17			
A	80	12.5	7.5
B	90	10	0
C	97.5	2.5	0
Q18			
A	55	12.5	32.5
B	75	12.5	12.5
C	80	15	5
Q19			
A	10	82.5	7.5
B	20	80	0
C	30	70	0
Q20			
A	15	85	0
B	0	100	0
C	2.5	97.5	0

% YES	% NO	% UNKNOWN
89.17	8.33	2.50
70.00	13.33	16.67
20.00	77.50	2.50
5.83	94.17	0.00

	bad cond./ poverty	blacks	unsafe sex/ drugs/ alcohol/ rapists	prostitutes/ nude ppl	unanswered	mixing blood	anybody
Q21							
A	10	37.5	10	2.5	40	0	0
B	7.5	20	32.5	5	22.5	7.5	5
C	27.5	10	42.5	5	5	2.5	7.5

bad cond./poverty	blacks	unsafe sex/drugs/alcohol/rapists	prostitutes/nude ppl	unanswered	mixing blood	anybody
15.00	22.50	28.33	4.17	22.50	3.33	4.17

Legend:

A -	Grade 4, 9-10 years old, 40 learners
B -	Grade 5, 10-11 years old, 40 learners
C -	Grade 6, 11-12 years old, 40 learners

Total Number of learners: 120